American Association for Respiratory Care's

Home Care Bulletin

July / August 2002

Notes From the Chair: Update of Activities

by Joseph Lewarski, BS, RRT

The last couple of months have been busy ones in the home respiratory care arena. Here's an overview of what's been happening:

Competitive bidding

Medicare is trying to move forward with national competitive bidding for HME. Some states, including Florida, Texas, and North Carolina, have already developed plans. In fact, Florida's plan just cleared the courts and the bids are underway.

The sole purpose of competitive bidding is to drive down payments. Medicare and Medicaid view HME as a commodity and don't see any value or difference in service - and clearly do not see the benefit of RTs. But by limiting patient choice and reducing the competition for business, competitive bidding is actually anti-competitive.

We all know that free market competition helps drive up quality, especially when the payment is the same and there is no standard of care. However, once service is eliminated from the equation, I would predict that service levels will drop off immediately. Anecdotal reports already suggest that companies in demonstration areas have pulled RTs from involvement in the care of patients being serviced under the bid contract.

The AARC opposes competitive bidding for respiratory related products and has sent letters to Congress and the Centers for Medicare and Medicaid Services (CMS) explaining our position. I strongly urge you to contact

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Notes From The Editor: Telehealth is on the Way

by James Stegmaier, RRT, RPFT, CCM

"We have a choice: we get involved, or we stand by and watch other professional groups make decisions about our future," are the words of Marlene Maheu, PhD, a leader in telehealth.

What is telehealth or telemedicine? Telehealth is defined as communication between the health care professional and the patient that occurs through electronic means and takes place while each is at a different location. The technology to allow the home care respiratory therapist to apply telehealth to apnea monitoring, CPAP systems, and mechanical ventilation has been around for several years now. But only recently has there been a growing interest in the benefits of telehealth for home respiratory care.

Although telehealth is still in its infancy, according to Dr. Maheu, it "will be part of the normal health care delivery system" in the very near future. Many regulatory issues, such as patient confidentiality, still need refinement, but the benefits - including decreased costs of care - make it difficult not to stop and look at the possibility of incorporating telemedicine into the home care organization.

The ability to change parameters on a CPAP system or apnea monitor, as well as download clinical information from these systems, without having to drive to a patient's private residence could bring large financial benefits to the home care provider. The larger the service area of the durable medical equipment provider, the greater the benefit. The time savings realized through a decrease in drive time could then be used to increase contact time with other patients.

This process, however, should not replace the home visit entirely. Telehealth will have its greatest impact by working in conjunction with the policies and procedures of a home care organization regarding home visits to maximize patient care.

In this issue we are fortunate to have an article by Todd Ringeisen, RRT, the pulmonary service coordinator for Kids Home Care Inc., in St. Petersburg, FL, who shares his experiences with telehealth for the benefit of all section members. As patients and health care professionals become more comfortable with the use of technology to improve the communication of health care information, telehealth will continue to grow and gain additional acceptance as part of the standard of practice of care. ◆

OIG Recommends Elimination of Semi-Annual Maintenance Payment

The Office of the Inspector General (OIG) is recommending that the Centers for Medicare and Medicaid Services (CMS) eliminate the semi-annual maintenance payment for rental equipment and instead pay only for repairs when necessary. The move comes after the OIG tracked more than 3.500 pieces of capped rental equipment for beneficiaries who decided to rent or purchase the equipment in 1996. The analysis showed Medicare paid substantially more for maintenance on rented equipment than repairs on purchased equipment. Further analysis of more than 250 maintenance services from June of 2000 found only 9% of the capped rental equipment actually received any maintenance and servicing.

The OIG believes CMS could save about $100 million a year by eliminating the maintenance payment for rental equipment. CMS is currently considering a legislative initiative to eliminate the 15-month rental option altogether, says the OIG ◆

Home Care Rep Added to JCAHO Board

The home care industry recently got an increased voice at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Frances Baby, president of HomeReach in central Ohio, was appointed to fill a special, new non-voting seat on the JCAHO Board of Commissioners beginning in July.

Baby's two-year appointment is part of a larger effort to build and strengthen relationships between home care organizations and the JCAHO Board. JCAHO has also selected a Board member to serve as the Home Care Program liaison and plans to have a group of home care leaders meet annually with the Executive Committee of the Board to discuss standards and policy issues of interest to the home care field.

"The home care industry can now be assured that their views will be carried to the highest levels of the Joint Commission," says Dennis S. O'Leary, MD, Joint Commission president. "The Board has made a clear statement about the importance of the Home Care Program to the Joint Commission." ◆

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you legislators and express your concerns. The AARC's letter, which is available online (http://www.aarc.org/headlines/dme_issue/letter.pdf) went to members of the House Ways and Means and the House Energy and Commerce Committees, which will consider this legislation. Read more about how you can help the AARC promote patient safety and access to qualified respiratory therapists for DME users at the AARC Capitol Connection: http://capwiz.com/aarc/home/.

