Home Care Bulletin

Sept./Oct. '99

American Association for Respiratory Care

Notes from the Chair

by Joseph S. Lewarski, RRT

As I write this article, we are already nearing Labor Day and the end of summer here in Ohio. My, how quickly time moves by. However, as you read this issue, it will almost be time for this year's AARC International Congress in Las Vegas, and I will be completing my first year as the Home Care Section Chair.

This has been an interesting and exciting year for me as chair of the section. I hope the material we have presented through the *Bulletin* and the listserv have provided you with pertinent information and, at a minimum, provoked thought and conversation. So much is happening in home care that it is hard to keep up. We are still very interested in hearing from those of you in the silent majority. If you have issues or concerns that you feel haven't been addressed, please share these with me via email at joerrt@aol.com or phone at (440) 255-4468, extension 106. I'll make sure your voice is heard within the section and the AARC.

After a somewhat long and arduous search, I have finally found a *Bulletin* coordinator! He is Barry Johnson, RRT, and he is with an independent company, Texas Medical. Barry has over 20 years experience in home care and will be a welcome addition to our staff. He will be taking over with the next issue (November/December). Thanks Barry!

I hope to hear from many of you soon and to see you at the AARC Congress in December. ■

HCFA Slams Home Medical with New NPPV Policy

by Joseph Lewarski, RRT

As predicted, the new NPPV policy released in the June 1999 Medicare Bulletin provided more twists and contortions than its draft and is most definitely in conflict with many of the recommendations offered by the expert panel. The AARC is promoting a letter-writing campaign and urging all members to contact their senators and representatives to help block these changes. For more information on how you can effectively contact your congressmen, check out the AARC web site at www.aarc.org or look for the information in your mail. Please make your concerns heard!

Aside from the many obvious problems with the new policy, there is one area that deserves particular attention: HCFA is attempting to set a new policy precedent, one that ignores the power of the Food and Drug Administration (FDA) and conflicts with prominent medical literature. This new precedent would allow HFCA to change the FDA classification and accepted standard of practice of a medical device through simple semantics. By simply calling noninvasive positive pressure ventilators "respiratory assist devices," they feel they can change the design application and, of course, the payment.

Is HCFA so arrogant that they believe their power supersedes all others? *Yes.* If HCFA wishes to call a "duck" a "dog," apparently all they have to do is put it in writing. Unfortunately, their only motive is economic. HCFA doesn't care if you call it a "duck" or a "dog" unless the

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"dog" is much less expensive than the "duck" and it works to their financial advantage. In medical terms, it is similar to calling MRI an "advanced radiograph" and offering to pay only slightly more than a standard radiograph.

The new policy actually requires physicians to write "off label" prescriptions for the use of bi-level devices in place of NPPV. This is in complete conflict with most insurance practices, which prohibit the coverage of "off-label" uses of drugs and other products.

So make some noise by writing your congressmen and help prevent further erosion of patient care and profitability within home care. If we don't, no one else will. ■

What Skills and Traits Make Up a Home Care Respiratory Therapist?

by James P. Stegmaier, RRT, RPFT, CCM, director of clinical services, Hytech Homecare

The home care respiratory therapist is unique to the profession of respiratory care. Unfortunately, home care receives very little time and attention in most respiratory education programs. With very little formal training, what skills are needed, and how does one excel in the home care industry as an RT? After working and managing in the field of respiratory care for over 15 years, I have identified a few distinct qualities that I look for when hiring an RT to fill this important position in our organization.

The home care RT must have a strong and diverse clinical background, including intensive care, pediatrics, and chronic care. He or she must have a complete and current understanding of all phases of acute and subacute care and the ability to adapt many traditional respiratory procedures or therapies to the home care process. Discharge planning experience helps the RT understand what his or her institutional-based counterparts are experiencing when making a referral. The RT must also be knowledgeable about lesser known procedures that may not be at the cutting edge of respiratory care at the present (IPPB, IPV, In-Exsufflator, etc.), but which may have a unique application with a specific patient.

