Home Care Bulletin
July/Aug. '01



American Association for Respiratory Care

# Notes from the Chair

**by Joseph Lewarski, BS, RRT**

By now, many of you may have heard that I left my position at Hytech Homecare to pursue an opportunity with a unique organization known as The MED Group. I am in the newly created position of director of the National Respiratory Network. MED is a network services company that provides professional support, consulting, lobbying, and group-purchasing services to its members, which are independently owned home medical equipment providers. One of MED's primary goals is to provide independent companies and their personnel with the tools needed to excel in their markets. Although I won't be running my own HME company anymore, I'll get the chance to work with hundreds of wonderful companies. Hopefully, I'll be able to share my experiences with them and learn more about our industry in return, with an end result of being able to help advance the profession. For those of you needing to reach me, my new contact information appears on page 2. As always, please feel free to contact me if I can help you in any way.

This year's AARC International Respiratory Congress is scheduled for December 1-4 in beautiful San Antonio, TX. Although the final program hasn't been made public as of this writing in early summer, I do know that more than 20 lectures related to home respiratory care will be presented by leaders from our profession. If you thought last year's meeting was a success, be sure to attend this year!

We are still facing concerns related to the retesting of Group I home oxygen patients. Although the furor in the industry trade press has died down since the announcement that the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) has delegated retesting to the DMERCs, this issue is far from over. The DMERC medical directors are rumored to have a draft policy circulating at CMS, which includes the retesting of all new oxygen patients.

One issue that greatly disturbs me is the fact that CMS and the DMERCs are citing the paper published by Yuji Oba, et al., in the April 2000 issue of RESPIRATORY CARE1 as the primary reference influencing this proposed change. Although the paper met the necessary criteria of peer review, it was based on an extremely small sample of a very specific group of 226 patients studied at one location by one set of investigators. The sample size represents less than 0.0003% of the estimated 850,000+ home oxygen users. This is insufficient for extrapolation across the country. I personally believe that Oba's work is important and suggests that further study is warranted in this area. However, I believe that it is inappropriate to base a major policy change that will potentially affect hundreds of thousands of patients requiring home oxygen on this study.

To date, the AARC is the only organized industry group to offer an official statement expressing concerns regarding the implementation of such a complex policy. We are expecting to see similar statements from other key organizations and physician groups, expressing concern and asking for considerably more data before initiating such a dramatic change. The entire AARC leadership is in tune with this issue. I will keep you informed as we uncover more information.

You will notice a new name among our writers this issue. Jim Stegmaier, RRT, RPFT,CCM, is joining our team as the co-coordinator of the *Bulletin* in concert with Barry Johnson. Jim is a 10+ year home care veteran who is currently the vice president of clinical services at Hytech Homecare. Please join me in welcoming Jim to our writing staff.

Speaking of writers, it is a tough job coming up with stories for this *Bulletin*. If you have ever thought about writing an article or if you have a strong opinion on something and want to share it, please volunteer to author an article. It's a great way to get started in the writing business and may even lead to future publications. It doesn't look too bad on your CV either! Give it a try!

***Reference***

1. Oba, Y, et al. "Reevaluation of Continuous Oxygen Therapy After Initial Prescription in Patients with Chronic Obstructive Pulmonary Disease." Respiratory Care. 2000;45(4):401-406. ■

# Options in Accreditation

*by James Stegmaier RRT, RPFT, CCM*

For more than ten years, home care providers have had a choice when it comes to accreditation. But traditionally, most home care respiratory therapists have only been acquainted with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), largely due to its size and the fact that it is the premiere accrediting program for hospitals. Over the past couple of years, however, other accreditation programs have become increasingly familiar to health care professionals involved in home care. These other programs for accreditation include the Accreditation Commission for Health Care (ACHC) and Community Health Accreditation Program (CHAP).

