

PORTFOLIO

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Respiratory TherapyTM

The Journal of Pulmonary Technique



Life After Mechanical Ventilation: An Expert Interview on a New Accreditation to Improve Outcomes

Nathaniel A Miller, PhD

Executive Summary

When patients are unable to breathe sufficiently on their own, mechanical ventilation may be required. Mechanical ventilation is the most common intervention used in patients admitted to ICUs (Intensive Care Units). Mechanical intervention saves lives in acute cases, but numerous studies document how prolonged mechanical ventilation can lead to a host of negative physical, financial, and mental outcomes for patients. Over the past twenty years, Gene Gantt, RRT, FAARC has worked with TennCare, Tennessee's state Medicaid program, to develop best practices for safely and successfully weaning patients off of long-term mechanical ventilation. In this interview, he discusses his successes, which have recently been standardized as a widely-recognized accreditation available nationally through the non-profit Physician-Patient Alliance for Health & Safety.

Consequences of Prolonged Mechanical Ventilation

The need for mechanical ventilation may occur as a result of a range of breathing and respiratory illnesses, including acute asthma, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, pneumonia, lung cancer, and trauma. During the COVID pandemic, there was a surge in patients requiring mechanical ventilation. In the US, one study found that almost 90% of COVID patients required mechanical ventilation. An audit of patients from England, Wales, and Northern Ireland found that two-thirds of COVID patients who required critical care in the UK had mechanical ventilation within 24 hours of admission. Most COVID patients who experienced respiratory failure often required prolonged mechanical ventilation for two weeks or longer.

More than a million patients who are admitted to US intensive care units (ICUs) receive mechanical ventilation each year. Nearly 10% of all critically ill patients and up to 34% of those ventilated for more than two days require extended periods of ventilatory support. Prolonged mechanical ventilation (PMV) has been defined as ventilation for more than 21 days or for more than four days following a tracheostomy. Currently, over 100,000 patients per year require prolonged mechanical ventilation. With advances in skill and technology, the rate of PMV cases is increasing rapidly from year to year.

Nathaniel Miller is a freelance writer who lives in Denver. He is a recovering academic who previously held a visiting professorship and research fellowships at the University of Cambridge and New York University Abu Dhabi. His writing has appeared in The New York Times, The Marginalia Review, Reading Religion, and elsewhere.

When prolonged, mechanical ventilation, especially in alternate care settings where most patients are elderly, becomes a major safety issue. In the vast majority of states in the US, there are little to no quality requirements for mechanical ventilation in long-term care facilities (such as Skilled Nursing Facilities) that establish adequate staffing ratios of qualified respiratory therapists, advanced monitoring of pulse oximetry/end-tidal CO₂, outcomes tracking, use of advanced technologies, or quality oversight. Additionally, there is no accreditation program focused on this specialty service. As a result, there are ventilator-dependent/tracheostomized patients who receive substandard long-term care where no outcomes are achieved or expected.

Researchers have found that the care of patients who have prolonged mechanical ventilation is expensive and their overall outcomes are often poor. As Dr Mario Fadila and his colleagues at the SIU School of Medicine and the University of Missouri write:

“Prolonged mechanical ventilation increases the risk of pneumonia, barotrauma, tracheal injuries and musculoskeletal deconditioning. At the same time, delayed weaning is associated with increased morbidity, mortality, hospital stay and risk of long-term care facility discharge.”

The seemingly simple example of device alarm failure illustrates the dangers patients undergoing prolonged mechanical ventilation face. In 2002, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) reviewed 23 reports of death or injury that were related to mechanical ventilation. Nineteen of those events resulted in death, four in a coma, and the vast majority — 65% — were related to alarms. There was often no response, or a delayed response, to mechanical ventilation alarms. In some cases, the alarm was set incorrectly. Some ventilator disconnections did not trigger an alarm. When an alarm was triggered, it was not always audible in all areas of patient care. This review prompted JCAHO to include alarm safety in the National Patient Safety Goals for 2003.

Until very recently, there have been no standardized protocols for safely weaning patients off of long-term mechanical ventilation.

