

Comments from some of these providers:

Notification of transfer/discharge as required by regulations is unnecessary since it is agreed upon and reviewed regularly with the resident.

Rules for transfer/discharge should be the same as in a hospital.

Notice requirement can slow up timely discharge.

When residents no longer need services, they should be able to be transferred.

There is currently no way to move residents out of the facility or room without their consent.

Facilities do not have the freedom to discharge residents when they no longer require subacute care.

We need the capability to transfer residents between rooms without a 30 day notice.

The facility should have the right to discharge a patient if s/he does not follow plan of care.

Activities, Social Work or Dental Care

"Regulations mandating services like activities or dental care are geared toward longer-staying residents."

When providers explained their reasons for wanting particular changes in regulations, several themes emerged. The most commonly cited complaint (22 providers) was that regulations mandating services like activities or dental care were geared toward longer-staying residents. Similarly, 5 providers felt that subacute residents actually did not want these mandated services as they do not consider themselves to be long term nursing home residents. An additional 5 providers felt that subacute residents were often too sick to participate in activities or to receive dental care.

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

Providers offering subacute services were more likely to believe that dental regulations should be waived or changed (chi square = 4.16; $p < .04$).

Providers who believe that these regulations are not needed stated:

These residents are only interested in completing therapy or care treatment and returning home.

Subacute residents are not interested in activities and prefer not to participate.

Residents are in for a short period of time. It is difficult to complete required dental work.

Social work should be for discharge planning only.

There is little need for social work during short term stay.

Assessment

"MDS + assessment requirements are too cumbersome due to timing of assessments vs. length of stay of some subacute residents."

Another large group of providers (17) felt that the timing specified in existing regulations often was not appropriate for short stays. For example, one provider points out that the MDS+ is a lengthy assessment tool that must be completed within three weeks of admission (sic), when some short-stay residents are about to return home. Thirteen providers (13) felt that the assessment tools mandated by regulations were not designed with short-stay residents in mind. The MDS+, in particular, was singled out as too lengthy and not targeting areas relevant to short-stay residents. Ten (10) providers found the existing documentation requirements too lengthy and cumbersome for residents who only remain in the facility for a short time.

Comments from these providers:

It is unrealistic to expect the same services and paperwork compliance for short term stays.

Paperwork is very difficult to maintain, particularly on short stays (less than 10 days).

MDS+ does not drive the care plan.

Assessment needs to be quicker than the 14 days required.

MDS+ is geared for the traditional long term care resident.

Assessments should be similar to what is done in hospitals for the subacute resident.

All of the assessment requirements for activities, dental and social work would not be done if a person just stayed in the hospital - it makes assessment and care in these areas excessive compared to a hospital.

Adapt the MDS system and let us do what we do best, love and care for all residents.

A short screen for most people could work better as a trigger to larger problems.

General Comments About Regulations

Unless an individual is looking at long-term subacute, their condition makes many of the regulations less beneficial.

These regulations are not really appropriate.

I believe separate regulations should be adopted specifically for subacute.

There should be a separate category with modified regulations.

For short-term, much of the regulations are excessive and costly, provide little benefit, detract from resources needed to actually address real problems.

The trend seems to be for very short-term under managed care - regulations are for long-term residents.

Regulations should be modified to reflect acute care regulations.

Let individual patients' needs drive what is provided.

Other Regulations That Should Be Changed

Other regulations that some providers believed should be waived or changed included: reimbursement (6); the traditional admission agreement (2); care planning (2); medicare regulations re: 3 day hospitalization (1); podiatry/audiology/vision (1); homelike environment issues (1); wearing personal apparel (1); physical plant in facility with existing buildings (1); PRI/ Screen (1); medical services (1); quality of standards of care provided (1); more staff (1); dietary (1).

Six providers complained that they were not reimbursed sufficiently to provide mandated services to subacute residents. Finally, three providers complained that they found state regulations to be burdensome in general, while three others felt that greater flexibility was needed when caring for subacute residents.

Comments on reimbursement issues:

There is not enough reimbursement.

IV fluids, tracheotomy equipment, air compressor, tubes not reimbursed.

Medicaid reimbursement does not adequately address subacute care in New York State.

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 resident¹⁸ per day, although the majority (63.6%) did endorse it.

Many providers (14) that disagreed with this staffing guideline felt that fewer hours of skilled nursing care would be sufficient. Others (39) believed that the number of hours of skilled care provided should vary according to the needs of individual

¹⁸This 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 they believed that most traditional nursing home residents should get almost 4 hours per day. At least 5 hours was considered appropriate for subacute.

residents, and that staffing needs for a particular resident might change over the course of treatment. Four (4) providers felt that such extensive skilled care might be overwhelming or intrusive for some residents. Finally, seven providers felt that this guideline was unrealistic given current levels of staffing and reimbursement, and one provider calculated that hospital staffing levels were geared toward providing only 3 hours a day of skilled nursing care per patient.¹⁹

Table 23: Requirements or Guidelines

<u>GUIDELINE</u>	<u># CITING</u>	<u>% CITING</u>
Provide interdisciplinary team	217	99.1
Staffed by qualified, trained professionals	212	97.7
Meet both medical and non-medical needs	207	95.8
Identify measurable objectives and timetables for each patient	208	95.0
Frequent patient assessment	194	90.7
Provide 5.5 to 7 hours of skilled nursing care per patient per day	133	63.6

Significant Differences By Sponsorship

Public facilities were more likely to agree with the guideline recommending 5.5 to 7 hours of skilled care per day, while voluntary facilities were less likely (chi square = 7.36; $p < .02$).

Significant Differences By Size

Smaller providers were more likely to agree with the guideline to identify measurable objectives for each resident (chi square = 4.01; $p < .05$).

¹⁹The American Health Care Association, in "Facts and Trends: The Subacute Care Sourcebook, 1995, states, "Patients requiring subacute care generally need between 4 and 7 hours of skilled nursing care each day - compared to 8 or 9 for acute hospital patients and about 3 for nursing facility residents (p.2)."

Significant Differences By Case Mix Index

High CMI facilities were less likely to agree with the guideline suggesting that facilities identify measurable objectives for each resident (chi square = 4.57; $p < .03$).

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

Providers offering subacute care were less likely to agree with the suggested guideline of 5.5 to 7 hours of skilled care per day (chi square = 5.67; $p < .02$).

Logistic regression analysis indicates that both size (at a trend level of significance) and case mix index are the determining factors.

Comments from those few providers who disagreed with the guidelines:

Due to the fact that our residents often have multiple diagnoses, outcomes and timetables for an acute event are often inappropriate and may be undefinable.

We can't set timetables. It depends on the individual.

If subacute care is not effective as per clinical progress, the resident should be hospitalized immediately.

What if the patient doesn't need timetables which may be set by managed care companies interested in reimbursement rates?

Don't need an interdisciplinary team including clinical, rehabilitation and social work because residents are short-term stays.

Rural areas may not always have specialty professionals.

The guideline suggesting that the units be staffed by qualified and appropriately trained individuals is only realistic within the reimbursement stream and the needs of the residents.

There may not be a need to assess frequently.

Obstacles to Providing Subacute Services

Providers saw a number of obstacles to providing subacute care in New York State. By far, the most commonly cited obstacle (almost 90 percent) was insufficient reimbursement.²⁰ Problems in applying existing regulations to subacute care were also cited by more than half of the providers.

