Home Care Bulletin

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

NUMBER 7 FALL 1997

NOTES FROM THE CHAIR: COMMUNICATION HOLDS THE KEY

by Nicholas J. Macmillan, AGS, RRT

Well, the bomb has dropped and here we are, waiting and wondering what the ramifications will be. There's no doubt that a 25% reduction in home oxygen reimbursement in January 1998, followed by 5% in 1999 and a CPI freeze for five years, will ripple down to patient care. Certainly, we are all concerned with the bottom line. But we must keep our focus on patient care, despite these impending cuts.

One way we can do that is by taking full advantage of the communications opportunities afforded by this publication. A primary objective of the *Bulletin* is to provide the section membership with useful information relative to patient care, and our guest editors have worked hard to solicit your input, with some success. As we face these reductions in reimbursement, however, we need to pull together to make this an even more productive medium for exchange. Indeed, without an effective medium, we are destined to repeat costly mistakes at a time when, in the eyes of our patients, cost will receive more attention than is warranted.

I implore you to do your part in supporting the *Bulletin* by submitting a "Tricks of the Trade" item, a technical review, or an original article for an upcoming issue. To aid in narrowing the focus, I am requesting the following input for the next issue:

- Experience with, and protocols on, patient acuity programs
- Experiences with concentrator telemonitoring
- Experiences and hot spots with your JCAHO survey

I can't help but wonder if part of the reason for the dearth of unsolicited submissions we have experienced to date has to do with the proprietary nature of the material. If this is the case, please call me so we can discuss. I would really like to know if this is a real or perceived problem. I have to believe that we can share bits and pieces of our success without "giving away the farm." In any case, I encourage you to call me so we can discuss the success of this section and this publication. I hope to bring this topic up during the Home Care Section meeting at the AARC Respiratory Congress in New Orleans as well.

Visit AARC on the Internet — `http://www.aarc.org`

WASHINGTON UPDATE: MEDICARE CARE CUTS TARGET HOME HEALTH

by Cheryl West, MHA

Cheryl West is the AARC's director of government affairs in Washington, DC.

In an effort to balance the federal budget, Congress and the President have sliced away at the Medicare program, coming up with $115 billion in cuts over the next five years. No Medicare provider has been left untouched, and home health is suffering right along with everyone else. In spite of intense lobbying efforts by industry and beneficiary groups, HME suppliers have taken the following cuts:

- An oxygen payment reduction of 25% of the current fee schedules, beginning January 1, 1998, with an additional reduction of 5% January 1, 1999.
- A freeze until 2002 on inflation adjustments to the fee schedule for DME.

The secretary of HHS has the authority to develop different categories of pricing for the different classes of oxygen (i.e., liquid, gas, and concentrators). The secretary also has the authority to set service standards for O_2 suppliers.

However, there are several positive outcomes for HME in the bill as well. In the short term, HMEs can offer patient upgrades for equipment, with patients paying the difference between what is reimbursed by Medicare and DME pricing. This will be closely monitored to ensure that no undue pressure is put on beneficiaries to upgrade against their will. Long-term, two studies have been ordered to clarify issues related to home oxygen equipment—

1. A report from the Comptroller General of the U.S. due to Congress in 18 months on issues relating to the access of home oxygen equipment.

2. A report from the department of HHS permitting peer review organizations the ability to evaluate the quality of home oxygen equipment.

Much of the "ammunition" the Hill used to justify cuts comes from the release of two well-timed (no coincidence) reports on overutilization of services. An Inspector General report stated that nearly 14% of all Medicare services (to the tune of $23 billion per year) were unnecessary. The report primarily focused on home health agencies and nursing homes, and particularly on PT, OT, and physician office services. This became the rationale used to justify such severe cuts to these providers in this budget-go-round.

The other report was from the Government Accounting Office (GAO) and specifically dealt with home oxygen therapy.

The report concluded that the current Medicare reimbursement for oxygen therapy is excessive. Currently, the average price is $270 per month, or $320 per month with a portable oxygen system. The report recommended that Medicare reimburse more in accordance with the V.A. Medical system reimbursement, which currently is $155 per month. To take into account the differences between V.A. oxygen services and Medicare services, the report recommended that Medicare pay the V.A. prices plus 30%, resulting in a final reimbursement recommendation of $200 per month. Based on the GAO report, Congress then passed its recommended reduction in payments.

