Home Care Bulletin
Nov./Dec. '01

American Association for Respiratory Care

Notes From the Chair

by Joseph Lewarski, BS, RRT

As I write this column in early October, we are only a few weeks past the most horrific national tragedy of my lifetime. By the time this issue reaches you, some of the sting may have faded, but the memory won't have. *Nothing will ever be the same*. Many years from now we will discuss the attacks the way we have discussed "where we were when President Kennedy was assassinated," or the way many of our parents and grandparents discussed the attack on Pearl Harbor and the many events of the Second World War. Never has anything so devastating and destructive hit us here at home. I pray that it never does again.

If there is any ray of light shinning from this tragedy, it is the strength of the American spirit. The outpouring of support in the way of volunteers, blood donations, and money has rekindled the flame that is at core of our foundation. In my hometown, American flags have been on backorder since the attack and they sell out as soon as they arrive. Patriotism reigns, and people are proud to pledge allegiance to the flag and sing the national anthem. Fellow citizens seem friendlier and genuinely more concerned. I hope this level patriotism and national pride continues throughout the balance of my lifetime.

We may not always think alike, which is what makes us great, but when the pressure is on we sure know how to walk together. We live in the greatest country on earth. God bless America.

As President Bush has ordered, it is time to get back to work and keep the economy going. So here is some information on what has been going on since I last corresponded with you —

Board of Directors: Because of you and your membership, we have earned our seat on the AARC Board of Directors. I will be joining the board this year at the annual meeting. I will do my best to represent the profession of home respiratory care and look out for all of your interests. Please keep me abreast of your concerns, as it is my job to make sure they are heard. As always, email seems to be my most efficient communication tool. I can be reached at: Jlewarski@medgroup.com or joerrt@aol.com.

Draft Oxygen Re-Testing Policy: As of October 1, we had yet to hear the outcome of the public hearings and the response regarding the DMERC draft oxygen policy. As I have stated in earlier communications, I am very proud of our profession, the home medical equipment industry, and the pulmonary physician community for the support and attention given to this issue. In my career, I have not witnessed a response to an issue that was so quick, powerful, and united. Regardless of the outcome, we represented ourselves in a highly professional and ethical manner. Thanks to all of you who wrote the DMERCs and used Capitol Connection to write your legislators, and especially to those of you who took the time to attend and testify at the public meetings.

OIG and NPPV: As I write this, the AARC is preparing a formal response to the OIG report recommending that NPPV be moved into the "capped rental" payment category. The AARC opposes this move because it is not in the best interest of patient care. NPPV is mechanical ventilation and is normally used to treat patients with progressive disorders that contribute to worsening respiratory insufficiency and failure. Close monitoring and regular intervention is critical to the safe and effective management of NPPV patients, and we all know that the funding for this care is derived from the monthly rental payment. Hopefully, as you read this *Bulletin*, the NPPV issue will have been resolved favorably.

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Clinical Work and Publications: Our profession is still plagued by a lack of scientific evidence and clinical outcomes. More work is needed to establish strong clinical practice standards and define appropriate care. The foundation for this is peer-reviewed work. If you are doing interesting and clinically justified work that defines our clinical practice (disease management, clinical management, weaning, titrating, home diagnostics, etc.), please consider writing about your work. The Open Forum abstract is the perfect vehicle to begin your scientific writing career while objectively validating your work. If you need help in this area, please contact me and I will assist you or steer you to a mentor who can help you publish your work.

Writers Needed: 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 write for the *Bulletin*. It is a great way to get started in the writing business and maybe it will lead to future publications. It doesn't look too bad on your CV either! Give it a try. ■

Notes from the Co-Editor

by James Stegmaier, RRT, RPFT, CCM

Your *Bulletin* editors are hard at work searching for topics for next year's editions. Our goals are to provide timely and informative articles that you can use in your daily practice as home care providers. All section members are invited to email either myself or Barry Johnson at the addresses found on this page with ideas for topics you would like to see covered in this newsletter. I will be happy to assist you in getting your article ready for publication in the *Bulletin*. If you have an idea for a topic but cannot or do not want to write the article yourself, email me anyway and I will find an author with expertise in the area of interest and ask them to develop and write the article. I cannot stress enough that the greater the participation of the membership, the greater the exchange of information between members.