Table 24: Obstacles to Providing Subacute Services

<u>OBSTACLE</u>	<u># CITING</u>	<u>% CITING</u>
Insufficient reimbursement to cover costs	208	89.3
Existing regulations inappropriate for subacute services	131	56.2
Physical plants do not meet the needs of subacute care	100	42.9
Difficult to keep beds filled with appropriate patients	100	42.9
Physicians are not available to work in nursing homes for the time needed	90	38.6
Difficult to attract qualified staff to the nursing home setting	55	23.6

Other obstacles described by providers included: competition with hospitals (4); NYS doesn't recognize distinct units for reimbursement purposes (3); holidays and appointments to specialists cause therapies to be missed (1); insurance companies very slow to pay - cash flow a problem (1); current discharge regulations for acute care hospitals make it difficult to get residents to leave - no leverage to move out (1); the philosophy of care is different in many aspects i.e., not as aggressive in treatment modalities, hospice, etc.(1); availability of medical specialists in rural areas (1); educating Mds, HMOs, hospitals & government as to the ability of

²⁰Some of the providers called in followup telephone calls who were part of the federal case mix demonstration project for Medicare, believed that the reimbursement rates used in the project were adequate.

nursing homes to provide subacute in more cost effective setting (1); managed care companies do not adequately recognize the role of nursing homes in subacute care (1); lack of community services available to the patient prevents a discharge which often creates a nursing home resident who shouldn't be there (1); RUGS III (Resource Utilization Groups version III: federal reimbursement system) has improved reimbursement issues some (1).

Significant Differences By Sponsorship

In discussing obstacles to providing subacute care, public providers were more likely to endorse keeping beds filled with appropriate residents, while proprietary facilities were less likely to report this as a problem (chi square = 5.90; $p < .05$).

Significant Differences By Size

Smaller facilities were more likely to complain of a shortage of doctors willing to work in nursing home settings (chi square = 9.12; $p < .003$).

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

Facilities offering subacute services were more likely to feel that inappropriate regulations were a barrier to providing subacute services (chi square = 5.24; $p < .02$).

Significant Differences By Location

Upstate facilities were more likely to complain about inappropriate regulations as a barrier to providing subacute services (chi square = 4.43, $p < .04$).

Benefits of Subacute Care

Despite the obstacles discussed above, providers saw many benefits of subacute care to both residents and providers. 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.

Table 25: Benefits of Subacute Care

<u>BENEFITS</u>	<u># CITING</u>	<u>% CITING</u>
Increased case mix index	198	85.0
Shorter hospital stays	195	83.7
Lower health care costs	190	81.5
Less frequent hospitalizations for nursing home residents	185	79.4
More stimulation and activities than in hospital	174	74.7
Provide new areas of recruitment to maintain patient census	132	56.7
Attracting more qualified staff	96	41.2
Increased profits/surplus	78	33.5

In addition, individual providers cited other benefits for nursing home staff, traditional residents, facilities, and the larger community.

Benefits to staff included providing more challenges (2) and increasing the skills of existing staff (2). Five (5) providers felt that subacute care made more clinically skilled care available to the traditional chronically-ill, geriatric resident and made staff more sensitive to their needs.

Benefits to facilities included offsetting deficits (4) and improving their image in the community (2). Finally, two (2) providers felt that subacute care helped meet community needs.

Significant Differences By Sponsorship

Proprietary facilities were more likely to report that increased profits were a benefit of subacute care while voluntary facilities were less likely (chi square = 12.01; $p < .002$).

Significant Differences By Size

Larger providers were more likely to see increasing the case mix index as a benefit

of subacute care (chi square = 8.09; $p < .004$).

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

Providers offering subacute services saw several benefits to subacute care, including fewer hospitalizations for nursing home residents (chi square = 4.33; $p < .04$); attracting more qualified staff (chi square = 6.79; $p < .009$); increasing case mix index (chi square = 6.35; $p < .05$), and increased profits (chi square = 4.96, $p < .03$).

Significant Differences By Location

Downstate facilities were more likely to see increasing the facility's case mix as an advantage of subacute care (chi square = 6.09, $p < .01$).

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

"There should be an increase in revenue to the nursing homes through the Medicaid reimbursement system earmarked solely for staff education, training and inservice."

The largest group of providers responding to this issue (63) felt that increased reimbursement or new sources of funding would allow providers to hire more, better trained staff.

Comment:

We need more reimbursement to allow for hiring more staff.

Others suggested other ideas: 28 suggested more extensive training within homes, or various creative solutions for recruiting trained staff. These included scholarship programs, affiliations with colleges and hospitals, state- and union-sponsored training programs, and using attending physicians to teach nursing home staff.

There should be demonstration projects funded.

Train current staff for all care areas - cross train.

Educate high school students of the attractiveness of these positions.

Develop programs for the certification of nurses.

This is hard to solve. Nursing homes still have a stigma or are not desirable for prospective employees.

The administration of some facilities need to be more selective in hiring staff.

Seventeen providers (17) felt that this would not be a problem in New York State, particularly in light of downsizing at area hospitals. Two (2) suggested reducing documentation requirements to free up staff time for direct care, while two (2) other providers suggested drafting regulations to mandate better staffing ratios.

Some comments:

With current hospital-wide layoffs, trained staff would be available.

Certified rehabilitation and occupational assistants are as qualified as certified therapists.

Two (2) providers suggested establishing staffing ratios for subacute units and requiring monitoring their compliance.

Violation of existing regulations (particularly transfer/discharge)

"As in hospitals, we need to have the right to move people according to level of care needed."

The overwhelming majority of providers (72) 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. Most believed that existing regulations should be waived or new regulations written specifically geared toward the needs of subacute care.

Only three (3) of these providers advocated more stringent regulations or documentation requirements to prevent violations of patient rights related to

transfer or discharge, while one (1) called for clarification of existing requirements as they relate to subacute residents. Other providers (8) called for more careful planning during the admissions process, so that the plan of care would include eventual discharge plans for subacute residents.

Some comments:

There should be more severe penalties including mandatory documentation.

On admission, discharge or transfer plans should be discussed and worked on by comprehensive care team including the resident. If in fact the team understands the complexity of the problem and plans accordingly for discharge there should be no violation of any regulation.

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. Three (3) of these providers expressed the opinion that it was the former "HRF" (health-related) resident, rather than the traditional SNF (skilled nursing) resident, that experienced difficulties in finding a long term care bed.

Another large group of providers (35) suggested that increased reimbursement by Medicaid or cultivating alternative sources of funding could prevent this problem. Finally, individual providers suggested a number of changes in regulations or facilities to make more beds available. For example, providers suggested establishing distinct units for Medicaid residents, or to accommodate each classification of patient. Others suggested turning unused acute care beds over to subacute or long term care. Others suggested easing certificate of need requirements to add subacute beds.

Some comments:

Legislation should be provided to encourage the purchase of long term care insurance.

Medicaid does not reimburse me enough for traditional long term care residents.

We should establish a network of facilities to provide for these needs before we start subacute care.

Allow more life care communities.

This would have to be worked out through alliances and partnerships so that the needs of these residents would not be overlooked. This concerns me as an ethical issue.

Perhaps develop a discrete unit within the long term care system that would address the needs of rehabilitative residents who no longer qualify for subacute care services.

Establish Medicaid-only beds.

Doing needs assessments would identify the number of beds needed for specialty programs.