To ensure that home oxygen therapy payments were decreased, HCFA released a notice that the agency would activate the Inherently Reasonable (IR) process. Congress long ago gave HCFA the statutory authority to increase or decrease reimbursements based on whether or not the payments were inherently reasonable. HCFA maintains that current oxygen therapy reimbursements are "grossly excessive" and thus inherently unreasonable. HCFA's proposed notice recommended a 40.11% reduction in current oxygen therapy payments. It is well understood by the HME industry that the timing of the release of the proposed notice served as a warning — i.e., unless Congress cuts home oxygen reimbursement "enough," we (HCFA) will go ahead, via regulatory authority, and reduce payments. Basically, this is HCFA's ace in the hole; they won't use it unless they have to. The regulatory process in implementing such a reduction is very cumbersome and time consuming, and it is far simpler for Congress to, with a stroke of a pen, reduce reimbursements. The comment period for the proposed IR reduction is September 15, and the AARC will submit its comments by that date.

NOTES FROM THE GUEST EDITOR: THERE'S NO PLACE LIKE HOME

by Greg Spratt, BS, RRT

When I moved from the acute care setting to home care in 1985, I wondered what I was getting myself into. After all, I was one of those therapists who loved being in the thick of things, working with a critically ill infant or a trauma case in the ER. Knowing that I would no longer have that kind of exposure left questions in my mind as to how content I was going to be in my new responsibilities.

Here I am, 12 years later, still in home care. I quickly discovered that every area, including home care, has its challenges and opportunities. The challenge of seeing a patient in the ER with flail chest was quickly replaced with that of a COPD patient 60 miles from his doctor who was starting to show the signs and symptoms of an acute infection. Left with nothing but my stethoscope, an oximeter, and my assessment skills to guide me in making my recommendations to both the patient and the physician, I quickly gained a new appreciation for the home care field. You look into the distressed eyes of the patient and his anxious spouse and realize that there isn't a hospital full of physicians, nurses, therapists, and other clinical personnel waiting just outside the door for support.

I also discovered the rewards of home care when I returned a month later and that same patient was back to his usual smiling self, unable to thank me enough for what I did to help. The coffee and piece of home-made blackberry pie (my personal favorite) waiting on the table said it all.

With the challenges we currently face as home care therapists, it is good to remind ourselves that what we do is useful and that it is based on sound principles, including the following —

- The home is the least expensive place to deliver care.
- Patients prefer to receive medical care in their own home whenever possible.
- Chronic respiratory diseases such as asthma, emphysema, and chronic bronchitis require the provision of skilled home respiratory care.
- Programs designed to manage these illnesses in the home setting are both cost effective and effective at decreasing morbidity and mortality (see "Asthma disease management program outcomes show savings" in the summer issue).
- Factors such as increases in the incidence of asthma and the graying of the baby boom generation will only increase the need for these services.
- More and more services traditionally supplied at higher levels of care will continue to move toward the home setting (e.g., sleep diagnostics, ventilation).

It is also good to learn from the mistakes of the past and not limit ourselves to a single mechanism through which these services will be provided. Forces such as managed care and health care reform will certainly continue to shape our profession and the dynamics of the delivery system, but they will not alter the principles stated above.

For us to rise to the occasion and meet the challenges of the day, we must ensure that our responses are firmly based on those principles. The best way to accomplish that goal is to recognize the importance of —

- **Education:** I couldn't agree more with Nicholas Macmillan's "Notes From The Chair" in the summer issue entitled "Advocacy Begins with Education." We must educate everyone affected (i.e., physicians, discharge planners, other therapists, and patients) on the importance of supporting quality respiratory home care that is provided by those best equipped to do the job — i.e., respiratory care practitioners.
- **Expertise:** Most home care therapists were not hired for their managerial or marketing skills, but for their clinical expertise. Expertise is what brought us to home care in the first place, and if we are to remain here, it will be what keeps us here. We must not only continue to maintain and expand our expertise (see the following article on staying current), we must also apply that expertise to new opportunities as they present.
- **Flexibility:** In an age when many hospital RC departments are downsizing, I have watched some departments respond by seeking out nontraditional

delivery models and flourish as a result. We must learn to do the same. We should look for opportunities with physicians, managed care providers, home health nursing agencies, hospices, and other home health providers to provide our services.

