



# Adult Acute Care

May/June '99

Bulletin

2

AARC to Offer  
Assessment Course

1999 Summer Forum

3

FYI....

## AARC Research Program: How To Apply

In 1996, the AARC earmarked \$1,000,000 for a research program to fund projects aimed at determining the relationships between clinical interventions by respiratory therapists and the outcomes of care. The primary purpose of the program is to sponsor research initiatives that can document the clinical and economic impact of respiratory therapists in the delivery of health care. Clinical trials and effectiveness research to determine how clinical interventions by respiratory therapists affect the overall health of patients, including physiologic indicators and quality of life, will be considered for funding.

**The AARC requires submission of a "Research Plan Abstract" form prior to the submission of a complete application.** These abstracts will be used to plan the proposal review process. The abstract is not binding on the AARC or the applicant. The AARC will forward application packages to applicants whose abstracts propose projects that support the AARC's research agenda. The AARC will notify the applicant if a full application is not warranted.

### Research agenda

1. To determine the outcomes of care provided by respiratory therapists with expanded roles and scope of practice in various settings (acute care, subacute care, outpatient care, long-term care, and home care).
2. To determine the outcomes of systems for delivering respiratory care services in various settings.

In pursuing this agenda, investigators may evaluate and compare the roles, effectiveness, and efficiency of respiratory therapists and other providers of respiratory care in various settings. Initiatives to explore both the clinical and economic impact of respiratory therapists in traditional and

expanded roles in health care will be considered.

### Research fund guidelines

1. Project hypothesis includes measurement of the value of respiratory therapists in a health care setting.
2. Research methodology is:
  - prospective in design
  - randomizes assignments into control and experimental groups
  - sizes of control and experimental groups are sufficient to detect significant differences in primary outcome measure (power analysis)
3. Researchers identified have:
  - experience in performing similar medical studies
  - published such a study in a specific journal
  - identified assistance of a statistician
  - involved RTs where feasible
4. Funding requests have:
  - reasonable allocations of indirect staff costs
  - limited percentage of expenses in capital or travel
  - defined project deliverables at each stage of funding
5. Because of the potential conflict of interest and to assure credibility of research results with external parties (third party payors, policy makers, etc.), the AARC will not fund research in which the principal investigator is employed by an organization that stands to realize financial gain from the outcome of the study.

Failure to meet the above criteria does not necessarily bar the proposal from acceptance. The proposal may still be accepted if the researcher can adequately address the issue to the satisfaction of the panel.

"How to Apply" continued on page 2

"How to Apply" continued from page 1

### Priority projects

The panel will give priority to research proposals in the following care settings:

- Home health
- Outpatient clinics and physician offices
- Long-term care
- Managed care

- Integrated delivery systems
- Other settings outside inpatient areas within acute care hospitals

*Projects in acute care hospitals will be considered only if sufficiently different from grants approved to date.*

### Research Plan Abstract

Individuals who intend to apply for funding are encouraged to first submit a completed "Research Plan Abstract." You can access the

Research Plan Abstract on the AARC web site at <http://www.aarc.org/awards/program.html> or call the AARC at (972) 243-2272 for a copy. Mail completed abstracts to: AARC Research Program, c/o AARC Executive Office, 11030 Ables Lane, Dallas, TX 75229. Application receipt dates each year: February 1; June 1; October 1. ■

## AARC To Offer Assessment Course

Due to overwhelming requests, the patient assessment course for respiratory therapists will be offered twice this year. Space is at a premium and prerequisite is required. Successful com-

pletion of the course will earn participants 16 hours of CRCE credit and a certificate of course completion. Each attendee will also be given a pocket guide to physical assessment.

Advance registration is required. AARC members may take the course for \$250. The nonmember fee is \$325. The course will be held in the following locations:

- Phoenix, AZ, July 18-20  
*Location:* The Pointe Hilton Resort at Squaw Peak, 7677 North 16th Street, Phoenix, AZ 85020-9832, (602) 997-2626  
*Room Rates:* \$89 single or double + 10.35% tax  
*For Reservations Call:* (800) 876-4683 or (602) 997-2626 and identify yourself as an attendee at the July 18-20, 1999, AARC Meeting.  
*Room Reservations Deadline:* Monday, June 21, 1999  
*Course Registration Deadline:* Thursday, July 1, 1999  
*Enrollment Limit:* 200 attendees  
**Advance registration required**  
All activities will be conducted at

the hotel. Check in time is from noon until 1 p.m. on the first day. Following the last class, participants will take a 100-item test developed by the NBRC, which should take about one and a half hours to complete. Attendees should finish the test by 1 p.m. on the last day of the course. Tests will be graded on-site for those wishing to obtain their scores immediately.

After the course, the graduate will be able to:

- Function as a member of an interdisciplinary care team.
- Determine the patient's physical condition, assess the patient's needs, monitor and evaluate services and outcomes, and document services and activities.
- Look at the whole person, including family life, living conditions, work situation, and leisure activities, in relation to the disease state of the patient.