Enact presumptive Medicaid legislation.

This will continue until someone takes the initial step in using the oversupply of acute care beds.

There should be prior approval for subacute units. However, I don't think this is as much of a problem as portended.

More medical model

"This is not a problem."

"Residents with complex needs create a more "medical model." Facilities should limit their numbers to ensure a less medical model for other residents."

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 (52) 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.

Some comments:

Yes, we already have a medical model.

What does this mean, we take care of chronically ill, and do it well.

We should align nursing homes with hospitals.

We should change the regulations from "homelike environment."

Please remember that when regulations came into existence most long term care facilities who had the capability increased their case mix adding what you call subacute residents. Nursing homes already look like the hospitals of the past.

Other providers did suggest ways to limit the impact of a more medical model on traditional residents. Eight (8) providers called for carefully balancing the needs of these two groups of residents by attending carefully to psychosocial as well as medical needs. One (1) of these providers even suggested limiting the number of subacute residents admitted to a facility. Seven (7) providers suggested separating traditional and subacute residents to create distinct programs tailored to each population. Seven (7) providers felt that changes in staffing, such as hiring nurse practitioners, a more highly trained nursing staff, or geriatrician, would reverse some of the shift to a medical model.

Some comments:

The biggest problem integrating subacute care into a residential health care facility is the fact that the higher acuity and acute care mentality diminishes the home-like care and setting.

Concurrent development of assisted living should alleviate some of this pressure.

We need to balance the medical and social needs.

Psychosocial aspects must be involved.

Health care is changing, but surveillance, educated consumers and regulations are needed.

Finally, 17 providers blamed insufficient reimbursement or excessive regulations for this shift in model. Some believed that additional funding would enable facilities to meet psychosocial needs more fully. Others felt that existing regulations emphasized a medical model, leading to "excess medical management" in some cases.

Some comments:

Liability and fears of litigation prompt excess medical management in some cases.

We need more reimbursement.

The issue is managed care reimbursement model.

Advancing the assessment skills of nurses will help.

Appropriate staff must be maintained.

Residents not prepared for move to another bed

A number of providers (34) 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 discharge²¹.

Some comments:

I can't imagine how this could happen. We will never have ICU's (intensive care units) so the range of acuity for nursing home residents should not be affected by a bed transfer.

Residents are not prepared in hospitals yet they move from the emergency rooms to operating room to recovery to acute care to alternate level of care.

All New York State beds are Medicare certified, therefore movement is less common.

This is not a priority to appropriate cost-saving care.

²¹This 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.

Residents should be prepared and moved depending on their medical need - this isn't a real problem.

A large group of providers (37) suggested particular interventions to make the transfer process smoother. Of these, 20 felt that transfer and discharge policies need to be made clear to subacute residents in advance to avoid confusion or distress after subacute care is complete. Ten (10) suggested increased social work involvement to facilitate the process, while two (2) felt increased family involvement would be helpful.

Some comments:

Provide educational procedures for residents and families.

Conduct team meetings between the rehabilitation team and the long term care unit staff prior to the transfer.

Twenty three (23) providers cited changes in the structure of facilities or in regulations that might address this issue. Suggestions included establishing transitional units, extending coverage if additional days of care are required, integrating subacute care into the facility as a whole so residents would not have to move when subacute care was complete, more thorough assessment and discharge planning, and changes in the regulations to require shorter notification periods prior to transferring shorter-stay residents.

Some comments:

If any bed can serve any need, why move the resident?

We should integrate subacute and long term care residents in the same units.

There should be standard guidelines for transfers.

Decline in traditional residents' quality of life

Many providers (35) 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).²² Many expressed the opinion that all of the efforts

²²Many consumers feel that a shift from a social model to a medical model will lead to a decline in resident quality of life.

of nursing homes and regulators were geared toward enhancing residents' quality of life.

Others suggested ways to ameliorate this potential problem. Nineteen (19) providers felt that this problem could easily be controlled by good management and vigilance on the part of providers.

Other providers (15) felt that separating traditional and subacute residents would be the best way to avoid this problem for traditional residents. Seven (7) providers pointed to increased reimbursement as the best way to avoid decreased services to traditional residents.

However, 12 providers stated that this was a problem already, and might be the inevitable result of the changing focus in long term care.

Some comments:

Facilities must not let this happen.

There should be more activities for each level of the resident population.

Staff must be aware of the residents' individuality.

Programs relying on cross-trained staff of other disciplines will help maintain one-to-one interaction and socialization so important to maintain quality of life.

There should be separate units.

We should reduce numbers of subacute residents and integrate them into the general resident population.

Have separate social and activity programs.

If more money was paid for subacute care, resources wouldn't be so limited for everyone.

Guidelines for Subacute Care

"Guidelines must be appropriate for subacute needs."

Providers were asked what guidelines they would suggest if they could write the

guidelines for subacute care in New York State.

Some providers suggested using the JCAHO guidelines (5).

One (1) provider believed that we needed regulations often suggested by the Nursing Home Community Coalition of New York State as well as surveillance and educated consumers.

Some comments:

I believe we should start from scratch and truly define what we are trying to create.

There should be a universal definition for subacute.

There should be training guidelines and assessment requirements.

Timely team conferences should include residents.

There should be stated hours of nursing care, medical coverage and extent of rehabilitation services.

There should be a full-time medical director on the premises.

There should be competent staff.

Clinical paths must meet "standard of care." There should be an evaluation of client response and outcomes resulting from care provided.

The needs of children and other special populations must be adequately reflected.

Some providers believed that the regulations for all nursing home residents were fine.

CHAPTER SIX:
COMPARISON OF CONSUMER RESPONSES AND PROVIDER RESPONSES

Responses From Consumers and Providers Were Similar On A Number Of Issues

Types of Services

Reports of the types of services given by the consumers across the country were somewhat similar to the types of services offered in New York State. The most frequent reported services by consumers were also the most frequent services being offered in New York State: rehabilitation and wound management.

Payer Source

Medicaid seems to be more of a payer in New York State, with 73.9 percent of the provider respondents stating that Medicaid was a payer. Only 52.7 percent of the consumers stated that Medicaid was a payer in their states.

Potential Benefits

Most of the provider respondents in New York State cited shorter hospital stays and less frequent hospitalizations for nursing home residents as potential benefits of subacute care. Many consumers across the country agree that these significant benefits were realized.

Obstacles to Offering Subacute Care

Over half of the advocate respondents agreed with the providers that there were significant obstacles to providing subacute care, such as insufficient reimbursement.

There Were Significant Differences Relating To The Need For Regulations

Need for Regulations

It is here that consumer and provider responses differ most significantly. Most providers believe that there is too much regulation already and that many of the regulations for traditional nursing home residents should not be used for subacute residents. Many advocates voiced the need for guidelines or regulations covering subacute care.

Violations of Regulations

While more than a third of the advocate respondents stated that nursing home

regulations were being consistently violated by subacute providers in their states and that the most common regulation reported to be violated was transfer/discharge followed by activities, provider respondents did not seem to think that this was a problem. The overwhelming majority felt that the best way to avoid the problem of violating these regulations (which they believed were not needed) found in other states was to change the existing regulations for providers of subacute care.

Need to Change Regulations

Although almost a quarter of the consumer respondents believed that regulations should be changed for subacute providers, most of these believed they should be strengthened, not weakened, to protect subacute residents. Most provider respondents want to waive or change regulations like activities, transfer/discharge, or dental care because many believe they are not geared for the shorter stay resident.