- **Creativity:** It will take bold thinkers to design disease management programs, home diagnostic services, rehabilitation programs, and disease prevention curriculums which respond to the needs created by health care reform. Those who respond accordingly will lead us into the next generation of home respiratory care.

I believe we can have a bright future, but only if we are able to recognize and respond to the needs of our day. This familiar quotation summarizes the challenge that lies before us: "A bend in the road is not the end of the road, unless you fail to make the turn."

KEEPING OUR SKILLS CURRENT

by Greg Spratt BS, RRT

One of my responsibilities as a manager of home respiratory services includes the hiring of new therapists for the companies within my region. This process includes a review of their experience, references, credentials, and work-history, along with one or more interviews in which we try to get a feel for the character, communication skills, and clinical skills of the applicant.

In evaluating the clinical skills of the therapist, I have created five commonly encountered scenarios in which the applicant is given a set amount of patient information (e.g., ABG values, PFT results, patient symptoms), then is asked to provide an oral evaluation of that information, and suggestions for treatment and further evaluation based upon the initial testing. The result of this evaluation is often discouraging. I find that most therapists have spent little time and effort in maintaining their skills.

In the home care setting, it is easy to allow our skills to become rusty. Many therapists fall into the "rut" of doing routine patient assessments and equipment setups and no longer feel the need to maintain skills, learn new techniques, and grow in their expertise. To me, this is rather ironic because in the home setting, where the nearest physician and hospital can be miles away, your expertise in patient assessment may be all that you have to lean on when making recommendations to the patient and the patient's physician.

As a result of my experiences, I have begun to change my approach in working with the therapists in our organization. In fact, I created a 40-question evaluation which I gave to all our clinicians. The evaluation tests areas such as current services being provided (e.g., oxygen therapy, noninvasive ventilation), ATS recommendations for COPD management, NHLBI guidelines for asthma management, respiratory medications, and home patient assessment. As I told the therapists, this was not done to embarrass them or to "weed out the undesirables" but 1) to let them see why ongoing education is necessary in keeping their knowledge current and 2) to guide me in providing ongoing education for our staff.

As managers and home care therapists, we can provide an environment which is conducive to learning and growth of our therapists. Some of the ways we can do this include —

- **Maintaining an accessible and current library:** Many of the books which I purchased 12-16 years ago when I was going through my training have become outdated. I try to purchase new editions of respiratory textbooks and other books pertinent to our work (e.g., computer software manuals) and make them available to our staff.
- **Subscribing to home care and respiratory journals and periodicals:** Many of these magazines are available at no cost and contain excellent articles on subjects ranging from equipment reviews to marketing respiratory services. Subscription journals provide information on the latest clinical studies and standards of care.
- **Internet services, newsgroups, and computer assisted learning:** The advent of the computer age has created a host of new technologies available to the medical professional. Examples of those that I use with regularity include —
  - a CD-ROM with over 30 quarterly-updated medical textbooks
  - a CD-ROM with lectures from a sleep disorder seminar
  - e-mail for communicating with colleagues
  - newsgroups (e.g., RC World) where I can pose questions to hundreds of therapists (and receive dozens of answers)
  - web services such as Medline, a search engine which accesses thousands of medical abstracts
  - AARC's home page, where the latest CPGs and other information is free for the asking
  - a fiberoptic communication network that includes several hospitals in our area and features regular physician lectures on topics pertinent to home care therapists
- **Regular staff inservices:** Both formal and informal staff education should be made available. Don't fall into the trap of providing all of these inservices yourself. Delegate the responsibility to all members of your staff. Preparing to teach is one of the best ways to learn.
- **Journal Club:** I am in the process of starting a Journal Club in our area. Therapists come together on a regular basis (e.g., once a month), and on a rotational basis present articles from leading respiratory journals. You can assign each therapist a journal (e.g., Chest, Lancet, Respiratory Care) to scan for appropriate articles to bring to the club meetings. At each meeting, two-three presenters each have 15-30 minutes to discuss their article, with time for open discussion by the group after each presentation. I think it's a good idea to invite therapists from all settings (i.e., acute, subacute,

home) to get a wider range of exposure and provide everyone with the opportunity to stay informed on topics outside their own areas of expertise.

