



Notes From the Chair: Are We Losing Control of the HME Profession?

by Joseph Lewarski, BS, RRT

As I travel around the country and meet and work with respiratory therapists and HME owners, I see a trend that I fear may have serious ramifications. Specifically, many HME providers are losing control of too many facets of their businesses.

HME providers have long struggled with the ability to control their destiny. So many of the core business variables are influenced or controlled by third parties, which often have no vested interest in the success or failure of the individual company. The policies governing coverage of the products we distribute, the "allowed" amounts of payment for our goods and services, the referral sources' control over access to business, and the cost of goods are just some of the critical factors that are influenced — and in many cases, completely controlled by — outside agents. This is the nature of the beast.

Our success in this very regulated and controlled environment has, to date, relied on our ability to take control and balance the variables by implementing specific operational protocols and selecting products that best meet the clinical, technical and economic needs of the clients we service. Now these last two areas are coming under attack as well.

In many markets I find providers changing their business practices (i.e., reacting) to accommodate demands from referrals and manufacturers that seem to have developed unprecedented power and control over the direction of business in the particular market. Referral sources are requiring specific products,

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Notes From The Editor: CPAP Compliance

by James Stegmaier, RRT, RPFT, CCM

I recently contacted several sleep laboratories and physicians who prescribe CPAP on a regular basis. I asked a simple question: how many hours per night is considered compliant for CPAP therapy and does humidification improve compliance?

Each health care professional gave me a different answer, and no one could provide me with any documentation to substantiate the definition they use for compliance. However, each laboratory was collecting compliance data and in some cases requiring the home care provider to supply the compliance information for their accreditation requirements.

While there is an abundance of anecdotal information on the benefits of heated humidification, there is very little documented research on how heated and/or cool passover humidification systems affect compliance for the patient on CPAP. There is, at this point, no standard or consensus on the optimal level of humidification for a CPAP patient. Due to this lack of agreement on the relative humidification level, how should the respiratory therapist and ordering physician determine if a humidifier is needed, and if needed, whether should it be a heated or non-heated system? Take this one step further and we must also ask: is a humidifier for CPAP a commodity item in the same fashion as is a bubble humidifier for oxygen therapy, and should the humidifier used in clinical practice by a home care provider be based on price and/or clinical performance in regard to relative humidity increase over the ambient relative humidity?

The current standard of practice for humidification for CPAP therapy in the United States varies greatly, from areas where 100% of the patients receive heated humidification, to areas where cool humidification systems are used and heated systems are reserved for patients who have symptoms of nasal mucosal drying, to areas where no humidification system is used at all.

It is encouraging to note that guidelines for qualification for CPAP therapy from the Centers for Medicare and Medicaid Services (CMS) now include language stating that, with appropriate diagnosis and documentation, heated humidification will be a covered piece of durable medical equipment after July 1. The appropriate CMS code and reimbursement figure has been available for several years, but until this point heated humidification was always down coded to the cool passover humidification code and reimbursed at that level, which was generally less than the cost of a heated humidifier.

Further research is needed to define the standard of practice for the use of humidification and its impact on the patient's compliance with the physician's order. The research needs to define the relative humidity at which the patient benefits from decreasing symptoms and increasing compliance. Once the respiratory community comes to a consensus on the standard for relative humidity, then research can determine if the appropriate level can be achieved with a cool passover humidifier or if a heated humidifier system is required to achieve this optimal level of humidification.

Research must also look at compliance based on factors other than humidification issues, such as the impact patient education delivered by the physician, sleep laboratory professionals and the home care RT has on adherence to the prescribed usage of the CPAP system. In other words, does good education improve CPAP compliance? Further, what role does the interface play in compliance? Is compliance the same for the majority of interfaces if good training and education is performed, or does the interface play an independent role in how compliant the patient will be with the therapy?

All these issues have been widely discussed, and any manufacturer will be happy to tell

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Section Connection

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Help the AARC increase its efficiency by signing up to receive the Bulletin via the section homepage on the AARC web site (www.aarc.org). To change your option to the electronic Bulletin, send an email to: mendoza@aarc.org.

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Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: www.aarc.org/members_area/resources/jcaho.asp.

SECTION LISTSERVE:

Start networking with your colleagues via the section listserv. Go to the section homepage on www.aarc.org and follow the directions to sign up.

AARC Converges on Capitol Hill

The AARC went after the last piece of the Medicare reimbursement pie for respiratory therapists on April 15 when 50 Association members converged on Capitol Hill to lobby more than 100 U.S. Senators and Representatives for inclusion of RTs in the Medicare home health benefit.