Over 40 percent of the consumer respondents believed that regulations should not be changed because subacute residents had the same as or more needs than traditional residents.

Thus, over 53 percent of the consumers believe that the nursing home regulations should remain as they are or should be strengthened.

Need to Strengthen Transfer/Discharge Regulations

One of the reasons that many advocates urged strengthened transfer/discharge regulations for subacute residents is because of their experiences with subacute residents when their insurance runs out or they no longer need subacute care services. Most of the consumers stated that residents who must move from their room are either not prepared for the move or are prepared only some of the time. Of those respondents who reported that the resident cannot even stay in the same facility, most reported that the residents are either not prepared for this move or are prepared only some of the time.

Differences in Provider Responses

Managed Care

Large nursing homes and downstate nursing homes were more likely to cite establishing close relationships with managed care companies as a reason for offering subacute services and were more likely to accept reimbursement from managed care companies. As discussed above, the determining factor seems to be location: downstate facilities offering subacute services seem to rely more on

managed care. This is not surprising as managed care has taken on more of a hold downstate. As managed care becomes more a force, we may see more and more upstate nursing homes relying on managed care reimbursement.

It is also interesting to note that sponsorship also has an effect here. Proprietary facilities were more likely to accept managed care reimbursement for subacute services.

Separate Units

Large, downstate facilities with high case mix index were more likely to have separate units for subacute residents.

Evaluation of Program Success

Although asked, no provider respondent stated what outcome measure she or he used. Downstate facilities were more likely than others to state that they evaluate their success in terms of resident outcomes.

Destination of Residents After Subacute Program

Voluntary facilities were less likely to report that their residents were moved to another unit once subacute care was no longer needed. Public and larger facilities were more likely to move these residents.

Interaction Between Residents

Proprietary facilities felt that interaction was more beneficial to both traditional and subacute residents than the other facilities and small facilities felt that the interaction was more beneficial to traditional residents than larger providers.

Waiving or Changing Transfer/Discharge Regulations

Facilities with a high case mix index tended to feel that regulations regarding transfer/discharge should be waived or changed.

Agreement With National Guidelines

Public facilities were more likely to agree with the guideline recommending 5.5 to 7 hours of skilled care per day, while voluntary facilities were less likely. A significant finding is that facilities offering subacute care were less likely to agree with this guideline. Thus, those who now give subacute care may not be giving residents this much skilled care, not believing it is necessary.

Smaller facilities were more likely to agree to identify measurable objectives for each resident. High case mix facilities were less likely to agree with this guideline.

Obstacles

Public facilities were more likely to feel that keeping beds filled with appropriate residents was an obstacle, while smaller facilities were more likely to complain of a shortage of doctors willing to work in nursing home settings.

Facilities now offering subacute services and upstate facilities complained more of inappropriate regulations.

Benefits

Downstate facilities and large facilities were more likely to see increasing case mix as an advantage.

Proprietary facilities were more likely to see increased profits as a benefit of offering subacute services.

Facilities now offering subacute services saw many benefits to both residents and providers: fewer hospitalizations for residents, attraction of more qualified staff, increasing the case mix, and increased profits were seen as benefits of subacute services.

CHAPTER SEVEN: **DISCUSSION**

Have Potential Positive Effects of Subacute Care Been Realized?

Less Hospitalization; Shorter Hospital Stays; Benefit of Remaining in the Nursing Home

There was agreement about this positive effect of subacute care in nursing homes. Both consumers and providers believe that subacute care can lead to less frequent hospitalizations for traditional nursing home residents as well as cut down on the length of time needed to be in the hospital. While fewer than the providers, nearly half of all the advocates believed that subacute care did result in less frequent hospitalizations for residents some or most of the time (this was 72 percent of the consumers who felt confident of giving an answer;²³ 48 respondents out of 67), while slightly more than half (or 95 percent of those that were not unsure; 41 out of 45) agreed that subacute care was instrumental in shortening hospital stays some or most of the time.

In addition, nearly half of the consumers believed that residents were better off in the nursing home than in a hospital because of a less clinical atmosphere and greater access to activities and social stimulation.

It is interesting to note that although so many cited this as an advantage, 45 percent of the provider respondents want to change or waive activities regulations and over 18 percent want to change or waive social work regulations. If these regulations are waived, some of the most significant benefits of remaining in the nursing home from the consumer perspective may be lost.

Almost 84 percent of the providers that responded stated that a benefit of subacute care is shorter hospital stays and almost 80 percent named less frequent hospitalization for nursing home residents.

Attracting More Qualified Staff

Providers and many consumers also agree on this issue. And, almost 98 percent of the providers agreed with the JCAHO guideline that suggests that subacute services should be staffed by qualified, trained professionals.

²³Most questions had "unsure" as a choice response. Thus, we assume that those who did not choose "unsure" felt confident enough about their experiences to answer the question.

Over 43 percent of the consumer respondents believed that subacute care does attract more qualified staff some or most of the time to the nursing home (a large number disagreed: 27.9 percent). In addition, 57 percent believed that traditional residents had access to these skilled services some or most of the time.

Focus on Speedy Recovery and Preparation for Discharge

Almost 90 percent of the providers believe that residents with short-term rehabilitation goals are appropriate for subacute care and 95 percent agreed that subacute care services should identify measurable objectives and timetables for each resident.

Less Costly Setting

Over 80 percent of the providers believe that one of the benefits of providing subacute care in the nursing home is lowering health care costs. However, it is interesting to note that many of the provider responses wrote of the need to provide more reimbursement for subacute care. It is possible that they believe that even with more reimbursement for subacute care in nursing homes it would still be less costly than hospital care.²⁴

Meeting the Continuum of Care Needs

Almost 72 percent of the providers who responded to the questionnaire stated that "meeting the continuum of care needs," was a reason to offer subacute care services.

What About Potential Negative Effects of Subacute Care?

Quality Care Will Suffer Because of Focus on Profit

According to advocate responses, this is still an open question and perhaps the reason why so many urged either not changing present regulations or strengthening regulation. Most advocates who responded report that the quality of care varies among facilities. However, even though most believe that at least some facilities in

²⁴In follow-up telephone interviews, a number of providers indicated that reimbursement as part of the Medicare Case Mix Demonstration Project seems to be adequate. It would be interesting to find out if more participants agree. In addition, some providers have indicated that at present, managed care companies are paying high rates for subacute care. This may change as more and more nursing homes compete for this market.

their area provided high quality care; many believe that the care is uneven. It is important to note that over 30 percent were unsure whether subacute providers in their area provide high quality care.

Quality Will Suffer Because of Few Guidelines or Regulations

The majority of consumer respondents believed that regulations should either remain the same or be strengthened to protect subacute residents. They do not want regulations weakened.

Consumers were asked about their experiences related to providers' following of JCAHO guidelines. Responses indicated that there was great variability in compliance with these guidelines for subacute care. When asked if providers followed the guidelines related to the use of interdisciplinary teams and weekly assessments, only about 15 percent stated that providers do not; almost 30 percent felt that most providers were using interdisciplinary teams and weekly assessments. However, 22 percent have experienced that providers are not giving the suggested number of hours of skilled nursing care; only a little over 19 percent believed that most providers were supplying this level of care.