To register for this excellent continuing education opportunity, contact the AARC at (972) 243-2272. ■

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## 1999 Summer Forum

The AARC will hold its annual Summer Forum July 16-18 in Phoenix, AZ. This outstanding meeting promises to provide a wealth of information for practitioners holding positions in management and education and should be of interest to anyone wanting up-to-the-minute information about the profes-

sion and where it is headed as we prepare to enter the new millennium.

For more information about the Forum and how you can attend this important meeting, see your April issue of *AARC Times* or visit the AARC's web site at [www.aarc.org](http://www.aarc.org). ■

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**FYI . . .**

**Pay me now or pay me later**

If the federal government wants to decrease the number of poor and frail older Americans in the next millennium, it will have to significantly increase the resources available for research and prevention of the diseases of aging, says Edward L. Schneider, MD, dean of the Ethel Percy Andrus Gerontology Center at the University of California. Although health care for seniors accounts for a third of the more than one trillion dollars spent on health annually, the federal government currently spends only about a billion dollars a year on aging research. "No corporation that spent a mere 0.3% of its revenues on research would last long in a competitive marketplace," says Schneider.

Aging baby boomers and continuing increases in life expectancy will swell the number of Americans aged 65 or older to 35 million in 2000 and 78 million in 2050, says Schneider. Middle estimates from the U.S. Census Bureau project about 18 million people 85 or older by 2050, but many demographers believe the bureau's higher projections of 31 million very old Americans are more likely to come true.

"A quantum increase in research on chronic diseases is necessary before we can make a dent in the projected growth of health care costs related to an aging population," says Schneider. "If we invest a reasonable percentage of the Medicare budget in research now (2 or 3%), we could save future generations from the physical, sociological, and economic scourges of aging." (Science, 2/5/99)

**Medicare overpayments decline**

According to the Department of Health and Human Services (HHS), improper Medicare payments to hospitals, doctors, and other health care providers declined dramatically last year to the lowest error rate since the government initiated comprehensive audits three years ago.

The error rate for fiscal year 1998 was an estimated 7.1%, representing estimated improper payments of \$12.6 billion. This compares with an error rate of 11%

in FY 1997, representing an estimated \$20.3 billion; and 14% in FY 1996, representing an estimated \$23.2 billion in improper payments.

"Today's report by the Inspector General is welcome proof that our zero tolerance policy against waste, fraud, and abuse is paying off," says HHS Secretary Donna E. Shalala. "We still have a big job to do in eliminating improper Medicare payments, but with a 45% reduction in improper payments in just two years, we are making real progress."

OIG auditors looked at a statistical selection of 600 beneficiaries nationwide with 5,540 claims valued at \$5.6 million, and determined that 915 of the claims did not comply with Medicare laws and regulations. By projecting the sample results over the universe of Medicare fee-for-service benefit payments, which totaled \$176.1 billion during the fiscal year, the OIG calculated that \$12.6 billion was the midpoint in the estimated range of improper payments.

The two major problem areas were billing for services that were not medically necessary and upcoding services to secure a higher reimbursement than justified. They combined to account for about \$9.3 billion of the estimated \$12.6 billion in improper payments. Another \$2.1 billion in overpayments was attributed to documentation discrepancies, and the remaining \$1.2 billion to billing for services not covered by Medicare and other types of errors. Ninety percent of these improper payments were detected through medical reviews coordinated by the Inspector General. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

Hospitals, physicians, and home health agencies accounted for more than 77% of the improper payments, with approximately 39% of the erroneous claims attributable to hospitals, nearly 26% to physicians, and almost 13% to home health agencies. Skilled nursing facilities, non-prospective payment system hospitals, laboratories, end stage renal disease centers, ambulance companies, ambulatory surgical centers, durable medical equipment suppliers, and hospices were responsible for the

balance of the improper payments, in that order. Virtually all major provider groups had significant error reductions from FY 1996. (HHS)

**Quality improvement programs save lives, reduce costs**

A new report from the American Health Quality Association (AHQA) on programs to improve the health care provided to seniors shows that quality improvement programs increase access to appropriate care, reduce deaths, and often lead to cost savings. The report showcases the results of 498 Quality Improvement Organization (QIO) projects conducted in hospitals and HMOs from April 1, 1996 through March 1998. Eighty-seven percent of completed projects resulted in measurable improvement in the quality of care.

Among the projects were those that focused on:

- Increasing flu immunizations among African-Americans. Eight QIOs partnered with historically black colleges and universities in eight southern states to address the disparity in flu shots for African-Americans. 1996 Medicare Part B data show overall immunization rates increased by as much as 5.4%.
- Preventing pneumonia complications and death. QIO projects involving 332 hospitals in 18 states boosted the number of pneumonia patients receiving antibiotics within four hours of hospitalization by 8.4%. These efforts seek to decrease inpatient mortality and other complications from pneumonia.

Funded by the Health Care Financing Administration, QIOs (also known as Peer Review Organizations for their Medicare work), collaborate with hospitals, health plans, providers, employers, community coalitions, and others to assess and improve quality of care for Medicare beneficiaries. In addition to evaluating and promoting improved quality of care, QIOs serve as a resource to beneficiaries with complaints about the quality of care provided to them in hospitals. In late 1999-2002, QIOs will expand their work to improve health care

"FYI" continued on page 4

"FYI" continued from page 3

delivery in the clinical areas of cardiovascular care, stroke prevention, mammography, flu, pneumonia, and diabetes.

