Home Care Bulletin

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

NUMBER 5 SPRING 1997

NOTES FROM THE CHAIR

by Nick Macmillan, AGS, RRT

Thanks to those of you have expressed interest in assisting with the Home Care Specialty Section for the coming year. I have been working with the AARC Executive Office and Membership Committee these past few months to continue to improve your benefits. Specifically, we have improved our communications network through increased utilization of a fax network and the development of a Home Care Section webpage.

I am also pleased to announce a couple of breakthroughs in regard to increasing the amount of home care information you receive in the *Bulletin*. Home Care Monday, a weekly faxed newsletter, has agreed to allow us to reprint respiratory related items, and the Association of Telemedicine Service Providers will be writing a regular column. These additions, along with other planned columns, should keep you abreast of the developments in our profession.

Thanks to everyone who contributed material for this issue. I urge your continued involvement in your specialty section.

NOTES FROM WASHINGTON, DC

by Cheryl West, MHA

Cheryl West is the AARC's director of government affairs based in Washington, DC.

While the details are still murky, it appears that most of President Clinton's six year, $138 billion Medicare "savings" will be achieved through cuts to hospitals, physicians, and "other providers." The HME industry is bracing for at least two onerous recommendations to show up in the fine print of the President's budget. One is the resurrection of competitive bidding for Medicare DME; the other is a home oxygen therapy (i.e., oxygen concentrator) cut between 10-15%.

Neither one of these provisions is new to Capitol Hill. Over the last three budget go-rounds, both HME cuts have been proposed, then dropped from final consideration. The AARC is a member of two coalitions whose sole purpose is to fight against enactment of either one of these recommendations. The bad news is that every year both cuts reappear during budget debates. The good news is, every year fewer members of Congress support the cuts because the coalitions' arguments, data, and constituent pressures have become more precise and effective.

Nevertheless, as the administration and Congress search the ever-shrinking pool of available Medicare cuts, these two issues continue to appear on the agenda. The AARC will continue to work with the coalitions to fight these ill-conceived cuts. When the time is right (i.e., when serious negotiations kick in, probably early summer), the AARC may call upon Home Care Section members to contact their members of Congress. I'll keep you informed.

1997 HOME CARE ISSUES IN THE STATES

by Jill Eicher

Jill Eicher is the AARC's director of state government affairs based in Washington, DC.

This year, states are addressing a number of issues of interest to respiratory home care providers. The first involves a growing interest in state licensure of home medical equipment (HME) providers. Currently, HME licensure laws exist only in Arkansas, Maryland, North Carolina, and Tennessee. However, Georgia and South Carolina introduced legislation this year, and Indiana is considering an HME licensure effort as well.

State HME licensure laws follow the usual licensure format, but include several provisions of concern to respiratory care. First, an HME licensure law establishes an advisory committee under the state's board of pharmacy. Since the scope of the law includes home care activities related to respiratory care, it is questionable whether pharmacy possesses the appropriate background, education, and training to address issues related to home respiratory care.

Second, unless a proposal includes an exemption for providers of care such as licensed or certified RCPs, it is unclear what effect, if any, an HME licensure law would have on state respiratory care licensure laws. Finally, HME licensure laws usually encompass all activities of an HME provider, including those services provided by HME truck drivers or delivery technicians. South Carolina's proposal, for example, requires an HME administrator to employ qualified personnel and ensure their adequate education.

Because of concerns regarding delivery technicians providing services beyond their education and training, it is uncertain how much judgment a licensure law would give an HME provider to determine the qualifications and abilities of their delivery technicians, and how their judgment might negatively impact the delivery of home respiratory care by qualified practitioners.

Another state issue of interest to home respiratory care is the continuing budget concerns regarding the Medicaid program. Although recent figures are very positive in that they show a decline in the annual spending growth for Medicaid, Congress and the President will still debate methods for reducing the Medicaid budget.

This issue will evolve over a number of years and presents some opportunities for home respiratory care. As the federal and state governments implement budget-cutting efforts such as Medicaid managed-care programs, they will look for new budget-cutting mechanisms. These new mechanisms are likely to include efforts to move more care from institutions into home- and community-based settings. Each state Medicaid program has an opportunity to rewrite its coverage guidelines to allow more home-based respiratory care services to be delivered by RCPs. In addition, long-term care is a growing budget concern that affords RCPs a significant role as providers for the chronically ill and disabled populations.

Efforts to provide more health care while controlling costs will continue to dominate the political scene in the states and offer many opportunities and challenges for the respiratory care community.