The overwhelming majority of the providers expressed agreement with most of the JCAHO guidelines. The only guideline that had less than 90 percent agreement related to suggested number of hours of skilled nursing care which garnered over 63 percent agreement.

Quality Will Suffer Because of Violation of Present Regulations

Many advocates already report that regulations are consistently being violated by providers of subacute care. More than a third of the advocates reported that nursing home regulations were consistently being violated; this was 64 percent (40 respondents of 63) of those respondents that were confident of the answer.

The most common regulation reported to be violated was transfer/discharge, followed by activities. Many written comments made by the consumer respondents talk to the problem that many residents have when transfer/discharge regulations are violated.

These questions elicited the most responses from advocates who were confident of their answers. While most consumers stated that residents who no longer need subacute care but do need long term care remain in the same facility, 22 percent report that residents who are transferred to another bed are not prepared for the move. Forty-two (42) percent of the advocates have experienced lack of preparation when residents are moved to another nursing home entirely.

Access Will be Denied to Traditional Residents

Only a small percentage of consumers report that traditional residents were having trouble finding a bed. However, between a quarter and a third anticipate future problems.

Providers in New York State do not believe that this access will be a problem in New York State. They believe that the surplus of beds in New York means most nursing homes will always welcome the traditional nursing home resident. It is of course, difficult to tell if things may change in the future. Not too long ago, we had few vacancies in our nursing homes. Our vacancy rates are still quite high.

Quality of Life Will Decline

Medical Models Will Prevail

This is a major fear of advocates. Most consumers believe that a medical model, which emphasizes medical needs rather than social needs such as socialization, activities, and a feeling of home, will lower the quality of life for most residents.

Many of the provider respondents did not have the same reaction to the movement toward the medical model.

While only 20 percent (or 58 percent of those who were confident of their answer) of the advocates stated that facilities offering subacute services had become more medicalized, over 27 percent expected them to become more medicalized (or 82 percent of those who were confident of their answer).

Provider respondents agreed that medicalization will increase, but they did not see this change as a problem. Many viewed it as a positive and inevitable change related to changing resident needs.

General Decline of Quality of Life

This did not seem to be a major problem. While almost a quarter of the consumers felt that there were problems in this area, over 40 percent did not believe that quality of life had declined; this was 61 percent of those that were confident of their response.

Many of the providers in New York State strongly believed that this would not be a problem.

In addition, when asked about interaction between subacute and traditional residents, most of the providers believed that this interaction was somewhat or

very beneficial for both groups of residents.

Is Subacute Care New?

Some Services Are Not New

It is clear that some of what providers are now calling subacute care is actually care that many facilities have always given. Thus, rehabilitation services given to nursing home residents who are at the high end of the skilled care continuum, have long been given in nursing homes, and have always been part of the Medicare benefit.

Some Services Are Services The Hospital Used to Give

Some subacute services may be services that Medicare is already paying for in the hospital rate. As discussed earlier, the PPS system has led hospitals to discharge patients as quickly as they could. The earlier they discharge patients, the more of the reimbursement rate they can keep without having to spend it on care. Thus, many patients may be leaving the hospital still needing care. In some cases, according to at least one nursing home provider, hospital patients are being discharged with fevers and infections. Nursing homes have begun to fill the gap in care left when hospitals discharge patients earlier than ever. Nursing home providers who admit rehabilitation patients with fevers and infections have to treat these acute care needs before rehabilitation is started.

Some Services May Be New or There May Be More Residents Admitted Needing These Services

However, some of the services do seem to be new or provided to more residents than ever before. Because of technological advances permitting some care outside the hospital, some services are new to nursing homes (e.g., cardiac rehabilitation). Other services were offered in nursing homes for years. However, where nursing homes may have had 1 or 2 residents with tracheostomy care needs in the past, now they are admitting many more.

Is Government Paying Twice for the Same Service?

Are nursing homes being reimbursed for care that was already reimbursed to the hospital?

HCFA officials state that they prefer not to recognize a new class of provider, called subacute, because they believe that the care provided is high-end skilled nursing care, already a Medicare benefit. They believe that the introduction of a case mix rate, which correlates rates with assessed needs of all patients, will cover

any additional costs if the present rate does not cover all the care needed.²⁵

In fact, a recent article in the Wall Street Journal (October 3, 1996), discusses a new initiative by hospitals to get more money from Medicare by cutting patients' stays in half, and transferring them to new subacute units in the hospital so that the Medicare "billing clock can be restarted." Thus, the hospital receives both the PPS rate for the hospital stay and a per day rate for any time spent in the subacute unit.

The Health Care Financing Administration's Responsibility

HCFA must make sure that necessary care is being given for the reimbursement received, whether in the hospital under a PPS payment or in the nursing home under the Medicare rate.

It must make sure that hospitals are giving patients all the care they need before discharging them. HCFA should support research that looks at the average length of stay for the various DRGs that might lead to subacute care needs to see if it has dropped over a period of time. This might indicate that hospitals are discharging these patients too early, in order to save money and/or to increase revenue with new subacute care units. HCFA should not be paying twice for the same service, whether in the hospital or the nursing home.

We Must Recognize Subacute Care as Separate From Traditional Long Term Care Services

Even though it is clear that much of this type of service has always been given in nursing homes, technological advances, proliferation of managed care, and Medicare's Prospective Payment System (PPS) have led nursing home providers to market this service in a new way. Nursing homes are attracting large numbers of residents needing this care. We must educate consumers about subacute care and we must suggest guidelines or regulations appropriate to the increasing numbers of short-term residents in order to ensure proper treatment.

Should We Modify Nursing Home Regulations for Short-term Subacute Care?

Providers and even some consumers have raised the issue that some of the

²⁵Presentation by Sharon B. Arnold, Ph.D., Director, Medicare Part A Analysis, at the National Citizens' Coalition for Nursing Home Reform's Annual Conference, October 15, 1996, Washington, DC. She is referring to the Medicare Case Mix Demonstration Project which some subacute care providers believe does give adequate reimbursement.

regulations for traditional long-term care residents may not be appropriate for short-term care residents.

Providers have raised objections to regulations related to assessment, transfer/discharge, activities and dental services.

assessment

If we are looking at services for people whose length of stay may be between 15 and 100 days, it does seem as if the assessment requirements for long-term stay residents may not be appropriate. These residents need assessment more quickly and more frequently.²⁶

transfer/discharge

Many providers complained that it was impossible to give short-term residents a 30 day notice of discharge when many of them were not in the home for 30 days. Many also felt that it was unfair that they could not immediately discharge or transfer a resident they felt no longer needed subacute care.²⁷ Some believed that they should be governed by hospital rules which they feel are much less stringent.

Consumers, on the other hand, were very concerned about the violation of transfer/discharge regulations and urged that they be enforced or made stronger.

Some providers, in follow-up telephone interviews, described a process by which restorative goals and discharge dates are decided within the first 2 weeks.

We Should Add Guidelines or Regulations For Short-Term Subacute Care

It is clear that we need specific guidelines or regulations that are specific to the needs of the subacute resident. They must relate to the need to assess quickly and

²⁶Facilities in HCFA's Case Mix Demonstration Project in the 6 states in the demonstration (South Dakota, Kansas, Texas, Mississippi, Maine and New York) are required to assess all of their Medicare residents at least 5 times during the first 100 days: by day 7, day 14, day 30, day 60 and day 90. In addition, the number may increase if there are any significant changes.