Superior clinical assessment skills are a must. Effectively used, these skills allow us to be an extension of the physician in the field. The RT must be able to assess the patient globally, not strictly from a cardiopulmonary system viewpoint. Without solid assessment skills, the RT will be unable to get much of the vital information back to the physician and/or other health care professionals.

Assessment skills are especially important when working with managed care programs because they provide the information used to show the response to and benefit from therapy (outcomes) being experienced by the patient. Assessment goes beyond breath sounds and vital signs to include medical history, medication profiles, social/family situation, advanced directives, and other relevant information related to the care and service of the patient in the home.

A thorough understanding of the reimbursement structure for home care is required because the reimbursement and medical necessity criteria vary from insurance carrier to insurance carrier, and sometimes even within the same carrier. The RT must understand and provide this information to a wide spectrum of people, from medical professionals to family members and/or the patients themselves. Home care RTs must have the drive to continually update themselves on reimbursement issues, as these issues change very quickly in this fast paced environment. Delivering poor or incorrect information to a patient or physician can quickly damage relationships, and the repair process can be difficult and lengthy (just ask our sales department). Remember, too, that new technology often arrives at the hospitals before anyone in the home care reimbursement sector is aware it exists. Since much of this new technology does not have any traditional reimbursement, the RT is often pulled into the billing loop to help explain and justify its use.

Communication skills — written and oral — are critical to success in any position and even more so in home care. Written skills are required to draft patient care plans and follow up reports for physicians and case managers. With the growth of disease management, the RT must be able to provide written feedback to all interested parties. This effective communication is vital to the success of the organization's disease management program.

Oral communication skills are essential because home care RTs must be able to speak at multiple levels. They must be able to break down technical information into lay terms for patients and families from a myriad of ethnic, cultural, and educational backgrounds. In the metropolitan

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areas we service, it is not uncommon to face language and literacy problems on a daily basis.

At the same time, the RT must be able to communicate with physicians and other health care professionals. An RT who cannot communicate effectively (both orally and through the written word) with confidence, knowledge, diplomacy, and respect will never make it working in home care. We are often the only medical professional overseeing a patient's care and relaying pertinent and valuable information to the managing physician.

How does an RT obtain these qualities? Health care is a never-ending learning process, and home care is no different. Keeping up-to-date on what is happening in acute respiratory care is important since this is where most of our patients come from. We regularly review most of the main respiratory peer review journals, as well as most of the industry trade journals. Home care is great because most of the trade journals are free and often full of relevant information. Peer reviewed articles on home care tend to be harder to find, but an effort should be made to seek them out.

I have found that one of the best ways to stay current is to attempt to write an article. This puts you in the proper frame of mind to ask yourself probing questions regarding the mechanism of action for a particular therapy or procedure. The writing process involves seeking and finding the information you need for your article. This exercise not only benefits your own knowledge of respiratory care but allows you to share with your peers important information needed to improve care and advance the profession.

Assessment skills are often developed through practice; however, there are a multitude of books and seminars on the topic. The art of taking a good medical history is also an on-the-job learning experience and improves with time. If you need assistance in this area, your medical director may be able to help you refine your technique.

Learning the financial aspects of reimbursement will require you to probe the other members of your home care organization, as well as individuals from the medical equipment organizations. Since this is a dynamic area, you must continue to read, review, and ask questions regarding the constant changes that occur in reimbursement.

Communication skills often improve over time and with practice. Remember, you only get one chance to make a first impression. Rehearse what you plan to say before you make the call. Have someone proofread your written work.

Home care RTs are an important and critical part of the profession. But they are made, not born. Most of the successful home care RTs I know have very diverse and impressive resumes, which I think reflects the diversity of home respiratory care. ■

Opportunities in Home Care

by James P. Stegmaier, RRT, RCP, CCM, director of clinical services, Hytech Homecare

I have been a Registered Respiratory Therapist for the past 15 years and a Registered Pulmonary Function Technologist and perinatal/pediatric specialist for the past nine years. During the first ten years of my career, I worked my way from a staff therapy position at a large academic medical center to a supervisory position at a 500-bed general hospital to a department head position at a 150-bed community hospital. Due to the many changes in health care and in my market, I left the community hospital for the position of respiratory department head at a rehabilitation/transitional hospital with a large subacute population. I did this for two years before taking my present position three years ago as the director of clinical services for an extremely progressive home care organization. Based on my past experiences, I feel that the opportunities available today in home care are unparalleled by either the acute or subacute sectors of respiratory care.