A new section was added to the *Bulletin* in 2001 called People on the Move. This column is devoted to promotions, achievements, and awards within home care. Please email the editors with any items for this column. ■

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People On The Move

- Joseph Lewarski BS, RRT, has been chosen to receive the Invacare Excellence in Home Care Award for 2001. Joe was scheduled to receive the award at 47th International Respiratory Congress in San Antonio, TX, in December.
- Hytech Homecare in Mentor, OH, was awarded an Honorable Mention in the 2001 ADVANCE National Respiratory Achievement Awards Competition in the best clinical practice category. ■

Accreditation Commission for Health Care

by James Stegmaier, RRT, RPFT, CCM

Editor's Note: *This is the final installment in a three-part series highlighting different options home care providers have for choosing an organization to meet their accreditation needs.*

In an article published in the April 2000 issue of *Home Health Care Management and Practice*, Tom Cesar, president and CEO of the Accreditation Commission for Health Care (ACHC), states, "The availability of quality home care services is a primary concern for clients, their families, and those making referrals to home care providers." He further states that the provider organization has the challenge of providing cost-efficient care that can produce positive patient results. ACHC feels it can accomplish the goals of both the organization and its clients through its accreditation program.

ACHC defines the accreditation process as a benchmark system which will provide the organization and client with a measurement of the quality of the organization when compared to established national standards. ACHC was established in Raleigh, NC, in 1986. Until 1996, ACHC only offered accreditation services within North Carolina. In 1996, ACHC began offering accreditation services on a national level. As of February 2000, ACHC had accredited over 102 organizations in over 20 states.

What makes ACHC different from the other options home health care providers

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have for accreditation? ACHC answers this question by stating that the organization provides a unique set of standards for each program that takes advantage of its accreditation services. By providing different standards for different services, ACHC feels it is has the flexibility to better meet the needs of the organization and the client. ACHC provides accreditation for HME/respiratory, home infusion therapy, home health, hospice, specialty pharmacy, and women's health care products and services.

An organization seeking accreditation through ACHC is required to demonstrate compliance in seven core areas in addition to the requirements of the individual program. The core areas are: Organization and Administration, Program Management, Human Resources, Fiscal Management, Client Care Coordination, Quality Improvement, and Infection and Safety Control.

The first step in the accreditation process is a self-study conducted by the organization. This self-study is then reviewed along with the organization's policies and procedures prior to the site visit. ACHC also offers a program called PEP talk, which stands for Preliminary Evidence Preparation Talk. The program is designed to assist organizations in determining survey readiness. The program is scheduled no later two months before the actual survey.

Under the PEP talk program, a site visit is made to the organization after a desk review of the organization's policies and procedures. The organization works with ACHC to develop the agenda for the site visit. The surveyor provides a written report back to the organization within 30 days after the site visit highlighting the organization's areas of strength and weakness. The organization then has an opportunity to improve itself prior to the actual survey.

The number of surveyors for the final survey is determined by the size and scope of the services the organization provides. The surveyors are trained to ask specific questions to every organization receiving a survey to keep the process uniform from survey to survey. The survey process is designed to provide feedback to the organization on how well it performed. This occurs at the conclusion of the survey. The organization is informed of the accreditation decision approximately four to six weeks after the survey is performed.

ACHC feels another benefit of its program is that no external benchmarking program is required. The organization is able to save money on the cost of the external benchmarking program as well as the cost to operate the program itself.

The cost of the accreditation process through ACHC is based upon size of the organization, services offered, number of patients, and number of locations. The cost of a one location HME/respiratory company is approximately $5,000 for a three-year accreditation.

ACHC's philosophy is to provide accreditation services with an emphasis on quality, user-friendly standards and interpretations, and friendly, helpful staff and surveyors. Through its user-friendly and cost effective approaches, ACHC feels it can meet the needs of DME/respiratory organizations and their patients nationwide. ACHC feels it will be recognized as a leader in promoting and measuring quality health services in the years to come. ■

Survey Supports Payment for Services

A new survey commission from the Lewin Group by AAHomecare (the American Association for Home Care) supports the need for the federal government to adequately reimburse for the services that are provided to Medicare patients in conjunction with prescription respiratory drugs. The comprehensive study of providers and suppliers of inhalation and infusion therapies concludes that the cost of the drugs represents only one small portion of the overall cost of caring for these patients.