- **Seminars/CME courses:** I list this last not because it is the least important, but because it is the one that most people think of first. Seminars and special training courses tend to be very expensive and should be reserved for topics that are difficult to address in a less costly way. They may also be used to reward staffers who have shown diligence in their work and will take full advantage of the learning opportunity.

Finally, set the example. Telling your staff to stay current when you aren't doing so personally rings hollow. If we, as respiratory therapists, are to remain active and viable members of the home care team, knowledge will be one of our best allies.

JCAHO UPDATE: MORE ABOUT CLINICAL RESPIRATORY SERVICES

by Kathleen Brinton, RRT, MPH

Kathleen Brinton is an associate director at the Joint Commission on Accreditation of Healthcare Organizations.

When an organization provides Equipment Management Services only, it is responsible for the selection, delivery, setup, and maintenance of the equipment. It is also responsible for providing patient education about the equipment, reinforcing safety measures, maintaining the equipment in the home, and monitoring the patients' compliance and usage.

Clinical Respiratory Services (CRS) are performed when a health professional gathers clinical data or administers treatment to a patient on an ongoing basis. An organization is eligible for a Joint Commission survey for Clinical Respiratory Services only when the health professionals provide certain services. It is the type of services provided by the health professional that determines the eligibility — not the fact that the organization employs health care professionals or provides certain types of equipment.

Ongoing clinical services may include, but are not limited to, chest assessment, oximetry testing, monitoring vital signs, cough, sputum, edema, blood pressure testing, pulmonary function testing, drawing blood, suctioning, and chest physical therapy. Organizations that conduct only a one-time clinical assessment at the time of equipment setup are not utilizing data to make clinical judgments about the patients' *ongoing* status and are therefore not eligible to be surveyed for Clinical Respiratory Services.

Electing to provide Clinical Respiratory Services simply moves the organization to a different level of care. Unfortunately, apprehension and misperceptions about this level of care and the thought of compliance with additional standards have sometimes become a stumbling block to CRS accreditation. However, when an HME company is employing credentialed professionals who are rendering appropriate care, the most important step in achieving compliance with the additional standards has already been accomplished.

Standards that relate specifically to organizations providing professional services such as Clinical Respiratory Services are primarily found in two chapters in the *Comprehensive Accreditation Manual for Home Care:* "Care, Treatment, and Service" and "Management of Information." The standards in "Care, Treatment and Service" are organized under six headings —

- Care planning process
- Preparation and dispensing
- Medication administration
- Patient medication monitoring
- Nutrition care
- Diagnostic services

If an organization provides only HME, the applicable standards will be included in the first section. If an organization also provides enteral products, it will also need to review the standards in the Nutrition section. When an organization also provides Clinical Respiratory Services, it will need to review all the standards for applicability, particularly those related to medication administration and monitoring. The standards address an organization's process for reporting significant medication errors, adverse drug reactions, collaborative medication monitoring, and response to care. Patients receiving Clinical Respiratory Services must be monitored for their medication use. This entails two steps.

First, the clinician must determine what medications the patient is taking. This includes prescription drugs, over-the-counter drugs, and home remedies. This list should include the dosage, route of administration, frequency, and any other pertinent information. This information is frequently part of the patient's initial assessment and is simply updated with any changes whenever the clinician returns to the patient's home. The updated information can be easily obtained by asking a question such as, "Have you changed your liter flow or any of your medications since the last time I was here?"

The second step is to monitor the patient's use of the medication. For respiratory therapists, this includes a knowledge of the actions, side effects, and contraindications of the patient's respiratory medications. Common problems include overuse or under use of the prescribed medication, side effects such as trembling on a rebound reaction to a medication, and inability to prepare a unit dose medication according to directions.

For example, the patient may be unable to open the medication container because of weakness or an arthritic condition in the fingers, or the patient may dispense an incorrect amount of medication or diluent into a nebulizer cup because of poor eyesight or difficulty comprehending measurement marks on the medication container or dropper. Under use or overuse of medications, particularly unit dose medications, is most frequently noted when the supplier is requested to send medication prior to the next anticipated date of shipment, or the patient has a significant supply of the medication that has been unused when the next shipment arrives.