Home care is essentially an under-recognized area of respiratory care. Although respiratory therapists do work for a large majority of home care organizations, providing basic instruction for the common respiratory modalities, I believe their real value not well known. The real value for the patient, physician, and insurance carrier lies in a strong clinical program. A well-organized clinical program will provide an ideal model for home respiratory care and ensure the best level of care and service to the patient. In addition, it provides an incredible wealth of opportunity for the RT to improve his or her skills; participate in research, case management, and disease management; and work with cutting edge technology.

I have kept my assessment skills sharp during my career and promoted myself as a "good clinician." But despite all of my acute and subacute experience, home care is the first place where I have felt that the use of my clinical skills brings real value to the physician and other health care professionals on a daily basis. Clinical assessments are normally done in a patient's private residence with few, if any, other medical professionals present. When you encounter a problem or concern, the sole responsibility to analyze, process, and intervene is yours.

Although RTs don't write orders or make independent clinical decisions, often the physician is relying on our expertise and judgment to make decisions that will directly affect the life of a patient. Although many of these decisions are not life-threatening, they are important to the well-being and safety of the patient. Being a home care RT in a very clinically-focused company gives me the chance to use training and skills that I often didn't use in my previous positions. I may see a neonatal ventilator patient in the morning and an ALS patient on NPPV in the afternoon. In both cases, I may be required to perform a clinical assessment and make treatment recommendations. It is

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robably as close as we can currently et to becoming independently oper- ing practitioners.

As I stated earlier, I believe respi- atory care is under-recognized in ome care. This is particularly true hen it comes to research. In my pre- nt position, I have had the opportu- ity to participate in, publish, and resent several abstracts and research rojects regarding respiratory care in e home. This has helped me devel- p a new way of thinking and prob- m-solving. As I look to the pub- shed literature for help, I find that ere are little data (either scientific anecdotal) regarding home respira- ory care. This is an area where home are RTs have an opportunity and bligation to step up to the plate. lthough we may never equal our cademic-based peers, we can con- ibute valuable and important infor- ation to the science and practice of espiratory care. This opportunity not nly provides job satisfaction, but nproves patient care as well.

Before I got into home care, I, like any others, felt that research and ublishing were reserved for the elite ho work at prestigious medical cen- rs. I thought that publishing some- ing as simple as an abstract was out f my reach. But since home care is uch a blank slate, my supervisor and decided to give it a shot and write bout work that we felt was important the profession. Research often egins with just asking simple ques- ons. When the answers are not satis- actory or cannot be found, a project born. Home care, as an industry, eeds greater representation in the orld of published works. As a home are clinical director, I am working ith my boss to achieve the goal of ublishing in a peer review journal at ast once a year. I am proud to note at for the past three years we have resented an abstract and poster at the ARC International Respiratory ongress.

Another area of medicine that I have learned more about through my experiences in home care is case management. As I learned more about home care and transitioning patients from hospital to home, I found myself functioning more and more as a case manager. Although initially I didn't realize I was case managing, I found myself spending an increased amount of time coordinating referrals, arranging family meetings, and coordinating discharges of medically complex patients. Hytech has always worked hard to have a good relationship with all of the case managers that they deal with. This relationship has developed to the point where many case managers turn to us to determine what is and is not appropriate for our patients.

The Hytech goal for 1999-2000 is to have all supervising respiratory therapists credentialed as Certified Case Managers. I became certified in June of this year. This is another opportunity that came as a direct result of working in home care.

Disease management is in its infancy in home care (and probably everywhere else). Although I was introduced to "critical pathways" or "care paths" while working in acute care, they only represented the tip of the disease management iceberg. Limited to specific protocols, medications, and tests, early care paths were more protocol-based than patient-specific.