BECOME PART OF THE SOLUTION

by Robert F. Jasensky, BA, RRT

Robert Jasensky is clinical director at Prime Care Medical Supplies Inc. in Flushing, NY.

Due to the current wave of respiratory care department decentralizing, downsizing, or, as they are now calling it, "rightsizing," I get at least two to three phone calls per week from hospital-based RCPs who are now considering home care as a viable option. But when the question is asked about home care experience, the answer is invariably, "none."

Many of us in home care bemoan the fact that we have to spend an extraordinary amount of time orienting new employees. Of course, the reality is that if you wait for someone with experience who can get right to work with little or no orientation, your wait will be a long one. One solution that has worked for us is to volunteer to teach students about home care at local colleges. After all, who is more qualified to educate future RCPs about what we do every day than we are?

Many of you may be thinking (as I did), what college teaching experience do I have? But when you think about what you do every day, you will see that you are already an educator. I'm on the telephone most of the day educating nurses, doctors, patient caregivers, and fellow RCPs about home care and its many facets. How many inservices have you given? At least 50% of what we do is education.

I became involved with a college program in my area several years ago through the efforts of Teresa Barrett, RRT, program director of respiratory care at Molloy College in Rockville Centre, NY. Since the NBRC was incorporating home-care related questions in its credentialing examinations, more students were asking questions about home care, and more of her colleagues were leaving the hospital to become a part of home care, she wanted to enhance the home care component in her curriculum. Teresa invited me to give several guest lectures on home care, and I was more than happy to oblige.

Today my involvement with the college consists of five or six hour-long lectures that I present to the senior year students. Part of their clinical experience also includes a two day rotation through our company, where they accompany our RCPs on patient visits. Many of the students have expressed a sincere desire to seek employment in home care upon graduation, and the experience has been a positive one for everyone involved.

Getting involved with Molloy College and the RC students there has been personally rewarding as well. With every new group of respiratory care students, I am reminded of all the reasons that I chose the field of respiratory care in the first place. Their idealism and enthusiasm are wonderful for my morale and the morale of our respiratory care staff. Our RCPs enjoy their role as mentor to the students and, in lieu of salary, receive free tuition at the college. I, for one, put this benefit to good use and obtained my bachelor of arts degree in business.

When you get involved in sharing your knowledge and expertise with a respiratory care educational program, the company you work for benefits through positive public relations, referrals, and potential new employees. The respiratory care program benefits from a more well-rounded student at minimal cost to the college.

I urge all home care companies to be advocates for home care by becoming involved with your local respiratory care programs. From my perspective, it is a definite "win-win" situation.

NOT ALL OXYGEN-CONSERVING DEVICES ARE APPROPRIATE FOR ALL PATIENTS

Since the advent of continuous-flow oxygen therapy, manufacturers have looked for ways to make portable oxygen units lighter, smaller, and more efficient. Such improvements could enhance mobility and activity for patients—two desirable goals that can lead to improved quality of life.

Because continuous-flow oxygen therapy can result in wasted oxygen use, especially during the exhalation phase of the respiratory cycle, oxygen-conserving systems have been developed. The goal of such systems is to time delivery of oxygen therapy to the inspiratory phase of the respiratory cycle to conserve oxygen and reduce costs. Although the oxygen-conserving systems currently available share these goals, their oxygen-conservation approaches and their effect on the patient may differ.

The following study compares the effectiveness of two different oxygen-conserving systems: a pulse-demand liquid oxygen system and a fixed-pulse high-pressure cylinder system. The study illustrates how the two systems can result in dramatically different oxygen saturation levels for

the patient, highlighting the need for home care prescribers and providers to understand the difference between various types of systems and the effect they have on the patient's oxygenation.

Desert Hospital is a 300-bed acute care hospital in Palm Springs, CA. Amy Wente, RCP, RRT, manager of the hospital's Pulmonary Rehabilitation Program, and Danielle Bratis, an exercise physiologist for the program, conduct a COPD maintenance exercise class for patients who have completed their comprehensive pulmonary rehabilitation program. They initiated the comparison study in spring 1996, when several participants arrived at the classroom with low oxygen saturations (typically between 74% and 85%) after an 80-yard walk from the parking lot.

These patients were using high-pressure oxygen cylinders, some of which included an Oxymatic conserving device (Chad Therapeutics), for their oxygen therapy. The Oxymatic is a simple pulse dose system that delivers a fixed amount of oxygen at set breathing intervals. The dose of oxygen delivered can be set from once every four breaths to every breath.