New HCPCS coded items

Some of you have asked for information about E0482 (cough assist) and E0483 (IPV). I spoke recently with one of the DMERC medical directors, who told me that they are working on a policy for E0482 and expect to have something out in a couple of months. He also stated that E0483 will continue to have a non-coverage policy, as was previously the case under national CMS policy. By the time you receive this edition of the Bulletin, this information should have been released by the DMERCs.

HIPAA

Earlier this year I worked with a volunteer group lead by Marcia Nusgart to address the Medicaid and other local HCPCS coding issues that must be resolved as part of HIPAA. All local Medicaid and private insurance HCPCS codes must be reviewed and included in the Medicare approved HCPCS codes in order to be used. In the 2002 HCPCS coding guides, many of the items historically not covered or coded by CMS are now listed under a group of new S-codes. These codes are for non-Medicare covered items that are often billed under Medicaid.

Despite the new S-codes, the working group still identified about 40-50 items that need a HCPCS code to ensure that they will be covered under the HIPAA plan. I'll try to keep you informed as this unfolds.

AARC Congress in Tampa

As you can see from your July issue of *AARC Times*, the Congress will feature an abundance of home care lectures and symposiums. In fact, I think we have more than last year! To keep home care at the forefront, we must demonstrate our support and show strong attendance at the meeting. Start planning now! I hope to see many of you there in Tampa. If you have never been to an AARC Congress, this would be a great year to start.

Board meeting

I attended my second AARC Board meeting as the Home Care Section Board member in mid-June. I reinforced to the Board the concerns we have in regards to competitive bidding, along with a number of other current industry-related issues. The AARC supports the role of the home RT, and I am working to make sure this support remains at the front of the line.

Our section numbers were reported, and we are still under 1000 members. Please remember to renew your AARC membership and your Home Care Section membership as well. If we can't sustain 1000 members, we'll lose our seat on the Board. We fought long and hard to get here - let's not let it slip away. Keep your membership current and encourage your friends and colleagues to do the same.

The Bulletin

After a long review of the data and comments from members, it was agreed to reduce the number of Section Bulletins from six per year to four, starting in 2003. In addition, we are hoping to encourage more members to opt for the electronic version of the Bulletin (available now on the section home page on www.aarc.org) over the paper version.

Keep in touch

Last, please remember that I am here to represent the AARC members working in home care. Please keep me apprised of your needs and concerns and I'll ensure they are addressed by the AARC leadership and Board. ◆

Telemedicine: Having Your Patient Just A Mouse Click Away

by Todd Ringeisen, RRT, AS, pulmonary services coordinator, Kids Home Care, Inc., All Children's Hospital, St. Petersburg, FL

Today a radiologist can sit in his den at 3:00 a.m. and view a CT of a car accident patient with the same quality as if he was in the control room with the radiology technologist. A surgeon can perform an operation on a patient 3,000 miles away through a computer with the exact precision as if he was holding the scalpel. But if Mr. Smith's BiPAP unit isn't working correctly, the home care respiratory therapist will be making an unplanned trip to Mr. Smith's home.

The last 10 years have seen a great explosion in the communication market. You can call, page, fax, or e-mail just about anyone from anywhere in the world. In today's fast paced, information-craved, "gotta have it now" society, using the airwaves to instantly access another person is a must. But the home care field seems to be slightly behind the times when it comes to the telemedicine age.

There is hope. Some equipment is already here. Many brands of apnea monitors have telemedicine capabilities, as do a smattering of other home respiratory equipment. But most of the newer home ventilators, which have been promising this feature for years, have yet to fulfill that promise. Manufacturers acknowledge the need for telemedicine; but when they will actually be able to deliver it is another story.

The main stumbling block is the Food and Drug Administration (FDA). The FDA is wary of the idea of making adjustments to a patient's piece of equipment via a computer without a practitioner present. It's easy to see why. No one wants just anyone jumping online and changing a patient's ventilator settings.

Another issue facing respiratory care telemedicine is technology itself. Many people are turning away from the traditional home telephone line in favor of the cellular phone. Cell phones have all the features of the standard telephone, with the added plus of mobility. Technology allows for Internet access through a cell phone; however, few people have that capability. It would be wise for manufacturers to stay a step ahead of the times and begin exploring how to best connect their equipment through cell phones.

What is the great advantage of telemedicine for the home care practitioner? First, it is time saved. The ability to connect to a home patient's apnea monitor over a modem line, download the monitor, and print your report before you would otherwise get halfway to the patient's home would save countless hours. It would also save in personnel needs. One person at a computer could download dozens of monitors in a single day. It would take four or five practitioners all day to handle the same number of patients. These factors are significant in the days of downsizing and dwindling reimbursement from payors.