Asthma and COPD boast very large numbers of patients and together represent a major portion of those serviced by home care companies. I have participated in the development and implementation of two successful disease management programs for these conditions. To date, I have personally seen approximately 100 patients through these disease management programs. The information gathered at the home is by far more valuable than that collected at a medical facility or by telephone. The home environment provides many answers as to why patients present themselves as they do. I have seen the benefits of my work as I follow patients through their disease education process.

One of my fears entering home care was losing my high technology skills. After all, home care is known for oxygen concentrators, walkers, and commodes. Not many people think of cutting edge technology when they envision home care. Wrong again! Although I'm not as current as my acute care peers on the latest critical care technology, I work with new and innovative products every day.

Indeed, we are always looking at new technology and reviving existing technology that has fallen out of favor to determine if a product has a unique application to optimize patient care. Once a particular device or product is determined to have a specific application, the process usually does not end there — you must be willing to fight on a semi-regular basis to get reimbursement for patients who have needs that fall outside the norm. This takes work, but the satisfaction and the opportunity it offers is unquestioned. Once benefit is shown to a case manager or insurance carrier, the start of a relationship is formed, and the next time you have a unique patient, it may not be as difficult to get the needed reimbursement as it was the first time around.

I entered the arena of health care and became a respiratory therapist because I wanted to make difference. Although all RTs make a difference, for me personally, home care has afforded the opportunity to use my knowledge and skills to their maximum potential while at the same time learning new things everyday. Work where you are happy and you make a difference. Opportunity knocks at your door on a daily basis — all you have to do is answer. If you do, both you and the profession of respiratory care will reap the benefits.

Home care made a difference in my life, and as a result, I feel as though I make a difference in the lives of my patients. ■

Request for Assistance: New Technology

Susan Blonshine is writing a "clinical perspectives" article for AARC Times on new technologies in 1999 and would like to know what new technology this year has had the greatest impact on your specialty area and why.

Please respond by October 10 to Susan by email (sblonshin @aol.com) or fax (517-676-7018). ▮

FYI . . .

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) is a federal statute that requires school districts to mainstream disabled children into their schools. The act is divided into two sections: Part B pertains to children age three and older and Part C pertains to children up to age three. Both require school districts to develop plans of care aimed at helping these children achieve their educational potential.

Under Part B, this includes the provision of all appropriate special education and related services that the child may require during the school day, including transportation, speech-language pathology and audiology, psychological services, physical and occupational therapy, therapeutic recreation, social work services, rehabilitation counseling, and medical services.

The statute is expected to have an impact on home care providers, who are likely to be called upon by school districts to meet the needs of these special students. Under the regulations, schools may either provide this care themselves or contract with home health agencies for the provision of the services these children require.

Experts predict that many districts will opt to use the same health care providers being utilized by the child in the home, although there is no requirement that they do so. At any rate, home health agencies that provide these services may find that they have to prepare two separate bills: one for the child's insurance carrier and another for the school district. (NAHC Report No. 817, 7/2/99)

HCFA recognizes Joint Commission hospice accreditation

The Health Care Financing Administration (HCFA) has formally recognized the Joint Commission on Accreditation of Healthcare Organizations' hospice accreditation program. HCFA will deem an organization to be in compliance with the Conditions of Participation for hospice when it achieves accreditation through the Joint Commission survey process.

The decision was published in the June 18 Federal Register and went into effect September 14. All hospice organizations, including the more than 1,100 already accredited by the Joint Commission, will now be eligible to seek deemed status.

A hospice organization choosing the deemed status option will be evaluated by the Joint Commission using Joint Commission standards that have included in the Joint Commission intents the Medicare Conditions of Participation and standards for hospice organizations.

Accreditation remains voluntary, and seeking deemed status through accreditation is an option, not a requirement for Medicare certification.

While Joint Commission surveys will continue to include observations; interviews with leadership, staff, patients, and families; and review of written material, one significant change in the process will be that all hospice deemed status surveys will be unannounced. The survey cycle will continue to be three years.

"The Joint Commission is pleased to receive this recognition of its accreditation of hospice organizations," says Maryanne Popovich, RN, executive director, Home Care Program. "We look forward to collaborating with HCFA to provide quality oversight for hospice organizations."

For more information about federal or state deemed status, please contact the Joint Commission's Division of Government Relations and External Affairs at (630) 792.5269.