Finally, patients often use medications more frequently or in greater amounts than ordered, particularly medications dispensed in inhalers. When monitoring reveals problems

with medication use, the clinician should contact the patient's physician or provide additional education and monitoring to alleviate the situation. The standards do not require a respiratory therapist or other allied health professional, such as a physical therapist, to monitor drugs which are generally considered to be outside the scope of their practice.

In the "Management of Information" chapter, there are additional standards for organizations providing professional services, including CRS. These standards are all related to documentation in the patient's home care record, and often elicit the greatest amount of anxiety in both staff and leaders who are concerned about providing the additional service. In reality, most of the documentation can be completed by filling in blanks with a brief statement or single word, or by marking a checklist or applicable box on a standardized form.

Many organizations meet part of all of the home care record standards by use of three documents: an assessment form (both initial and follow-up), an education and safety checklist, and the HCFA 485. Some organizations use a combination of these forms, and still other companies create their own documents. The Joint Commission has no requirements for particular formats, or for specific charting procedures, such as SOAP charting. Each organization is encouraged to review its documentation format, and to make it as brief and effortless as possible. In addition, unless there is a significant lack of any documentation in the home care record, lapses in documentation do not generally result in any follow-up survey activity. The actual provision of the care, rather than the documentation in the home care record, is the significant factor when reviewing any service being provided. Only when lack of documentation negatively affects the patient's care will these standards begin to impact the results of the survey.

If you have any questions about your eligibility for Clinical Respiratory Services or your organization's processes for providing these services, please contact the Home Care Department at the Joint Commission at (630)792-5741.

THE WAVE OF OUR FUTURE

by Cheryl L. Westrich RRT, RRCP

Cheryl L. Westrich is a clinical director at Cape Area Vocational-Technical School in Cape Girardeau, MO.

The "rippling affect" of health care change has definitely made an impact on the clinical education of students. As a clinical director of education, I've had to incorporate changes into our program's clinical curriculum. Adapting to these changes brings new challenges and requires new goals to be included in the curriculum.

Let's start with the "restructuring" aspect of health care and "decentralized" departments. The first challenge is to accept the changes and focus on the positive aspects. When scheduling students at a facility that had undergone patient focused care, for example, our concerns were: "Will the students be getting adequate experience?" "Who will the students rotate with?" and "What type of skills will the students be exposed to?" However, after discussing matters with therapists at the facility, scheduling actually became fairly easy. Therapists there were assigned to specific areas of the hospital, each with responsibilities specified for that area. Students were assigned with these therapists to those areas, which included the emergency room, sleep lab, critical care units, primary pulmonary areas, med-surg areas, and SNF units. The students' clinical rotations were with respiratory therapists, and they were having positive experiences. They were also being exposed to many different skills, depending on the area in which they were rotating.

At another clinical facility, our students were able to make rounds with the consult service, which is made up of respiratory therapists. Students had the chance to incorporate assessment skills and apply patient-driven protocols to the care plans made for patients.

The clinical experiences that our students have today, however, are not limited to hospital based settings. Several of our hospitals have affiliations with subacute/rehab facilities in the area, and this has provided a wonderful clinical experience for the students. Students are able to rotate through these facilities and are exposed to other aspects of respiratory care.

An area of primary growth in respiratory care today appears to be occurring in the SNF units. When scheduled in the SNF units, some of our students were able to attend care plan meetings with respiratory therapy, physical therapy, occupational therapy, speech therapy, nursing, and physicians. The interaction with other staff members helped these students better understand their role in the care of the patients.

Home care facilities are another alternate site used in our clinical rotations. Students, again, are exposed to different aspects of respiratory care. Alternate clinical settings allow students to broaden their scope of opportunities to include areas which otherwise might be overlooked. For example, some of our students who had a certain "mind-set" in their perception of SNFs prior to clinical rotations actually enjoyed their experience and continued to pursue career paths in that direction.

Careful evaluation of student needs in this ever-changing field of respiratory care, however, includes more than just expanding clinical opportunities. We must also take a look at our curriculums. The growing areas of this field are skilled nursing and home care/DME. We, as instructors, need to communicate with these facilities and incorporate the skills necessary to excel in these growth areas in our curriculums.