New accreditation is now available from the Physician-Patient Alliance for Health & Safety (PPAHS), a national non-profit (501(c)(3)) advocating for patient health and safety priorities. The PPAHS Accreditation in Enhanced Respiratory Care builds

on a program developed by Gene Gantt, Registered Respiratory Therapist, for TennCare. Gantt's program has achieved a 65% liberation rate from long-term mechanical ventilation and the American College of Chest Physicians awarded it a national recognition of excellence. The newly available Accreditation in Enhanced Respiratory Care is based on standards published by the American Association for Respiratory Care (AARC), where Gantt was also the former chair of the long-term care section and AARC representative to the Respiratory Compromise Institute.

I sat down to chat with Gene about TennCare's successes and the role of the new Accreditation in Enhanced Respiratory Care in translating these successes to the national level.

An Interview with Gene Gantt, RRT, FAARC **What are the main issues and challenges healthcare providers face when it comes to patients on mechanical ventilation?**

The main issue is finding the most appropriate quality resource for long-term ventilation. These vary from state to state. There are three discharge options:

- Long-term acute care hospitals, where available. These are still considered acute care and have a length of stay of 28-30 days, but then they too need discharge options for long-term care if liberation from ventilation isn't achieved in that time frame.
- Skilled nursing facilities. These vary in scope, quality, and payment availability. Depending on state Medicaid options a state may or may not cover these higher-acuity services.
- Direct discharge to home, where continued efforts to wean from ventilation are much less likely.

On the national level, what mechanisms are in place to ensure high standards of respiratory care for patients on long-term mechanical ventilation?

There are no national standards from the Centers for Medicare & Medicaid Services or any other governing bodies that provide target standards for long-term ventilator care. In terms of costs, which affect provision, each state sets its own payment rate and requirements.

Tell me about your role in starting the Enhanced Respiratory Care program in Tennessee.

We originally established Tennessee's very first long-term ventilator program in a Skilled Nursing Facility, which is to say, a state-regulated nursing home, in 2001, as a means of preparing families for ventilator care at home. Our idea was that we could do a better job preparing caregivers if we could do so at a slower pace than traditionally done in a busy hospital ICU. At that time we were the hands-on providers of respiratory care and as clinicians, we wanted to make our facility as safe and clinically sound as possible. Although there were no standard requirements at the time we opted to staff our unit 24 hours a day with respiratory therapists and to provide redundant monitoring in case of ventilator failure or accidental disconnect.

Once we admitted our first patients, our respiratory therapists recognized that the majority had weaning potential so they began the process of weaning them from the ventilator. In our first year, we were successful in liberating 65% of those admitted to the unit.

Realizing that model was successful, we developed the initial ten standards we felt to be key to our success and presented them to the Tennessee Board of Respiratory Care, who adopted

them as an official position statement. In 2007 we presented the Tennessee position statement to the AARC where it was adopted as a formal position statement there as well.

We continued our work as providers until 2013, and then joined the TennCare Bureau to develop the current pay-for-performance model we use today. We now oversee the quality of that program statewide.

Tell me about the relationship between national standards of respiratory care for patients on mechanical ventilation and Tennessee's efforts.

The standards of care were first developed and used in Tennessee beginning in 2001 and were first codified as a Medicaid requirement there in 2014. The successful outcomes achieved from following the standards stimulated the idea of national accreditation of facilities that met or exceeded the standards.

Could you describe the best practice for weaning a patient off mechanical ventilation?

The best practice will depend on the patient. Weaning from long-term ventilation is made more difficult due to patient stress and often deep depression. One of the very first steps we recommend is to humanize the patient so that they feel more optimistic. For example, the placement of a speaking valve so they can communicate does wonders for the weaning process. Not only does it allow them to speak but it's also beneficial in alveolar/lung recruitment resulting in more stable oxygen saturation. All of the patients in long-term care have failed standard protocols so respiratory therapists must be creative in their methods.

Where does PPAHS's Accreditation and Certification in Enhanced Respiratory Care fit into the national landscape of respiratory care provision?

There are two parts here to talk about, certification of the clinician, and then accreditation of facilities.