Report highlights include:

- Patient care service costs for the covered therapies vary greatly by type of treatment;
- The cost of goods represents 26% of total costs, while direct patient care costs average 46% and indirect costs such as accreditation, information systems, and Medicare/Medicaid regulatory compliance amount to another 25%.
- In the case of infusion therapies delivered to Medicare beneficiaries, providers' costs exceed the revenues, resulting in a negative operating margin of -22.2%. In the case of respiratory medications, providers report an after-tax average margin of 9.2%, which is considerably less than average after-tax margins of 14.4% reported by companies on the S&P index.

AAHomecare believes that in order to ensure these therapies are provided in the home setting, there must be a reimbursement system that covers all functions and services as well as the costs of the pharmaceuticals. ■

Is the Door Really Opening?

The new Advanced Beneficiary Notice (ABN) published by the Center for Medicare and Medicaid Services (CMS) may open the door for HME providers to charge Medicare beneficiaries for the use of oxygen conserving devices. According to an article on the HME web site, one of the hypothetical questions asked in a set of guidelines for using the ABN process issued by Invacare inquires whether it is acceptable to charge beneficiaries for upgrades to the portable oxygen benefit. The response states that pulse-dose conservers are "functional enhancements of the basic covered benefit. As such, the additional costs for these devices may be charged to the beneficiary if they have been fully informed of the enhancement and voluntarily sign an ABN." Invacare also believe the same process may enable upgrades to transfilling oxygen systems.

Many in the industry, however, are seeking further opinions from industry experts before charging for conservers, noting that the process is complicated and could do more harm to a provider than good. For example, if one provider in a market started charging for conversers while others did not, it could be difficult for the company that did charge to justify that charge. Former Home Care Section Chair Nick Macmillan, RRT, who is currently with Outside the Box Consulting in Bloomington, IN, was quoted in the article: "If not everybody gets on that train, you'd look pretty bad. If someone is willing to suck it up and provide conservers at no charge, that's a real benefit when it comes to marketing to referral sources."■

OIG Reviews Payments for Inhalation Drugs Made by Region C DMERC

The Office of the Inspector General (OIG) has issued a final report pointing out significant potential improper payments to suppliers for inhalation drugs by the Region C Durable Medical Equipment Regional Carrier (DMERC) for the 12-month period ending September 30, 1999. Based on a statistical sample, the OIG estimates such payments totaled $134 million. Forty-six million dollars worth of claims were unallowable because payments were for noncovered items of supplies (drugs billed without a prescription) or the items or supplies were not reasonable and necessary for the beneficiary's condition. Claims for which there was insufficient documentation to determine allowability totaled $88 million. The OIG says this problem occurred primarily because the DMERC had no procedures in place to "look behind" the claim at the beneficiary's medical record or at the documentation maintained by the suppliers. Recommendations call for improvements to procedures and controls, along with financial adjustments. ■

Prices Down, Demand Up

A new study by research firm Frost & Sullivan finds that reimbursement changes enacted in the Balanced Budget Act of 1997 have cut the average sales price of oxygen therapy devices by as much as 50%, but demand for such devices is soaring.

According to the report, "U.S. Oxygen Therapy Devices Market," manufacturers of concentrators, compressed gas cylinders, liquid oxygen, conservers, and regulators should see annual sales of these products rise from $274 million in 2000 to $377 million in 2007. The number of patients using oxygen therapy devices is expected to climb from 1.2 million to 1.4 million during the same time period. Among the new technologies that will grow at the expense of oxygen concentrators and electronic conservers: portable liquid oxygen systems and pneumatic conservers. ■

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 Site Visit Report

The following site visit report was posted recently on the AARC web site:

Aloha Medical Supplies and Services, Inc.

Patrick Velis

Inspection Date: August 5, 2001

What was the surveyors' focus during your last site visit?

Human resources and performance improvement (CQI).

What areas were cited as being exemplary?

Chart organization.

What suggestions were made by the surveyors?

CQI (performance improvement).

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

Hired part-time CQI person.

Additional comments: 88% passing — having an incorrect prescription on 0_2 flow really hurt us. ■

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? _____

_____

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_____

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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