The increased interest in options for accreditation is due to the financial costs involved in the preparation for the survey and the accreditation survey process itself, benchmarking programs, and the value of the standards being used to accredit an organization. Starting in this issue of the *Bulletin*, we will devote an article to each of the these accrediting organizations to provide information about how each organization performs its accreditation processes, the philosophy of the organization, and estimates of the financial costs involved. The articles are intended to provide information, but by no means endorse one accreditation organization over another. ■

# Joint Commission on Accreditation of Healthcare Organizations

*by James Stegmaier RRT, RPFT, CCM*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began in 1919 with its first onsite inspections of hospitals. JCAHO began accrediting health care organizations using professionally based standards and started evaluating compliance of organizations against these benchmarks in 1951. The Joint Commission Home Care Accreditation Program began in 1988 and has accredited more 5,600 home care organizations, more than 3,000 of which are suppliers of medical equipment.

JCAHO states that health care organizations seek accreditation for the following reasons: improve the quality of patient care, meet Medicare certification requirements, enhance community confidence, improve staff recruitment, enhance access to managed care contracts, fulfill state licensure requirements, and expedite third-party payment. JCAHO points out as well that accreditation is different from licensure. Licensure may be required by the state where the organization operates and is mandatory in nature, with inspections that emphasize enforcement. The accreditation process is a voluntary survey with an emphasis on improvement in patient care.

Home care organizations are defined by JCAHO as organizations which provide home health services, personal care and support services, home infusion and other pharmacy services, durable medical equipment, and hospice services.

The accreditation survey is performed, at a minimum, every three years to maintain accreditation. The standards used by JCAHO address the organization's performance in critical areas, including patient rights. The focus is on the actual performance, not what the organization states it performs. The standards are set to affect the quality of patient care delivered by the provider. The Joint Commission feels that the organization that follows the JCAHO standards closely will more likely have positive outcomes with its patients.

The Joint Commission also requires an external benchmarking program called the ORYX initiative. This program, developed in 1997, is being gradually introduced over several years. Under the process, each member chooses indicators relevant to the services provided by their organization and has these indicators benchmarked against similar providers. The first data were required to be submitted to JCAHO in the first quarter of 2000. The gradual phase-in of this project has gone from an initial reporting of two indicators to be benchmarked to six for the first quarter of 2001. The indicators are selected for a group of listed performance measurement systems approved by JCAHO. To date there have been over 15,000 performance measures submitted by over 300 performance measurement systems. One of the goals over time is to create a balanced set of indicators applicable to all types of home health organizations and allow comparison of processes and outcomes of patient care regardless of which performance measurement system is used by the accredited organization.

The Joint Commission states that, on average, it can take an organization four to six months to get ready for its initial survey, with many providers taking up to one year. When applying for the initial survey, the home care provider must be in compliance with the standards set forth by the Joint Commission for four months prior to the survey. The survey length will vary between one and ten days depending on the number of home care services provided, volume of patients within each service, and the number of sites and their distance from the main site.

The Joint Commission employs surveyors from a wide variety of disciplines, including nurses, respiratory therapists, pharmacists, psychologists, social workers, medical technologists, physicians, and health care administrators. JCAHO uses surveyor(s) with expertise in the areas of service that the organization provides based on the provider's application for accreditation. The typical survey will begin with an opening conference to introduce the organization to the survey process and the surveyor. After the opening conference, the survey will begin with the surveyor reviewing all aspects of the organization's services, including viewing patient setup and follow up; medical records review; contract review; maintenance programs and

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records; compliance with FDA, DOT, and OSHA standards; performance improvement processes; and human resource records.

When the survey is completed, a closing conference provides initial feedback on how the provider performed and met the established standards. The final report is sent to the organization after it is internally reviewed and approved at the Joint Commission. When the report is sent, the organization may be finished with survey, be required to submit further documentation, or have another survey to focus on a problem area.