Certification entails clinicians taking continuing medical education courses on Enhanced Respiratory Care. These courses educate clinicians through online and hands-on learning in:

- Culture of a Weaning Program
- Resident Selection
- Quality of Life
- Weaning Approaches
- Ventilator Unit Technology/Equipment
- Discharge Processes
- Process Improvement

There are relatively few training courses that are specific to long-term care. Respiratory therapists who specialize in this arena rely on manufacturers and clinical experience to learn the ropes. The PPAHS offers specialized programs targeted toward long-term care.

Accreditation of facilities is recognition that the facility has met or exceeded the national standard of care. Previously, there were no regulatory or Medicare/Medicaid standards from state to state. Enhanced Respiratory Accreditation offers facilities an opportunity to practice at a high level and to be recognized once they meet or exceed the standards. These standards create a safe environment for those receiving care in non-acute facilities. Additionally, it provides families with the assurance that the facilities are operating at a high clinical level and that their loved

Structuring reimbursement properly provides the best outcome for clinicians and their patients.

How can we continue to improve outcomes for weaning patients from mechanical ventilation?

By expecting success instead of settling for providing custodial care for long-term ventilation patients.

Where can clinicians and patients get more information on Enhanced Respiratory Care?

More information on certification and accreditation in Enhanced Respiratory Care can be obtained by going to <https://ppahs.org/enhanced-respiratory-care/>.

About Gene Gantt, RRT, FAARC

Gene Gantt is the co-founder and CEO of Eventa, LLC, and a well-respected registered respiratory therapist who has practiced in the post-acute care arena since 1984 and is widely recognized for his excellent work on critical patient safety issues. He has represented the American Association for Respiratory Care (AARC) at various conferences addressing the need for patient monitoring and promoting clinician awareness of early recognition of respiratory compromise. He is the AARC representative to the Respiratory Compromise Institute, a coalition of leading medical organizations, and the Physician-Patient Alliance for Health & Safety.

About Physician-Patient Alliance for Health & Safety

The Physician-Patient Alliance for Health & Safety is ranked internationally as a top-100 patient safety organization (Agilience Authority Index, July 2023) and is a national advocacy force for addressing patient health and safety priorities shared by patients, physicians, regulators, and industry. PPAHS seeks to ensure that the best medications, medical inventions, and technology that can improve care and reduce costs are employed. PPAHS works to advance patient health and safety by developing and highlighting best practices and recommendations through better use and application of clinical practices and experiences, information technologies and checklists, and healthcare information. As a voice in support of ideas and innovation that can improve care, we encourage a health ecosystem that fosters a culture of patient safety. For more about PPAHS, please visit www.ppahs.org.



West Meade Place (Nashville, TN) was the first facility to receive Enhanced Respiratory Care Accreditation. Pictured with Gene Gantt (far right) are Michael Wong (PPAHS) and James Wright and Clyde Heflin.

ones are being cared for according to a recognized standard of care.

What role does data collection/metrics tracking play in improving and maintaining high standards of respiratory care? What are some of the issues and challenges in data collection and management on state and national levels?

Collecting data is extremely important, if nothing is measured there is no benchmark for improvement. By collecting data and participating in accreditation a facility can benchmark their success to that of other institutions practicing in the same manner. This gives a facility a way to measure improvement.

The challenge to collecting accurate data is to make sure that each facility is using the same formulas for calculation. For example, if a facility only counts patients they “think” they can wean versus “all qualified admissions,” the data wouldn’t match up to those who use the “all qualified admissions” category.

How about equipment, what needs to change in terms of availability and training to improve and maintain high standards of respiratory care?

Many long-term care respiratory therapists don’t get the opportunity to attend live state or national seminars and as a result, they are not aware of the latest technological advances. That’s one of the main benefits of the new PPAHS certification. As new products become available, we will host periodic equipment showcase sessions where manufacturers will come to the respiratory therapists to showcase new products.

There will often need to be investments made to improve outcomes and many times these costs pose a challenge. However, improved outcomes should equal increased reimbursement from a payer like managed care or TennCare in order to offset the costs of investment in new equipment.