²⁷There are exceptions to the 30 day notice rule for residents who are in facilities less than 30 days and a resident's medical condition improves sufficiently so that the resident no longer needs nursing home care.

frequently, the need to have measurable goals and timetables for their achievement, the need to have early discharge dates, the need to have a method of evaluation, the need for intense and qualified staffing, the need to meet both medical and non-medical needs, the need to have strong physician presence and the need to have strong transfer and discharge protections.

New Regulations Need To Be Developed For Transfer and Discharge

New transfer and discharge regulations need to be developed for this population. These regulations should include requirements for early development of goals and discharge dates, with residents and family.

External appeals must be available for residents and family.

The state health department must be willing to conduct appeals requested by residents and/or family who disagree with the facility's decision to end subacute services. These appeals should focus on any disagreements between residents or family and the facility regarding the resident's inability to meet goals and the resident's ability to benefit from more therapy. This external appeal should determine if the resident still needs subacute care.

A facility should not be able to discharge a resident from a subacute program, even if benefits run out, if the external appeal determines that the resident still needs subacute care.

Subacute residents are chronically ill and need protection. The fact that their benefits run out does not mean that they no longer need subacute care. Facilities have a responsibility to provide for all the care needs for any resident they admit. In New York State, a facility cannot discharge a resident who still needs nursing home care if that resident's source of funding changes, or a benefit is pending, or if a resident does not have a source of funding because someone else has control of her/his finances and s/he is cooperating with the facility.²⁸ This must also apply to residents receiving subacute care. Thus, a resident whose Medicare, private insurance or managed care benefit runs out, should not have her/his services stopped if s/he still needs subacute services. If the resident is eligible, s/he will go on Medicaid; if not, s/he will pay privately for the continued subacute care. However, **the facility should not be allowed to charge any more than they were previously receiving under Medicare or private insurance.**

²⁸Title 10 of the New York Rules and Regulations, 415.3h.

activities

Many providers indicated that short-term residents are not interested in the activities generally offered in nursing homes. They are interested in getting well and going home. During the day they are too busy with therapies or too sick to go to activities. Thus, the providers believe that the regulations regarding activities are not appropriate for these residents.

One provider, in a follow-up telephone interview, stated that short-term residents are interested in being entertained in the evenings and weekends and that he had to provide such activities. He complained that the part of the activities regulation he objected to was required frequent assessment of activity needs.

In many ways, the regulations required for traditional residents are appropriate for subacute residents. Facilities are mandated to design activities to meet the interests of its residents. Although facilities are required to develop a written activities plan that should include individual, group and independent activities, if a resident does not want any formal activities, this plan will merely be a statement of that fact. Thus, providers are not required to create a formal program for any resident who is not interested. Thus, these regulations should remain for the subacute resident.

However, it might be appropriate to relook at these regulations in terms of the timing of assessments. Thus, the requirement that the plan must be reviewed on a quarterly basis does not make sense. In addition, it would make sense to try to limit the amount of paperwork necessary for this short-term resident.

dental

Here too, the ability to meet the dental needs might depend on how long the resident will be in the home. These regulations must make sense in regard to length of stay.

New Regulations Need To Be Developed For Required Hours of Care

Twenty-two (22) percent of the advocates (or 37 percent: 25 out of 59 of those who were confident of their response) believed that providers were not giving subacute residents at least 5 hours of daily skilled care which included not only nursing care, but physician, lab and pharmacy. In addition, over 36 percent of the providers did not agree that subacute care residents needed 5.5 daily hours of skilled care. The American Health Care Association, a national organization representing assisted living, nursing facility and subacute care providers, in their first edition of Facts and Trends: The Subacute Care Sourcebook list the number of hours of skilled care needed by subacute residents:

PROGRAM

NUMBER OF REQUIRED HOURS

Ventilator	6
Respiratory	6
Wound Care	6-8
Post-Surgical Care	8-9
Intensive Rehabilitation	4-7
Brain Injury	4-7

Most experts agree that most subacute residents need at least 4 to 5 hours of daily skilled nursing care, most needing more. Thus, regulations need to require this minimum amount of care with the hours going up depending on the care needs of the resident.

We Must Not Modify Regulations for Long-term Subacute Care

For what some call long-term subacute residents, such as people with AIDS, people on ventilators or with brain injury, the regulations must be kept in place as they are. Most of the arguments raised by providers relating to regulations really refer to the short-term resident. Long-term subacute residents need the protection of the regulations as written.

In New York State, we have additional programmatic regulations for these types of services. This is very important. In addition to the standard nursing home regulations, there must be specific regulations governing the medical and social care of residents with special service needs.

In addition, we must make sure that government surveyors are trained and expert enough to evaluate whether facilities are meeting the needs of these special residents as well as the needs of the traditional residents.

We Must Add Protections for Traditional Nursing Home Residents

There is also a need to add specific guidelines or regulations related to the transfer of traditional nursing home residents who are being transferred to make room for subacute residents. We need to consider whether facilities should be allowed to transfer residents from a room they may have lived in for many years so that a

subacute unit can be built.²⁹ In addition, given the high number of consumers citing lack of preparation for moves, regulations should focus on what facilities must do to prepare residents, subacute or traditional, for a move to a new room or floor.

Influence of Managed Care

As managed care becomes more of an influence, we need to be cognizant of the fact that managed care companies will be focusing on the least expensive setting. They may also try to limit the number of days that an individual will receive care. We must build in protections that do not allow managed care companies to impose the types of reimbursement systems that will discourage appropriate care. Such schemes as sub-capitation (a nursing home is given a set amount per resident rather than a negotiated rate per day) or gag rules³⁰ (used with physicians to stop them from discussing needed care if the managed care entity will not cover it) encourages less care or care by less qualified staff. In addition, we must build in access to external appeals for both residents and nursing homes.

The consumer responses from the subset of states where managed care has already proliferated (Arizona, California, Ohio, Massachusetts, Florida and Texas) indicate that in those states, residents were more likely to be moved from their facility when they no longer needed subacute care. This may be more facilities in these states that only accept short-term subacute care residents. We need to monitor this.

²⁹These preparations should be required whenever a resident is moved from one room to another, for whatever reason.

³⁰Under the Managed Care Bill of Rights gag rules are not allowed.

CHAPTER EIGHT: **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.³¹ 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.

³¹This 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.³²

- (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.

³²This 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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APPENDIX A

ID _____

DATE _____

IMPACT OF SUBACUTE CARE CONSUMER SURVEY

NURSING HOME COMMUNITY COALITION OF NEW YORK STATE

4. How are subacute services paid for in your state? *(Please circle all that apply).*
(NOTE: Do **NOT** include any managed care plans under Medicare, Medicaid, or Commercial Insurance; please list them separately as Managed Care.)