The cost of accreditation is charged to the organization in the year in which the survey is performed. There are no fees or costs to an organization in a non-survey year. The cost of a survey is based on services provided and patient volume. Survey fees range from $3,300 to $8,200 for the majority of home medical equipment suppliers.

There seems to be some confusion as to the clinical respiratory portion of the accreditation process with JCAHO. An organization that is pursing accreditation with the Joint Commission is not required to undergo the clinical respiratory portion of the survey process, even if respiratory therapists are employed by the organization. The JCAHO position on this issue is that services are accredited, not the type of personnel employed by the provider. The organization must be surveyed for clinical respiratory if patient assessments are performed (even if these consist of only a one time baseline assessment), treatment is administered, education related to respiratory care is delivered, or monitoring of the patient's respiratory status is performed.

The Joint Commission is always working to improve the home care accreditation process. In 1999 the Joint Commission formed a home care advisory group which meets quarterly to provide input and feedback to JCAHO regarding changes in the home health industry. JCHAO is also offering e-mail updates on changes in the accreditation process and home medical equipment-specific accreditation manuals. ■

# A Legal Perspective

***by Barry Johnson CRT, RCP***

Have you ever been served with papers telling you that you and your organization are being sued? Well, if you have not had this experience, you are among the lucky few home care providers. As a practical matter, you are eligible for this experience every day because of the very nature of what you do: provide home care services and equipment for customers.

This is a summary of how one home care organization was sued and survived. The names have been changed and some documentation omitted for obvious legal reasons. But all the facts in this case are true.

It was early one morning when the mailman brought in the mail to the receptionist at Dick's Homecare, Inc.. Mary proceeded to take the mail to Dick, who is the owner, and he began sifting through it for the payments from insurance companies, Medicare, and Medicaid. Near the bottom of the stack was an envelope from a law firm. This caught Dick's attention and he opened it first. The letter informed him that he was being sued for a variety of customer injuries related to some unknown product and customer that his company had serviced two years before.

Upon careful review, Dick contacted his business office to secure and review the customer's file. He noticed that Dick's Homecare, Inc., provided setup and delivery services for a managed care organization that had selected and purchased a scooter for a beneficiary in his service area.

Dick immediately contacted his insurance carrier, who told him an adjuster would make contact. Shortly thereafter, Dick received some confirmation papers from his liability carrier confirming a claim had been filed and that the adjuster would be calling.

In about two weeks an adjuster contacted the home care company and collected some details about the claim, such as dates of service, type of equipment, delivery point, and the customer's name, address, and telephone number, along with the name of the attorney representing the plaintiff. In addition to the general information, Dick was asked to make a statement about his part in the setup and delivery of the scooter. The adjuster told him an attorney would contact him within the week.

During the next week, Dick reviewed the customer documentation and realized it had been two days and two years since the scooter was setup and delivered for the managed care organization. Soon after this revelation, the attorney for his case called and the conversation went something like this: "Dick, this is Jon Jones, your attorney in the scooter case. How are you today?"

"Well, I have been better, but I sure need your help!"

"Dick, as your attorney, I will do everything to help you in this case."

"Thanks Jon. I know your firm's reputation and feel confident we will be okay."

Jon questioned Dick about the case for over an hour. Finally, Dick said, "Jon, I think the statute expired before I was served. Is there anything we can do to exercise us out of the deal?" Jon responded by saying that there was a slight chance; however, under the rules of law, procedures state that if the attorney for the plaintiff has filed a claim on a timely basis and is still trying to serve the defendant(s), it may still be a valid claim. Jon agreed to research Dick's information. In the end it was found that the plaintiff's counsel had followed the rules of law, and Dick's Homecare, Inc. was still going to have to prepare for trial.

Over the next 12 months Dick and the attorney spent hundreds of hours reviewing documents, taking depositions, and reviewing numerous options. In addition, they made an onsite visit to the customer's residence to review the "defective equipment" that allegedly caused the injury to the patient. Both Dick and Jon agreed that Dick's Homecare, Inc. did not sell, have decision powers for purchase, manufacture, perform testing, or engineer the scooter. Dick's Homecare, Inc. simply put the seat on the scooter and attached the tiller per assembly instructions.