Assessment skills are definitely number one on the priority list. The majority of our students are now finding career opportunities in the SNF and home care settings prior to graduation. My concern is not that our students lack the skills to work in these areas, but rather lack the experience necessary to perfect their assessment skills. Therefore, it is extremely important that students are exposed to these alternate sites during clinical rotations. Exposure, along with an emphasis on geriatric assessment skills, would be a great asset to any program. Review of Medicare reimbursement, charting skills, and terminology commonly used in these types of clinical settings also need to be incorporated.

The opportunities for our students today are overwhelming.

Some may find careers in traditional, acute care hospitals, others may work in skilled nursing facilities or find opportunities in the home care setting, and others may find careers elsewhere. As educators, the future is in our hands. We need to understand the needs of the changing health care system and adapt accordingly; if we do, our students cannot help but prosper in the years ahead.

1998 Congress on Integrated Health Care Management

Mark your calendars now for the Second Annual Congress on Integrated Health Care Management. The June issue of *AARC Times* highlighted several of the presentations from the first Congress, which was held in March 1997, and next year's event promises to be equally informative. Join other health care managers from each of the allied health disciplines in the second Congress, to be held February 5-8, 1998 in Dallas, TX, and take advantage of this opportunity to expand your management skills in a multidisciplinary environment.

The program begins with the keynote address, "Thriving on Change." Multiple concurrent sessions, as well as the general sessions include: "Exploring Discipline Issues," "Building Effective Relationships," "Achieving Clinical Integration," and "Achieving Balance in Life." The Congress provides multiple opportunities for networking in a retreat atmosphere at the Dallas Lakes Hilton. More information on the Congress program may be obtained by calling CLMA at (610) 995-9580 or (202) 543-7971.

ARCF Silent Auction Offers Unparalleled Opportunity for RC Managers

Attention RCPs! If you're planning to attend the AARC's 43rd International Respiratory Congress this December 6-9 in New Orleans there's a new attraction you won't want to miss. In an effort to raise funds for important projects aimed at improving quality of care for patients and positioning the RCP for success in our changing health care system, the American Respiratory Care Foundation is sponsoring the profession's first-ever Silent Auction.

Thanks to the generous support of the respiratory care industry and others in the respiratory community, the auction will feature items ranging from Las Vegas casino/hotel nights and ski lift passes to Disneyland vacations. Medical equipment to be auctioned off includes items such as capnographs, ventilators, and an oxygen system. You may also want to take advantage of the many New Orleans packages available, including fine dining, cruises, and voodoo tours. Since opening bids on all items have been set at just 25% of estimated retail value, its a great way to take advantage of a good deal for yourself and/or your department while supporting your profession at the same time.

The auction will run throughout the four-day meeting and all AARC members and officially registered attendees at the meeting are invited to come by Auction Headquarters as often as they like to place and/or raise bids. A preliminary catalog of items published in the October issue of *AARC Times* tells how the bidding process works, and a final catalog with an updated items list will be available onsite. So take a minute to see what's available, then come and join in the fun.

FYI...

Statistics explain the rush to prospective payment for post-acute providers

If you're still wondering why the federal government is in such a rush to come up with a prospective payment system to govern home care and other post-acute care providers, consider the following statistics from the April issue of *Hospitals & Health Networks*—

- The number of Medicare-certified home health agencies increased from 5,700 in 1990 to 9,800 in 1996.
- About 3/5 of the nation's hospitals now operate home health agencies of their own.
- The percentage of Medicare beneficiaries using home care services nearly doubled during the past seven years, from 5.6% to 10.1%.
- Since 1990, the average number of home visits per patient per year jumped by 43, from 33 to 76.
- Spending on home care services climbed from $3 billion in 1990 to $16 billion in 1996.
- Total post-acute outlays have grown from $8.3 billion in 1990 to more than $30 billion today, and now represent about 1/6 of all Medicare expenses.

(Source: *Hospitals & Health Networks*, 4/97)

Kaiser Family Foundation study helps explain jump in home care utilization, but questions for-profit providers

There's no question that utilization of the home health benefit under Medicare has grown by leaps and bounds over the past decade. (See previous article.) But a closer look at who is using more of these services helps to explain why.