Make yourself heard!

The Long Term Care Campaign, coalition of leading consumer group that advocates for a solution to th nation's long-term care crisis, ha created a quick and easy way fo Americans to contact would-be pres dential candidates. The "Contact th Candidates!" section of th Campaign's web site (www.ltccam paign.org) features hot-links to all o the presidential hopefuls' web site Most of these sites ask Americans t offer comments or ask questions, s net surfers can easily share their cor cerns about long-term care and as the candidates for information o their plans to address the problem.

In addition to hot-links to all of th campaign web sites, www.ltccam paign.org offers tips on contacting th presidential hopefuls, plus a sampl letter on long-term care that can b customized and contact informatio for each candidate's campaign head quarters.

"We are encouraging caregiver and families who have had exper ence with long-term care to shar their personal stories with those seek ing to be president — and then to as what each would-be candidate plan to do to address the growing long term care crisis," says Jon Dauphine the Long Term Care Campaign executive director.

The Long Term Care Campaign i a coalition of 147 aging, disability religious, consumer, and othe groups, with a combined membershi of more than 60 million.

Online access to health management publications

The Healthcare Intelligenc Network (http://www.hin.com) i offering online access to more than 5 health management publications cov ering managed care, reimbursemen

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the prospective payment system, behavioral health care, health care mergers, medical records, health care trends, wellness, outcomes, compliance, health care law and regulation, long-term care, credentialing, subacute care, and assisted living.

Available titles include: Briefings on Assisted Living, Briefings on Credentialing, Brown University Long-Term Care Quality Advisor, Bulletin on Long-Term Care Law, Competitive Healthcare Market Reporter, Corporate Compliance Officer, Directions: Looking Ahead in Healthcare, Executive Report on Managed Care, Health Law Week, Jenks Subacute Business Report, Medical Records Briefing, Outcomes and Accountability Alert, and Wellness Program Management Advisor.

The network also offers weekly headline news in each of the five major topic areas (managed care/health care industry, long-term care, behavioral health care, health law and regulation, and hospital and health system management), a bookstore for health care professionals, a health care conference planner, a personalized health management news service, and a searchable archive of health management news.

Religious attendance leads to lower mortality

A study of nearly 4,000 elderly North Carolinians has found that those who attended religious services every week were 46 percent less likely to die over a six-year period than people who attended less often or not at all, say researchers at Duke University Medical Center.

After controlling for factors that could influence death rates — such as medical illnesses, depression, social connections, health practices, and demographics — the frequent religious attenders were still 28 percent less likely to die than others in the study. The size of the effect was so strong that it was equal to that of not smoking cigarettes. ■

Come Celebrate AARC's Cultural Diversity

by Janyth Bolden, AARC Cultural Diversity Committee Chair

The AARC would like to hear your ideas on how "cultural diversity" should be addressed within the organization. In keeping with this goal, the Cultural Diversity Committee would like to invite you to attend a forum on cultural diversity. This first forum is being held at the Las Vegas Hilton Monday, Dec. 13, 1999 in conjunction with the 45th International Respiratory Congress. We are eager to listen to your ideas and suggestions, so please come share them with us.

We would like to make this a festive occasion — so why not dress the part? We invite and encourage you to wear something that identifies your ethnic, religious, or other cultural group. And keep in mind, "cultural diversity" does not refer only to Black, White, Brown and Yellow. It also includes Jewish, Hindu, German, Assyrian, Italian, American Indian, Greek, etc. Come prepared to show off!

The AARC Cultural Diversity Committee is made up of managers, educators, staff, and entrepreneurs who represent regions from around the globe. Please join us Dec. 13 for insightful, constructive conversation about our varied backgrounds. Let us not just point out our differences; let us also learn about and appreciate our similarities. It is by recognizing and utilizing our diversity that the AARC can become a "Fortune 500" association.

By the way, have you utilized the information found in the AARC Online cultural calendar? If not, why not? Check out this new feature on AARC Online at http://www.aarc.org/times_plus/cal endar.html. This special feature is just the beginning of things to come. If you have any comments or suggestions, feel free to contact me at jbolden@chw.edu. ■