1. Medicare	2. Medicaid	3. Private Pay
4. Managed Care	5. Commercial Insurance	6. Unsure

5. If possible, please tell which subacute services are covered by various payers.
-
-

REGULATIONS GOVERNING SUBACUTE CARE

6. The JCAHO has established guidelines for subacute care. Please give us your impressions as to whether nursing homes in your state comply with these guidelines.
- a. Care is provided by an interdisciplinary team including physicians, nurses, and other professionals with expertise specific to the services provided.
- | | | | |
|------------|------------|----------------|-----------|
| 1. Most do | 2. Some do | 3. Most do not | 4. Unsure |
|------------|------------|----------------|-----------|
- b. Residents are assessed at least once weekly until their condition has stabilized or treatment is complete.
- | | | | |
|------------|------------|----------------|-----------|
| 1. Most do | 2. Some do | 3. Most do not | 4. Unsure |
|------------|------------|----------------|-----------|
- c. Subacute residents receive five or more hours of nursing care each day, regular physician involvement, pharmacy support, and lab support.
- | | | | |
|------------|------------|----------------|-----------|
| 1. Most do | 2. Some do | 3. Most do not | 4. Unsure |
|------------|------------|----------------|-----------|
7. In your opinion, are subacute care services in your state provided by more highly trained, specialized staff than traditional chronic care?
- | | | |
|--------|-------|-----------|
| 1. Yes | 2. No | 3. Unsure |
|--------|-------|-----------|

IF YES:

- a. Which staff members receive specialized training? *(Please circle all that apply).*
- | | | |
|------------------------|-----------|----------|
| 1. RNs | 2. LPNs | 3. aides |
| 4. No special training | 5. Unsure | |
- b. Do facilities use more highly qualified staff to provide subacute care services?
- | | |
|---------------------------------|----------------------------------|
| 1. Yes, more highly trained RNs | 2. Yes, more highly trained LPNs |
| 3. No staffing changes | 4. Unsure |
8. Does your state apply existing nursing home regulations to subacute care services?
- | | | |
|--------|-------|-------------|
| 1. Yes | 2. No | 3. Not sure |
|--------|-------|-------------|

9. Does your state have any regulations or guidelines for subacute care that are separate from those covering all nursing home services? *(Please check all that apply).*

- ___ Separate state regulations cover all subacute care services.
- ___ Separate state regulations cover some subacute care services.
- ___ Suggested guidelines are available for all subacute care services.
- ___ Suggested guidelines are available for some subacute care services.
- ___ There are no separate state guidelines covering subacute care services.

If your state has separate regulations or guidelines regarding subacute care, please answer the following questions. [If your state has no separate regulations, please go on to Question 12].

10. What are the penalties for failure to comply with subacute care regulations?

11. Do you believe that your state's regulations are strong enough?

- 1. Yes
- 2. No
- 3. Unsure

12. Are any existing nursing home regulations being waived for facilities providing subacute services?

- 1. Yes
- 2. No
- 3. Unsure

If yes: Which ones? *(Please circle all that apply).*

- 1. Activities
- 2. Assessment
- 3. Transfer/Discharge
- 4. Dental services
- 5. Social Work
- 6. Unsure
- 7. Other _____

13. Are any existing nursing home regulations consistently being violated by subacute care providers?

- 1. Yes
- 2. No
- 3. Unsure

If yes: Which ones? *(Please circle all that apply).*

- 1. Activities
- 2. Assessment
- 3. Transfer/Discharge
- 4. Dental
- 5. Social Work
- 6. Unsure
- 7. Other _____

14. Do you believe that there are any existing nursing home regulations that should be waived or changed for subacute care providers?

1. Yes 2. No 3. Unsure

If YES: Please answer 14 a-c.

14a. Which ones? *(please circle the number next to all that apply).*

1. Activities 2. Assessment 3. Transfer/Discharge
4. Dental 5. Social Work 6. Unsure
7. Other _____

14b. How should these regulations be changed? _____

14c. Why should these regulations be changed? _____

If NO: Please answer 14d-e.

14d. Which of the following regulations should NOT be changed for subacute care services? *(please circle the number next to all that apply).*

1. Activities 2. Assessment 3. Transfer/Discharge
4. Dental 5. Social Work 6. Unsure
7. Other _____

14e. Why not? _____

IMPACT OF SUBACUTE CARE ON OTHER NURSING HOME RESIDENTS

The following questions assess the effect of subacute care on existing nursing home residents who need chronic care services. We understand that you do not have detailed information on the care provided in all facilities in your area. Please answer the following questions to the best of your knowledge, based upon your impressions of the care in facilities you are familiar with.

15. Do traditional nursing home residents (even those who pay privately) have trouble finding a nursing home bed because of an emphasis on subacute care residents?

1. Yes 2. Not yet; I expect future problems 3. No 4. Unsure

16. Do Medicaid residents have trouble finding a nursing home bed because of an emphasis on subacute care residents?

1. Yes 2. Not yet; I expect future problems 3. No 4. Unsure

17. Are nursing homes in your state adopting a more medical model of care as a result of subacute care services? (i.e. more focus on clinical rather than social issues).
- | | | | |
|--------|--------------------------------------|-------|-----------|
| 1. Yes | 2. Not yet; I expect future problems | 3. No | 4. Unsure |
|--------|--------------------------------------|-------|-----------|

18. Has quality of life declined for traditional nursing home residents because of an emphasis on subacute care services?
- | | | | |
|---------------------|---------------------|-------|-----------|
| 1. Most of the time | 2. Some of the time | 3. No | 4. Unsure |
|---------------------|---------------------|-------|-----------|

If yes: How? _____

IMPACT OF SUBACUTE CARE ON SUBACUTE CARE RESIDENTS

19. Do you feel that nursing homes in your state provide high quality subacute care services?
- | | | | |
|---------------------|---------------------|-------|-----------|
| 1. Most of the time | 2. Some of the time | 3. No | 4. Unsure |
|---------------------|---------------------|-------|-----------|

Please comment on the quality of subacute care in your state: _____

20. When residents no longer need subacute care, but still need nursing home care, can they remain in the same facility for long term care?

1. Most of the time	2. Some of the time	3. No	4. Unsure
---------------------	---------------------	-------	-----------

If YES: a. Are they transferred to another bed?

1. Most of the time	2. Some of the time	3. No	4. Unsure
---------------------	---------------------	-------	-----------

b. If residents are transferred to another bed, are they prepared for the move? (e.g. given appropriate notice in advance and the right to appeal the decision?)

1. Most of the time	2. Some of the time	3. No	4. Unsure
---------------------	---------------------	-------	-----------

If NO: Are residents prepared for the move? (e.g. given appropriate notice in advance and the right to appeal the decision?)

1. Most of the time	2. Some of the time	3. No	4. Unsure
---------------------	---------------------	-------	-----------

21. In your experience, if insurance coverage for subacute care runs out, what has happened to residents who require additional subacute care? _____

POTENTIAL BENEFITS OF SUBACUTE CARE SERVICES

Advocates of subacute care services cite many potential benefits for nursing home residents. Please indicate which of the following benefits you have observed in your state, and answer the questions related to each statement.

22. LESS FREQUENT HOSPITALIZATIONS FOR NURSING HOME RESIDENTS.

1. Most of the time	2. Some of the time	3. No	4. Unsure
---------------------	---------------------	-------	-----------

What type of subacute services have been most successful at reducing the frequency of hospitalizations? _____

23. SHORTER HOSPITAL STAYS.

1. Most of the time 2. Some of the time 3. No 4. Unsure

Please answer the following questions even if you don't consider shorter hospital stays or less frequent hospitalizations a benefit.

In your opinion, which of the following statements are true?

(Please circle all that apply).

1. Residents are better off in the less clinical atmosphere of the nursing home.
2. Residents are better off returning to the nursing home where meaningful activities and social stimulation are available.
3. Residents are better off remaining in the hospital where more sophisticated medical care is available.
4. Other _____

24. ATTRACTION OF MORE QUALIFIED STAFF TO NURSING HOMES.

1. Most of the time 2. Some of the time 3. No 4. Unsure

Please answer the following questions about staffing.