Despite the fact that RTs have long worked in the home as employees of HMEs, the AARC has long believed it essential to acquire official reimbursement under the home health benefit. "People can use our absence in home care to say that others are qualified to do our jobs for Medicare beneficiaries," explains Sam Giordano, MBA, RRT, AARC executive director. "This is the last piece to fully enfranchise RTs in the Medicare system." ♦

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Scott Bartow to Represent AARC at FDA Device Meeting

AARC Board member Scott Bartow, MS, RRT, FAARC, will represent respiratory care and the AARC at an upcoming FDA-sponsored meeting on increasing the safety and effectiveness of home medical devices. The suggestions made at this meeting may well influence future FDA policy on the use of medical devices in the home.

The two, one-day forums will be facilitated by the Food and Drug Law Institute and attended by representatives from the FDA's Center for Devices and Radiological Health. As the AARC's representative, Scott will join a select group representing manufacturers, distributors, trade associations, health care professional associations, caretaker and patient advocate organizations and others. ♦

JCAHO Clarifies Impact of California Regulation

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently clarified its stance on a California requirement governing instruction in the use of home based medical equipment. While JCAHO originally said it would adhere strictly to a regulation from the Respiratory Care Board of California stating that instruction in home respiratory equipment be provided only by licensed personnel (i.e. driver instruction not allowed), further discussions with the Board and the California Department of Health have led the Joint Commission to back off of that strict interpretation. JCAHO will now survey organizations in the state on less stringent criteria. For more, go to: <http://www.jcaho.org/news/HomeCare/hcb502.html>. ♦

No Additional Cuts Necessary, says Study

A new study conducted for the American Association for Homecare says further cuts to the Medicare home health benefit, including the 15% cut set to go into effect on October 1, are unnecessary because previous cuts have already resulted in anticipated savings - and then some.

Specifically, the study found that the home care interim payment system that was in effect between 1998 and 2000 generated more than \$35 billion in savings for Medicare, far outpacing Medicare's original five year savings goal, set by the Balanced Budget Act of 1997, of \$16.2 billion. What's more, Medicare is expected to receive another \$35 billion in savings in FY 2001 and FY2002 due to the home health prospective payment system, bringing the total savings it has realized from home health cutbacks to more than \$71 billion. ♦

The AARC Needs You!

Did you know it takes more than 500 active volunteers to successfully run the vast and varied programs and services offered by the AARC every year? Who should take on these responsibilities? How about you?

President-elect David Shelledy, PhD, RRT, is currently seeking volunteers to serve on various AARC committees and in numerous other capacities during his presidency in 2003. If you'd like to sign up - or just find out more about how you can become more involved in your professional association - check out the following link on AARC Online: www.aarc.org/headlines/volunteer ♦

Weight Gain Supplement Works for COPD

COPD patients may benefit from an appetite stimulant used to combat wasting in cancer and AIDS patients, finds a new study published in CHEST. According to Florida investigators, patients who took meggestrol acetate for eight weeks gained about 6.6 pounds on average over an eight week period. They also reported being able to breath easier, although the treatment did not improve respiratory muscle function or exercise tolerance. ♦

CPAP Medical Necessity Data Still Necessary

The new medical policy governing CPAPCMNs that went into effect in April doesn't mean you should stop collecting medical necessity information. According to a DMERC representative quoted on myhomehealth.com, the DMERC retains the right to request information to validate the patient's medical necessity. The web site also points out that providers will begin using the "KX" modifier on July 1 to indicate that they have established that their patient has met Medicare coverage criteria, including the requisite number of apneas and/or hypopneas. ♦

JCAHO Moves Forward on Patient Safety Goals

A new Joint Commission advisory group met in mid-April to begin work on the first set of National Patient Safety Goals being developed by the JCAHO for implementation next year. Named for the Joint Commission's widely read periodic patient safety advisory, the *Sentinel Event Alert*, the Sentinel Event Alert Advisory Group will initially conduct a thorough review of all existing *Alert* recommendations and identify those that are candidates for inclusion in the annual *National Patient Safety Goals*.

The first set of six National Patient Safety Goals will be announced in July, and health care organizations will be surveyed for compliance beginning in January of 2003. ♦

Keeping Them at Home

Two new JAMA studies focus on why people choose nursing home care over home care.

In the first paper, University of California at San Francisco investigators found caregivers with higher scores on cognitive impairment tests and/or advanced age were more likely to opt for nursing home care. The second study, from Yale University researchers, found that elderly patients who had been ill or hospitalized were less likely to end up in a nursing home after discharge if they were offered restorative care.