By all standards, Dick's Homecare, Inc. only acted as the delivery agent and had no clinical input into the scooters selection process. Unfortunately, Dick's Homecare was a victim of circumstances, caught in the middle between the customer and manufacturer. On several occasions, the attorney for Dick's Homecare, Inc. explained to the plaintiff's attorney that his client simply acted as the delivery agent. Unfortunately, there was no relief in sight for Dick's Homecare, Inc.

Three years from the date of the alleged patient accident Dick gave his deposition and told everyone, including the attorney for the manufacturer, that he did not have anything to do with the part that broke and caused the customer to be injured. Under grueling examination, Dick maintained his position, answered truthfully, and finally said, "We are just the company that delivered the scooter. We did not manufacture, engineer, or select the scooter for the customer and certainly did not know there were ever any problems with the scooter!" With this last word, the deposition was concluded, and Dick met with his attorneys to discuss further action.

It would seem as if the suit against Dick's Homecare, Inc. should have been immediately dismissed .However, it is still pending, awaiting the release from the plaintiff's attorney and other legal documentation. So while I can't reveal the final outcome of this case at this time, I'll keep you posted in future issues of the *Bulletin*. In the meantime, there are several good lessons to be learned from this case:

- Keep good customer records, including instructions provided and dates and times of delivery, plus product serial numbers for every part you assemble.
- You can be litigated even if you are only the delivery agent.
- Be careful who you align with as an agent for delivery and setup.
- Maintain current insurance coverage to protect your company, and secure named binders from all manufacturers your represent.
- Be proactive in your defense and let your attorney know you want to participate in all decisions related to your case.
- Be patient. It takes a long time to settle legal issues and, ultimately, preserve your good name. ■

# Sentinel Event Alert: *Fires in the Home Care Setting*

***Editor's Note:*** *The following article is reprinted from the JCAHO web site with permission from the Joint Commission.*

Since April 1997, 11 sentinel events have been received and reviewed by the Joint Commission related to home health care patients who were either injured or killed as a result of a fire in the home. These home care patients were receiving supplemental oxygen service and in each case, the patient was over the age of 65. Several risk factors for home care related fires have been identified through an intensive analysis of these sentinel events; these risk factors include 1) living alone, 2) lack of smoke detectors or presence of non-functional smoke detectors, 3) cognitive impairment, 4) an identified history of smoking while oxygen is running, and 5) flammable clothing. These home care sentinel events resulted in the death of seven patients and the loss of function or permanent disfigurement for four other patients. Cigarette smoking was determined to be a contributing factor in each of these cases.

In the 11 cases studied, the home care organizations have identified various root causes that are thought to have contributed to these sentinel events involving fires in the home. These root causes encompass patient care processes, the caregivers, the environment of care, and communication factors. With relation to patient care processes, more than one-third of the cases involved inconsistent identification of smokers and missed reassessment visits. In 18 percent of the cases, organizations determined they lacked a sufficient process for considering the termination of services to patients who persistently refuse to comply with prescribed precautions.

In assessing caregivers, nearly three-quarters of the cases identified that caregivers needed to increase their emphasis on home safety, while 45 percent of cases identified incomplete orientation processes for new staff. More than one-third of the cases found that caregiver training was not coordinated among the health care providers.

Assessments of the environment of care revealed that in 55 percent of the cases, there was no process in place for testing the smoke alarms, and in 36 percent of the cases no home safety assessment process was in place. In 18 percent of the cases, there was no identified plan or testing for evacuation in the event of a fire.

Finally, the home care organizations identified a number of communication factors, including failure to notify the primary care physician when a patient was noncompliant (73 percent); weak communication between home care providers, such as between home health nursing service and oxygen equipment provider (55 percent); and delayed reporting of hazardous conditions to the home care management team.