According to a recent Kaiser Family Foundation study conducted by the Project HOPE Center for Health Affairs, increases in home health spending have been largely driven by the highest utilizers of these services—Medicare beneficia-

ries who receive more than 200 visits a year. As a group, however, these beneficiaries exhibit characteristics justifying the expense. A profile of these beneficiaries shows that—

- One quarter had two or more hospital admissions per year.
- Nearly 80% report severe functional impairments.
- 80% live at or near the poverty level.

Says Tricia Neuman, director of the Kaiser Medicare Policy Project, "Medicare's home health benefit has evolved into a limited long-term care safety net, especially for high-utilizers. It has also become an important source of medical care for really sick seniors who are in and out of hospitals several times a year." Kaiser is concerned that current initiatives in Congress to add a co-payment for home health services would disproportionately affect near-poor beneficiaries who do not qualify for Medicaid, thus curtailing services to this population and endangering their medical care.

While the foundation warns against cuts in home health, however, other findings in the study have raised concerns regarding the provision of services by for-profit home health agencies. Specifically, researchers found that the average annual home health expenditure per beneficiary in 1994 ($4,442) was $1,064 higher for those served by for-profit providers than those served by non-profits or government-run agencies—an anomaly that could not be explained by differences in the patient populations served. The higher costs for for-profits resulted in an additional $1 billion in Medicare spending that year, a fact that researchers say warrants further investigation. (Source: Reuters Medical News, 7/2/97)

Submission Guidelines For Articles Written For The Home Care Section *Bulletin*

Article length: *Bulletin* articles should be between 500 and 1,500 words (about 1-4 typed, double-spaced pages).

Format: In addition to a paper copy, all articles should be submitted on a 3.5 inch floppy disk saved in Microsoft Word or TEXT ONLY (ASCII) formats, or e-mailed to the editor in one of those formats.

Deadlines: All articles must be submitted to the editor according to the following schedule of deadlines—

- Spring Issue: February 1
- Summer Issue: May 1
- Fall Issue: August 1
- Winter Issue: October 1

Article Review: All authors may review copies of their articles before they go to press. If you would like to review a copy of your article, please include a FAX number when you submit it to the editor. It is the responsibility of the author to 1) request the opportunity to review the article before it goes to press and 2) contact the editor by the stated deadline if any changes need to be made before the article goes to press.

Medicare ruling elicits change in accreditation eligibility for HMEs providing unit-dose bronchodilators

Due to a recent change in Medicare rules allowing providers of home medical equipment to bill directly for unit-dose bronchodilator medications provided in the home setting to patients whose clinical status is being monitored in the home, these providers are now eligible for accreditation for home pharmaceutical services under the Joint Commission's Home Care Accreditation Program.

Previously, Medicare required HME providers offering these drugs, either through a contract with a pharmacy or their own pharmaceutical services, to bill for the drugs as part of the equipment, thus making them ineligible for accreditation as a provider of home pharmaceutical services. For more information on the new eligibility, contact Darryl Rich, Pharm.D, MBA, (630) 792-5752, or Kathleen Brinton, RRT, MPH, (630) 792-5740. Both are associate directors of the Joint Commission's Home Care Accreditation Services. (Source: *Home Care Bulletin*, No. 1, 1997)

Coming soon to an organization near you: ORYX is on the way

ORYX: The Next Evolution in Accreditation may sound like a title for the latest holiday blockbuster, but health care organizations are soon to find out differently. In keeping with its ongoing efforts to redefine the accreditation process, the Joint Commission on Accreditation of Healthcare Organizations will soon be requiring all organizations to provide objective feedback about their performance to the Joint Commission that can be used "internally to support performance improvement activities and externally to demonstrate accountability to the public and other purchasers, payers, and stakeholders." The Joint Commission plans to integrate the data into its triennial onsite survey process, allowing for what it has termed a more "credible, objective, consistent, and useful" survey.

Long-term care facilities will be the first to come under the new requirements, followed shortly thereafter by hospitals. By the end of December, all accredited long-term care organizations are going to be asked to—

- Choose a performance measurement system from among 60 such systems that have been approved by the Joint Commission and;
- Select at least two clinical indicators from that system that relate to at least 20% of their patient population

—then report both to the JCAHO. Organizations must begin submitting data to the Joint Commission no later than the first quarter of 1999, and continue to submit data on a quarterly basis thereafter. For more information on the ORYX initiative, visit the Joint Commission's website at http://www.jcaho.com. (Source: JCAHO)

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