Arabic poetry of the Crusades-era Mediterranean: sacred violence and profane love

The Pearl of the Palace and the Annals of the Age is an anthology compiled by Saladin's secretary Imad al-Din al-Isfahani. Nathaniel Miller is examining its poems to illuminate the aesthetic and cultural sensibilities of medieval Sunnism

In 1060, Arab Sicily was invaded by the Normans. Sicily's Arab Muslims belonged to a large religious and linguistic community, stretching from Spain to the Indus. While relocating to escape non-Muslim rule was an option open to members of the elite and endorsed by Islamic religious scholars, it is difficult to characterise popular or unofficial reaction to the Normans' arrival. The Islamic world of the eleventh and twelfth centuries was in fact increasingly subject to occupation: in 1085 the Spanish reconquered Toledo, and in 1099, the Crusaders took Jerusalem.

One way to gauge contemporary sentiments is through poetry. For example, one Sicilian poet, Ibn Hamdis, who fled to Spain and then North Africa, composed panegyrics for any leader who could potentially lead the jihad to retake Sicily. Umar ibn Bishrun, on the other hand, chose to remain, and praised the Norman leader Roger II, describing the beauty of his palaces and calling him 'the king of the Caesars'.

Even poets who chose to flee 'the Franks' often displayed contradictory attitudes. Al-Adib al-Qaysarani fled Caesarea (in present-day Israel) for the court of Nur al-Din al-Zangi in Damascus. In his poetry, he promised that Nur al-Din would 'purify Jerusalem with flowing blood'. At the same time, he composed delicate verses about Christian women:

*Among the chaste virgins of the churches,
there is one like a gazelle, adorned with shy reticence.
She prostrates herself before icons;
if there were any justice,
the icons would bow down before her.*

The main source for such poetry is the seventeen-volume anthology *The Pearl of the Palace and the Annals of the Age*, compiled by Imad al-Din al-Isfahani (d. 1201), a prominent secretary of Saladin. Imad al-Din preserved the work of more than a thousand poets, members mostly of the vast cadre of minor bureaucrats and religious scholars, who also constituted the poems' main readership.

This overwhelmingly Sunni cultured class was concerned with more than religion and the counter-Crusade, and they evidently possessed a higher tolerance for sophisticated, complex, and ambivalent poetry than they did for religious heterodoxy. In this regard, *The Pearl of the Palace* sheds light on an enduring aspect of medieval Sunnism, not merely as a set of legal doctrines, but as an aesthetic and cultural sensibility formed in no small part through Mediterranean encounters between Christian Europe and the Islamic Near East. My study, therefore, will examine how the anthology's poems construct Sunnism as an affective stance, cultivated in *belles lettres*, rather than merely a theological or political position.

13th or 14th-century candlestick base
from Iraq or Syria. Muslim rulers from
Spain to Iran were depicted in the
same uniform pose: seated, drinking,
and listening to counsel or poetry.
Edward C. Moore Collection, Bequest
of Edward C. Moore, 1891



Hi there, good citizen!

The deadline for your tax returns is coming up soon, but if you're a freelancer, you're probably busy turning your entrepreneurial mojo into cold hard cash. Don't worry, you still have time to take the deductions you need for a plump refund check.

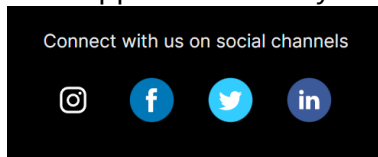
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If you haven't already downloaded our app, you can grab it [here](#). Just tap through the instructions and in as little as five minutes, our AI will have your taxes sorted out. Then, if you want, you can send it to one of our experienced CPAs to check it over and even file for you.

Let us know if you have any questions, we're here to help! You can email us at support@flyfin.tax

Wishing you many happy tax returns,

The Support Team at FlyFin



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ARABIT QUARTERLY

♦ The Joke

SUMMER 2022, VOLUME 5, ISSUE 2



Poetry

On Drunken, Partying Fleas

By 'Imad al-Din al-Isfahani

Translated by
Nathaniel A. Miller

'Imad al-Din al-Isfahani (d. 1201) was the head of Saladin's diplomatic correspondence, or chancery. The following poem records a night he spent being bitten by fleas in mid-June, 1155 CE, at Nahr Daqla outside Isfahan.