The AHQA is the trade association representing QIOs. For a copy of the full report, visit the organization's web site at [www.ahqa.org](http://www.ahqa.org). (American Health Quality Association)

### **RTs join colleagues in seeking union contract**

In a recent report posted on BusinessWire, respiratory therapists were listed among a group of 360 employees at Santa Rosa Memorial Hospital in Santa Rosa, CA, who filed a petition to be represented by the Santa Rosa-based Teamsters Union Local 624. The group sought union representation in response to cost cutting measures at the hospital that they say have reduced the quality of patient care, staffing levels, and professional services. Problems are said to be particularly acute on night shifts, where cuts have compromised the ability of employees to respond to multiple emergencies and have created long and uncomfortable waits for patients.

"This is where our families go, too," said respiratory therapist Geoff Williams in the article. "Our objective is to make Memorial a better hospital . . . hurting it would not benefit anyone."

Dennis Dowd, another RT at the hospital, was quoted as saying, "We believe our goals can be achieved through open dialogue and a mutually respectful partnership."

Williams, Dowd, and the rest of the employee group, which also includes medical technologists, x-ray technicians, licensed vocational nurses, clerks, dietary workers, nursing assistants, and housekeeping and maintenance staff, say they hope to achieve their goals through a cooperative, nonconfrontational relationship with management.

### **Discharge planning, home follow-up reduce readmissions**

A specialized in-hospital and home-care plan designed for high-risk hospitalized elderly patients decreases health care costs and reduces the percentage of hospital readmissions, say researchers

from the University of Pennsylvania in Philadelphia who studied a special plan for patients set in place and administered by advance practice nurses (APNs).

They found that 186 patients receiving "standard" discharge planning and home care were more likely to be readmitted to the hospital at least once than 177 patients in the intervention group (37% versus 20%). Hospital days per patient were higher in the control group when compared with those in the intervention group (4.09 versus 1.53). Twenty-five percent of control group patients were readmitted within 48 days after hospital discharge. Twenty-five percent of intervention patients were readmitted within 133 days.

All the patients in the study were 65 years or older and were admitted with one of nine diagnoses that ranked in the top ten Medicare beneficiary hospitalizations in 1992: coronary heart failure, angina, myocardial infarction, respiratory tract infection, coronary bypass graft, cardiac valve replacement, major small and large bowel procedure, and orthopedic procedures of lower extremities.

After six months, the intervention had generated an estimated savings in Medicare reimbursements for all post-discharge services of almost \$600,000 for the 177 intervention group beneficiaries, a mean per-patient savings of approximately \$3,000. (*JAMA* 1999;281:613-620)

### **National data set provides in-depth picture of hospital care**

The Agency for Health Care Policy and Research (AHCPR) has released a new data set on the use, quality, and costs of hospital inpatient care in the United States that includes detailed information on topics such as diagnoses, patient demographics, medical and surgical procedures, diagnostic tests, hospital charges, payment sources, and hospital characteristics.

The Nationwide Inpatient Sample (NIS) features hospital discharge information from approximately 6.5 million inpatient stays at over 900 hospitals in 19 states across the country in 1996 and is the only publicly available database to include payer information, permitting analyses of care covered by private insurance, Medicare, Medicaid, and

other sources. It joins similar data sets available for the years 1988 through 1995 and is a product of the Healthcare Cost and Utilization Project, a federal-state-industry partnership sponsored by AHCPR to produce standardized, high-quality data for use in measuring and evaluating the impact of changes in the health care system on access to services, quality, outcomes, and costs.

The NIS Release 5 for 1996 is available on CD-ROM (with accompanying documentation) for \$160 from the National Technical Information Service, Port Royal Road, Springfield, VA., 22161, (800) 553-6847 or (703) 605-6000. The product number is PB99-500480.

### **Combination MDI better for COPDers**

University of Arizona researchers have found that a metered dose inhaler combining ipratropium bromide and albuterol sulfate is more effective in the treatment of COPD patients than an MDI containing albuterol alone.

They compared the two techniques in a group of 357 patients enrolled at 17 centers, half of which received the combination therapy and half of which received albuterol alone. Those using the combination MDI exhibited a mean improvement in FEV1 over a six-hour period on day one and day 29 of the 29-day trial of at least 15% over baseline, and the overall response to the combined therapy was considered superior to albuterol alone, particularly in the first four hours of treatment.

In addition, more than twice as many patients in the albuterol alone group developed exacerbations requiring further treatment than those in the combination group. Those in the combination group had fewer hospital admissions and emergency room visits than those in the albuterol alone group.

About a quarter of the patients on the combined therapy reported adverse side effects or worsening of the preexisting condition, compared with about a third of those in the albuterol alone group. The most commonly reported side effects were lower respiratory tract disorders. (*Arch Intern Med* 1999;159:156-160) ■