The study compared this system to the Companion 550 portable liquid oxygen unit (Nellcor Puritan Bennett). This pulse-demand system delivers oxygen with every breath at the prescribed flow rate throughout inspiration, and also delivers a 12 mL bolus of oxygen at the onset of inspiration, compensating for dead space in the oral and nasal passages. To preserve oxygen, flow terminates when exhalation is sensed.

Methods

The five study participants, all on oxygen therapy for over one year, were tested individually. The same tests were performed for each oxygen-conserving system a week apart. Each participant was placed on a continuous-flow oxygen system for a rest period of 15 minutes, after which vital signs were recorded. The participants were then switched to the Oxymatic the first week, and the Companion system the second week, using the prescribed liter flow during activity. While using each system, they performed a six-minute walk. The oxygen saturation and heart rate were continuously monitored via Nellcor Puritan Bennett's N-20P pulse oximeter. SpO_2 levels were noted at each one-minute interval and vital signs were taken again at the end of the six minutes.

Results

The study showed that all five patients experienced lower oxygenation levels during the six-minute walk using the Oxymatic system. In fact, all six SPO_2 measurements taken for each patient were lower during the first phase of the study when this system was used.

The variance was minor in some instances and dramatic in others. The most significant difference in oxygen saturation was at the end of the six-minute walk. On the Oxymatic, patients showed oxygen saturation levels ranging from 6 to 12 percentage points lower compared to the Companion 550. Patient 1 experienced the greatest drop after the six-minute walk. This patient's SpO_2 fell 17 points, from 96% to 79%, using the Oxymatic, compared to a drop of 6 points, from 97% to 91%, using the Companion 550 (see Table 1).

Table 1 Desaturation Difference After 6 Minutes of Exercise

Patient	Phase 1 / SpO_2	Phase 2 / SpO_2
	Oxymatic	***Companion 550***
1	1 minute/96%	1 minute/97%
	6 minutes/79%	6 minutes/91%
	SpO_2 dropped 17 points	SpO_2 dropped 6 points
2	1 minute/98%	1 minute/99%
	6 minutes/86%	6 minutes/92%
	SpO_2 dropped 12 points	SpO_2 dropped 7 points
3	1 minute/94%	1 minute/98%
	6 minutes/86%	6 minutes/95%
	SpO_2 dropped 8 points	SpO_2 dropped 3 points
4	1 minute/95%	1 minute/97%
	6 minutes/86%	6 minutes/96%
	SpO_2 dropped 9 points	SpO_2 dropped 1 point
5	1 minute/96%	1 minute/99%
	6 minutes/85%	6 minutes/96%
	SpO_2 dropped 11 points	SpO_2 dropped 3 points

Discussion/Conclusion

This study demonstrates how using two different oxygen-conserving devices can result in significantly different oxygen saturation levels for the patient. The Companion 550, which provides oxygen flow throughout inspiration, better oxygenated the study participants. It produced higher SpO_2 levels during physical activity, which is what portable oxygen systems are intended to support.

The other system evaluated in this study is not necessarily inappropriate for all patients. It may provide adequate oxygenation for some patients with mild respiratory insufficiency or with low activity levels. However, for many patients, the extreme oxygen conservation and convenience of the Oxymatic system may come at a cost of oxygen deprivation.

SMOKING CESSATION: A RESEARCH PROJECT IDEA

by Heidi Weston, RRT

Heidi Weston is with Alliance Home Care, Manchester, KY.

During the AARC Convention in San Diego, I was intrigued by a presentation that Dr. Thomas Petty made on the National Lung Health Education Program's outcome study on the pulmonary function studies of smokers who had recently quit. Specifically, the study showed measur-

able improvement in pulmonary function after smoking cessation, a finding that held true even for those with a long-term pack history.

Living in rural Appalachia, I find that smoking is commonplace, and while many people wish to quit, the actual process either never happens or happens only until a crisis occurs in their life and they return to smoking. The problem here is that everyone enjoys smoking, so those who wish to quit are usually living and working in an environment where everyone around them smokes, making compliance with smoking cessation marginal at best. Since coal mining and the occurrence of black lung are still prominent in this area, this is disturbing.

In an effort to put the information I gained during the outcome study presentation to work for my own patients, I am currently in the process of designing a study that will follow the preliminary guidelines that Dr. Petty presented at the Convention. I plan to follow several patients as they struggle with smoking cessation over the next few years in order to obtain data that can be compared to the data presented in San Diego. Will the pulmonary function studies show an accelerated decline in these cases?

So far I have three study participants. The first is a 64-year-old male with a 100 pack-year history and marked COPD. The second is a 41-year-old male with a 40 pack-year history and some minor signs of early COPD, such as a persistent cough, audible rales, and rales upon auscultation. The third is the 31-year-old son of the first participant, who has a 22 pack-year history, along with a genetic and social attachment to another in the study. I hope to enroll about a dozen participants in all.