The studies appeared in the April 24 issue of *JAMA*. ♦

Telehealth Study Gauges Success

More than 95% of patients in Canada's largest home telehealth pilot report being satisfied overall with the home telehealth experience. According to a recent study on the pilot, access to care was increased using home telehealth, nurses were able to double the number of patient visits, and care was equivalent to in-home visits as measured by an accepted evaluation tool for quality of life. The program also reduced costs by significantly reducing "windshield" time required for each visit. The time saved was equivalent to 75 days of a nurse's time per year.

The study population consisted of patients with chronic diseases, including cardiac illness, respiratory illness, and cancer. ♦

SDB May Lead to ADHD

Children who snore on a regular basis are nearly twice as likely as other children to have attention and hyperactivity problems, and the link is strong for other sleep problems as well, say researchers from the University of Michigan Health System. The study, published in the March issue of *Pediatrics*, was based on a survey of the parents of 866 children who were waiting to be seen at a pediatric clinic.

Investigators found the link between sleep problems and attention deficit and hyperactivity to be strongest in boys under age eight; habitual snorers in this group were more than three times more likely than non-snorers to be hyperactive. ♦

Recent OIG Report Focuses on Home Respiratory Care

An audit of Medicaid payments for oxygen-related durable medical equipment and supplies provided by the Minnesota Department of Human Services reviewed more than 125,000 paid claims, totaling more than \$3 million. The OIG determined that while Medicaid reimbursements for several oxygen-related items exceeded the associated amounts allowable under payment limits, the overruns amounted to only about \$2200 and were offset by substantial savings attained by using competitive bidding for oxygen related DME equipment and supplies. ♦

Joint Commission Announces Fixed Performance Areas for 2002

The Joint Commission on Accreditation of Healthcare Organizations has announced its fixed performance areas for its 2002 Random Unannounced Surveys. Topics are as follows:

Home Care - Home Health

- Home Health-Planning and Provision of Care
- Human Resources Management
- Home Health-Patient Assessment
- Contract Management
- IOP-Aggregation and Analysis

Home Care - Equipment Management

- Equipment Management-Planning and Provision of Care
- Equipment Management-Maintenance, Testing and Inspection
- Equipment Management-Patient Assessment
- Equipment Management-Specific Patient Rights
- Equipment Management-Specific Patient Education ♦

AARC 2002 48th International Respiratory Congress

Tampa, Florida, October 5-8, 2002

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SPECIALTY PRACTITIONER OF THE YEAR:

Submit your nominations online at:
www.aarc.org/sections/home-care_section/mpoty/poll_form.html



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NOTES FROM THE EDITOR

you how his interface or humidification systems will improve client compliance and satisfaction. But there are no hard data to support these assertions. When performing compliance monitoring, one must keep in mind that only one parameter can be altered at a time. All other parameters must be held constant or the data will be flawed and invalid. Multiple studies with a variety of interfaces, educational programs and both heated and cool humidification systems will be needed to determine which variable or combination of variables provides maximum compliance of the patient with the therapy.

The profession is a long way from answering many of these questions. But the answers can be determined by home care RTs with minimal effort. If we expect Medicare and private insurance programs to reimburse for heated humidification and other services in the future, we, as a profession, must be willing to take the necessary steps to develop optimal protocols and ultimately determine a standard of practice for these modalities. ♦

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NOTES FROM THE CHAIR

often the most expensive or those with features that aren't covered, or worse yet, not medically indicated. In addition, many providers are demanding rapid service or have shifted non-covered responsibilities to the provider by warning, "if you don't provide this product or service, I'll send my business elsewhere."

We are also seeing the emergence of direct-to-consumer television ads for home medical devices. Often the ads provide limited information about medical necessity, medical appropriateness and insurance coverage criteria, and may even be offering products far in excess of what the patient really needs. But once the patient has seen the "platinum" product, how can he settle for "silver?" If you offer "silver," will he assume you are providing substandard care? These are serious concerns with serious ramifications.

Jim Stegmaier's article in this issue discusses a survey of sleep labs that require compliance reports yet can't define compliance and don't use the data for anything more than satisfying a credentialing criteria of showing proof of a follow-up with the patient. They have been educated by some manufacturers to demand this non-covered service from the provider. Why? Because they can. If you won't do it, someone else will for fear of lost opportunity, even if the product and service drives them to operate at a loss. I'm sure they will make it up in volume . . .

I don't have answers for all of the questions these issues raise, but I strongly believe the root of the problem lies in a lack of standards in home care and lack of clinical evidence. Both are needed to create clinical and economic business models that serve the best interests of patients and providers.

A colleague from the medical device industry joked with me recently that you don't need a good medical device to succeed in home care, just a good marketing and sales plan! This needs to change. ♦