Another advantage would be piece of mind for the patient/caregiver. For example, being able to immediately tell whether an alarm condition is real or not would greatly decrease patient/caregiver anxiety. Without telemedicine, they would have to wait until the RT was able to come out to their home to visually inspect the equipment.

With all this technology flying around, is there a downside for the patient? Yes. It's called loss of the personal touch. We want to have contact with our patients. We want to be able to listen to their breath sounds, assess their needs, and talk to them face-to-face - to get to know them. We want to showcase the respiratory therapist as a real person who cares for the patient as both a customer and a person. We cannot just do all of our work sitting in front of a laptop.

Telemedicine is a tool to be used by the respiratory therapist, just like the stethoscope, pulse oximeter, or oxygen analyzer. All of these tools must be used in conjunction with the patient assessment skills we have honed over the years. Being able to ask the patient how he feels and actually have compassion for him is something the computer can't do - yet. ◆

Vitamins May Combat Memory Loss

British and Scottish researchers believe vitamins may play a key role in maintaining memory in the elderly. Their study, published in a recent issue of the *American Journal of Clinical Nutrition*, found older people with lower levels of folic acid and vitamin B12 had lower scores on tests of cognitive abilities than those with higher levels.

The study involved 331 men and women who took part in Scottish Mental Surveys, intelligence tests conducted on schoolchildren in Scotland in 1932 and 1947. ◆

HMEs Get Reprieve from ORYX

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has suspended ORYX requirements for HME organizations until core measures can be identified. HMEs must still meet the performance measurement and improvement requirements outlined in the Home Care standards. They may also continue with current ORYX requirements if they choose, and use a performance measurement system.

The suspension came amid other changes involving ORYX reporting requirements for the Home Care Accreditation Program that are scheduled to go into effect next January. ◆

Dental Problems Linked to Aspiration Pneumonia

Elderly patients who have dental plaque or certain types of bacteria in their mouths may be at increased risk for aspiration pneumonia, finds a new study presented at a recent meeting of the American Geriatrics Society. Although the authors of the report emphasize more study is needed to determine a link between the two conditions, they suggest nursing homes and other providers stress the need for good oral hygiene among their older patients. Use of mouthwashes to reduce the amount of bacteria present in the mouth may be a worthwhile preventative measure.

The study was conduced by investigators from the University of Michigan and the Veterans Administration. ◆

Pulmonary Doc Appointed to MedPAC

The U.S. Comptroller General has appointed a pulmonary physician to serve on MedPAC, the independent federal body responsible for advising Congress on Medicare revisions and rates. Dr. Nicholas Wolter, pulmonary and critical care physician and chief executive officer of Deaconess Billings Clinic in Billings, MT, will join three other new appointees on the 17-member commission. ◆

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Healthy Lifestyles Benefit Even the Very Old

Elderly people who exercise more and smoke less are more likely to remain healthy into very old age, new research reveals. The study, published in the May/June issue of *Psychosomatic Medicine*, provides evidence that engaging in "proactive health-promoting efforts," even late in life, has important long-range benefits.

The investigators, from Case Western Reserve University, followed 1,000 people age 72 and older for nine years. All lived independently in retirement communities in Clearwater, FL, and were free of major mental or physical illness at the beginning of the study. Participants were interviewed annually about their health status and behaviors.

By the end of the study, 374 subjects had died and another 78 were too ill to continue. Researchers then compared this group to those still taking part in the study. Results showed participants who had smoked were less likely to survive than those who had never smoked, with the risk of dying more than twice as high among those who were smokers at the beginning of the study compared to those who had never smoked. Those who exercised the most at the start of the study generally reported fewer physical limitations, more frequent positive emotions, and a greater sense of meaning in life at the final interview, even when their health problems were taken into account. ◆

Caring for the Caregivers

An estimated 3.5 million American women care for demented spouses or parents at home, putting their own physical and emotional health at risk. New research indicates that a simple, home-based exercise program can reduce the personal toll their caregiving takes.

Investigators from Stanford University School of Medicine recruited 51 women who were caring for demented relatives. The women were at least 50 years old, not engaged in regular physical activity, and providing at least ten hours of care every week.

Each participant received an in-person counseling session with a health educator, who provided information and instruction on how to work up to a regular schedule of three or four 30- to 40-minute exercise sessions a week at home. Over the following 12 months, each caregiver/counselor team stayed in regular contact via telephone calls and mailed activity logs.

The researchers found that even though the caregivers provided an average of 71 hours of care a week, 70% adhered to their exercise program for a whole year. During this time, the amount and intensity of their exercise, as well as their knowledge of physical activity, significantly increased.

By the end of the year, the women were significantly less depressed and stressed than before starting the exercise program. Although their actual burdens did not decrease, their perception of how burdened they felt markedly improved. ◆

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