A variety of risk reduction strategies have been identified by the home care organizations involved in these home sentinel events. These strategies are in three primary areas: people-focused actions, process redesign, and environment/equipment redesign. In the first area, 45 percent of the organizations recommended improved staff training and orientation, especially with regard to identifying smokers and managing their care. Other recommendations included appointing a fire safety specialist or trainer and involving the fire department in employee and patient education activities.

Regarding process redesign, 64 percent recommended procedures for notifying the physician when a patient is noncompliant and 55 percent recommended procedures to improve communication between health care providers. Other suggestions included providing patients with smoking cessation information and assistance and involving the home care organization's Ethics Committee in reaching a decision to terminate home care services to non-compliant patients.

Finally, 55 percent of organizations recommended procedures for obtaining, testing and locating smoke detectors in the home; while 36 percent recommended procedures for home safety assessments. The development of evacuation plans and fire drill procedures were also suggested.

Burton Klein, PE, president of Burton Klein Associates, a firm specializing in health care electrical and fire safety issues, and a former health care fire protection engineer with the National Fire Protection Association, advises that home care organizations develop a thorough home safety assessment process that includes a review of electrical and gas systems, and the functioning of medical equipment. Local fire departments should also be involved in the assessment as appropriate. "It is important to include safety steps such as ensuring that the oxygen tanks are stored properly away from sunlight and heat, and making sure signs are posted advising firefighters that oxygen is in use." He also recommends a thorough evaluation of each patient's ability to communicate in order to identify patients who may have difficulty understanding verbal or written instructions. The evaluation should also include an assessment of the patient's sight and their ability to use equipment as intended by the manufacturer.

Scott Bartow, MS, RRT, FAARC, who represents the AARC on the Joint Commission's Home Care Professional and Technical Advisory Committee and is the director for Performance Home Medical Equipment, Ft. Worth, TX, recommends increased emphasis on initial and ongoing education and training for patients, family, and other health care providers. "It requires training and practice to become competent in recognizing and responding to potential hazards," he says. "Ongoing training is critical as environments, personnel, and situations are in a constant state of change." ■

# 2001 Home Care Coalition Strategy Includes RT

Recently, the Home Care Coalition set its strategic plan for 2001. Part of their strategy included the recognition of respiratory therapists under the home health services benefit.

"The AARC has been a long-standing member of the coalition," says Sam Giordano, executive director of the AARC.

At the February planning meeting, the group agreed to begin sharing the priority issues of the individual groups attending the meeting. For some time the AARC and its Home Care Section have been working to get the respiratory therapist recognized under the home health services benefit for Medicare.

"Because the group focuses on ensuring that access to appropriate community-based services is available to every American, we can agree to supporting their issues while they can agree to helping RTs get the recognition they need in the home care setting," Giordano adds.

The coalition is a diverse group of organizations representing consumers and patients, family caregivers, health care professionals, providers, and manufacturers. Included in the coalition are the American Home Care Coalition, National Association for Home Care, National Family Caregivers Association, and many others. The coalition focuses on education and communications advocating the benefits of home care to policymakers and the public. ■

# Get it on the Web

Want the latest news from the section in the quickest manner possible? Then access the *Bulletin* on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would get it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html. You can either read the *Bulletin* online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the *Bulletin* over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section *Bulletin*, send an email to: mendoza@aarc.org. ■

# JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

❏ Home Care
❏ Hospital
❏ Long Term Care
❏ Pathology & Clinical Laboratory Services

Inspection Date: _____

Facility Name:_____

Contact: _____
(Please provide name and e-mail address.)

1. What was the surveyors' focus during your site visit?_____
_____
_____
_____

2. What areas were cited as being exemplary?
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_____

3. What suggestions were made by the surveyors?
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_____
_____

4. What changes have you made to improve compliance with the guidelines?
_____
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_____

Additional comments:
_____
_____
_____
_____

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