- a. How has subacute care enhanced the quality of nursing home staff?

(Please circle all that apply).

1. Higher pay scales
2. More stringent educational criteria
3. Interesting work
4. More on-the-job training
5. Unsure
6. Other _____

- b. Do traditional nursing home residents have access to these skilled services?

1. Most of the time 2. Some of the time 3. No 4. Unsure

- c. Do traditional nursing home residents benefit from staffing changes in other ways?

1. Most of the time 2. Some of the time 3. No 4. Unsure

If yes: How? _____

PROVIDER CONCERNS

- 25. Which of the following concerns have you heard providers raise regarding subacute care in your area? (Please circle all that apply).**

1. Insufficient reimbursement to cover the costs of care.
2. Existing regulations are not appropriate for subacute care services.
3. Specific guidelines or regulations covering subacute care services are needed.
4. Qualified staff are unwilling to work in the nursing home setting.
5. Other _____

26. Do you agree with these concerns? 1. Yes 2. No 3. Unsure

If not: Why not? _____

BACKGROUND INFORMATION

To help us interpret our data, please take a few minutes to answer some questions about your own work.

1. What state do you work in? _____
2. How long have you been working as a nursing home advocate? _____
3. What is your exact advocacy role?
 1. state ombudsman
 2. local/regional ombudsman
 3. citizen advocacy group
 4. other _____
4. Do you visit nursing homes in your state? 1. Yes 2. No
5. Do you respond to complaints from residents? 1. Yes 2. No

Is there anything you would like to tell us about subacute care services that has not been covered in this questionnaire? *(Feel free to continue on additional sheets or on the back of this survey).* _____

We are anxious to hear more of your views about subacute care services in nursing homes. If you would be interested in speaking to us on the telephone to discuss these issues in more depth, please include your name, telephone number, and the best time to reach you.

Name: _____

Telephone Number: _____ Best time(s) to call _____

Would you like to receive a report of the findings of this survey? 1. Yes 2. No
If yes, please include your mailing address: _____

APPENDIX B

SUBACUTE CARE IN NURSING HOMES

Provider Survey

INSTRUCTIONS

Subacute care is a new and growing area of service provided by nursing homes. This survey is part of a project to gather information about this service. The goal of the project is to develop an educational brochure for consumers and to suggest guidelines for subacute care in New York State. We have information from consumer advocates across the country. We would like to include your experiences and beliefs in our final report.

Your responses to these questions will be kept strictly confidential. The survey is being conducted by an independent consultant, who will be the only one to see the original survey responses. Neither your name nor the name of your facility will be used in any reports to the Nursing Home Community Coalition; only group data will be reported.

Please help us in this important work by taking about 20 minutes to fill out this survey. Please complete as much of the survey as you can, to the best of your knowledge. When you have completed the survey, please return it in the enclosed envelope. By sharing your opinions and experiences in this survey, you will be helping to shape subacute care policies in New York State.

THANK YOU VERY MUCH FOR YOUR HELP!

IF YES:

- 8a. Has this interaction been beneficial for the subacute residents?
a. Very beneficial b. Somewhat beneficial c. Not sure
d. Somewhat harmful e. Extremely harmful
- 8b. Has this interaction been beneficial for the traditional residents?
a. Very beneficial b. Somewhat beneficial c. Not sure
d. Somewhat harmful e. Extremely harmful

Next we'd like to ask your opinions about subacute care.

9. What types of patients are appropriate for subacute care? *(Circle all that apply)*

- a. Patients needing short-term rehabilitation
b. Current nursing home residents who need more complex care
c. Patients who require some rehabilitation followed by long term care
d. Patients needing complex chronic care
e. Other (specify) _____

10. Do you feel that existing nursing home regulations are appropriate for subacute care providers?
a. Yes b. No

IF NO:

- 10a. Which regulations should be waived or changed?

- a. Activities b. Assessment c. Transfer/Discharge
d. Dental e. Social Work f. Other _____

- 10b. Please explain _____

11. Organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Health Care Association (AHCA) have identified several requirements for subacute care programs. Do you agree with these guidelines:

- a. Identify measurable objectives and timetables for each patient
a. Yes b. No If no: Why not? _____

- b. Provide an interdisciplinary team including clinical, rehabilitation, and social work.
a. Yes b. No If no: Why not? _____

- c. Meet both medical and non-medical needs.
a. Yes b. No If no: Why not? _____

- d. Provide between 5.5 and 7 hours of skilled nursing care per day for each patient (depending upon the patient's medical condition and individual needs).
a. Yes b. No If no: Why not? _____

- e. Staffed by qualified and appropriately trained professionals.
a. Yes b. No If no: Why not? _____

- f. Provide frequent patient assessment.
a. Yes b. No If no: Why not? _____

12. What are the obstacles to providing subacute care in New York State? *(Circle all that apply)*
a. Insufficient reimbursement to cover the costs of care.
b. Existing regulations are not appropriate for subacute care services.
c. It is difficult to attract qualified staff to work in the nursing home setting.
d. Physical plants do not meet the needs of subacute care.
e. Physicians are not available to work in nursing homes for the amount of time needed.
f. Difficulty keeping the beds filled with appropriate patients.
g. Other (specify) _____

13. In our national survey of state and local ombudsmen and consumer advocates, the following problems were raised by at least one quarter of the 117 respondents. Do you have any suggestions for preventing these problems from happening in New York?
a. Not enough highly trained staff.

- b. Violation of existing nursing home regulations, particularly transfer/discharge.

- c. Trouble finding a bed for Medicaid or traditional nursing home residents.

d. Nursing homes adopting a more medical model.

e. Residents who are moved to another bed are not prepared for the move.

f. Decline in the quality of life of traditional residents.

14. What do you see as the benefits of subacute care? (Circle all that apply)

- a. Shorter hospital stays
- b. Lower health care costs
- c. Providing patients with more stimulation and activities than in the hospital
- d. Less frequent hospitalizations for nursing home residents
- e. Attracting more qualified staff to nursing homes
- f. Increase case mix index
- g. Provide new area for recruitment of potential residents to maintain census
- h. Increased profits/surplus
- i. Other (Specify) _____

15. If you could write the guidelines for subacute care in New York State, what would you include? (Continue on the back or additional sheets if necessary). _____

To help us interpret our data, we'd like to ask a few final questions about your facility
(Your answers are strictly confidential, and will not be shared with NHCC, except in
aggregate form)

1. Where is your facility located? City/Town: _____ County: _____

2. What is the sponsorship of our facility?

- a. Proprietary
- b. Voluntary
- c. Public
- d. Other _____

3. How many beds are in your facility: Total _____ Subacute _____

4. What is your Case Mix Index? _____

Is there anything you would like to add that has not been covered in this survey? Feel free to continue on additional sheets or on the back of this survey. If you would like to receive a report of the findings or speak with us directly, please turn the page.

This page will be detached from your survey questionnaire to preserve anonymity

We are anxious to hear more of your views about subacute care services. If you would be interested in speaking with us on the telephone to discuss these issues in more depth, please include your name, telephone number, and the best time to reach you.

Name: _____

Telephone number: _____ Best time(s) to call: _____

Would you like to receive a report of the findings of this survey?

- a. Yes b. No

If yes, please include your mailing address: _____