He initially thought he was the first to use the image of drunk, partying fleas until he heard another flea poem by Abu 'Ali ibn Bakhtiyar in 1170 that does as well. He spent 15 years with that accomplishment filed away, but willingly conceded the glory to Abu 'Ali when he heard his poem.

The reference at the end of the poem is probably to the defeat of Ahmad Sanjar (r. 1118–57), the last major Seljuq sultan, by the central Asian Qara Khitai Dynasty at the battle of Qatwan in 1141.

يا لحي الله ليلةً قرصتني في دياجيرِها البراغيثُ قرصا
God curse the pitch night
those fleas bit bit bit me!

شربتُ بَقَّها دمي فتغتت وبراعيشُها تواجدنَ رَقْصا
My blood was their wine
they danced in euphoria.

قد تعرَّيتُ مِن ثيابي لكري غيرَ أَنِّي لبستُ منهمُ قُمْصا
Distressed I stripped naked
but still wore a flea-shirt—

كلِّما ارْزَدَدْتُ منعهمُ بحرصٍ عن فراشي شرهن فازددن حرصا
the more I hungered for freedom
the more they hungered for me.

مِن براغيثٍ خِلْتُها طافراتٍ طائراتٍ جَنَاحُها قد حُصا
Fleas that leapt up
like feather-bald birds,

عرَضَتْ جيشَها الفریقانِ حَوْلِي وهي أَوْفَى من أنْ تُعدَّ وتُحصى
two armies formed round me
in numbers beyond all count.

لو غزا سنجرٌ بها العُرُ يوماً لم يدع منهم على الأرض شَخْصا
If Sanjar had attacked the Turks with them
he'd have wiped them off the face of the earth.

←

Tweet

Pinned

Nathaniel A. Miller

@ClassyArabic

I'm happy to announce that my first book, The Emergence of Arabic Poetry: From Regional Identities to Islamic Canonization, is now starting production at the University of Pennsylvania Press, to appear around mid-2024 (under the expert oversight of @byjennytan).

10:05 AM · Jun 27, 2023 · 62.7K Views

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453 Likes

63 Bookmarks

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Reply

Nathaniel A. Miller @ClassyArabic · Jun 27

...

The book is a revision of my dissertation about the Hudhayl tribe's poetry. This Hijazi tribe's 4600 lines of verse date to 550-750 CE and deal with nomadic love, conflict, the hajj, hunting, and the coming of Islam.

2

1

31

2,127

Nathaniel A. Miller @ClassyArabic · Jun 27

...

I argue that this corpus sheds a great deal of light on "classical" Arabic poetry which, if you think about it, almost all comes from Najd.

1

1

24

1,916

Nathaniel A. Miller @ClassyArabic · Jun 27

...

The emblematic issue is the famous Arabian horsemanship. In contrast to horse-centered hunting and combat descriptions, Hudhayl boast about hunting and fighting on foot. They even _boast_ about being able to run away from a losing fight quickly! Smart.

1

27

1,569

Nathaniel A. Miller @ClassyArabic · Jun 27

...

In a sense, the Hijazi poetry of Hudhayl is marginal and peripheral compared to what was later canonized as typical Arabic poetry. Except that they are from the homeland of Islam.

1

30

2,333

Nathaniel A. Miller @ClassyArabic · Jun 27

...

This is why I also argue that the understanding of the Qur'an and early Islamic history needs to recognize that "pre-Islamic" poetry varied from region to region.

3

3

36

3,845

Nathaniel A. Miller @ClassyArabic · Jun 27

...

Hence the subtitle, From Regional Identities to Islamic Canonization. Scholars are familiar with the canonized version of early poetry that lumps all (nomadic) Arabs together. But there is much more to say about the local ecologies, economies, and cultures of pre-Islamic Arabia.

1

3

30

2,990

Nathaniel A. Miller @ClassyArabic · Jun 27

...

Poetry has a great deal to tell us about these regional cultures. Expect to be bombarded with threads on interesting and unexpected early poetic topics as the publication date draws closer 😊

 1

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 150