The study will be conducted with assistance from an internal medicine physician, who will offer his input and provide overall supervision of these patients. I plan to provide nicotine patches to participants who request them, and will also keep journals on the candidates to keep track of any social or concurrent medical issues. While some of these factors will have no effect on the pulmonary function studies, they may be interesting from the smoking cessation outcomes standpoint.

I have purchased a MicroDirect MicroLab for the purpose of performing and monitoring my pulmonary function studies. While I hesitate to personally endorse any product, this is an inexpensive, portable, and comprehensive device that will allow me to perform my own studies.

In order to increase the impact that this study could have on smoking cessation programs, I am currently seeking co-researchers from among the Home Care Section membership. If you would like to participate in this study by recruiting your own candidates and comparing data, or if you have any input on monitoring parameters or suggestions on anything related to this topic, please contact me at the address/phone number listed under "Guest Editor/Summer Issue" on the back page of this issue. Surely in home care we see patients everyday in our travels who would be great candidates for a study like this!

For more information on the National Lung Health Education Program, contact Thomas L. Petty, MD, chairman, NLHEP, HealthOne Center, 1719 East 19th Avenue, Denver, CO 80218.

AIHMES Hosts Second Annual DMERC Inservice

The Association of Indiana Home Medical Equipment Services (AIHMES) hosted their second annual Region B Durable Medical Equipment Regional Carriers (DMERC) Inservice in Indianapolis, IN, on January 29. This all-day educational opportunity reached over 250 Region B DMERC employees.

Volunteer members of AIHMES were posted at several "stations" where DMERC employees filed by for ten minute inservices. Topics and equipment included oxygen, CPAP, wheelchairs, beds, alternating pressure pads, compressor nebulizers, TENS, and other common home medical and respiratory equipment.

The event was coordinated by Colleen Russo, Region B council chair, Susan Joyce, manager of DMERC provider education, and AIHMES member Paula Koenig. In addition, volunteers from MedicAire, Lake Ridge, Restorative Care of America, ASCO, ProMed, ConvaCare, Cullen, Lincare, Memorial, Apria, and Grubbs participated by providing the equipment and individuals to do the training.

Volunteers were given the following guidelines to maintain uniformity while keeping the pace brisk so everyone could make it through the training:

- Explain what the product is and how the equipment features benefit the patient
- Share information about what services accompany the equipment
- Allow for hands-on whenever possible
- Avoid challenging medical policy or pricing discussions
- Do not promote specific suppliers

Like the inaugural event last year, this year's inservice was a total success. Through improvements suggested by the experiences of the previous year, more DMERC employees had an opportunity to see and learn about the many items they process claims for, creating a better understanding of the rationale behind the claim.

Once a DMERC employee finished touring the station, drinks and snacks were offered while they completed an evaluation of the event. As with the previous year, evaluations were overwhelmingly positive and it's certain that the inservice will be repeated.

JCAHO Accreditation Visit Reports

In an effort to keep you informed regarding JCAHO site visits, the AARC has been requesting information from organizations that have recently gone through the review process. (See JCAHO Accreditation Visit Form in this issue to provide input on your visit.) Here are two recent responses—

Homecare Medical Associates, Inc.
6600 NW 12th Avenue
Ft. Lauderdale, FL 33309
Contact: Jay J. Gutierrez, RRT, (954) 772-5052

Inspection Date: 1994

1. What was the surveyors' focus during your last site visit?
   QA / Infection control/documentation/pt care plans.
2. What areas were cited as being exemplary?
   QA
3. What suggestions were made by the surveyors?
   Further documentation on corrective actions taken/measure impact.
4. What changes have you made to improve compliance with the guidelines?
   More follow-up and documentation on any actions taken to correct a deficiency.

Additional comments: *More emphasis is being given to performance improvement. Patient care.*

Virginia Mason Home Care
925 Seneca St., Mailstop H4HHE
Seattle, WA 98111
Contact: Kathy Baillie, (206) 340-2011
Inspection Date: August 1995

1. What was the surveyors' focus during your last site visit?
   DME/clinical respiratory services.
2. What areas were cited as being exemplary?
   Clinical respiratory.
3. What suggestions were made by the surveyors?
   Needed improvement in infection control monitoring.
4. What changes have you made to improve compliance with the guidelines?
   Changed policy & procedure.

Additional comments: *None*

JCAHO News: Education Leads The Way

The Joint Commission has always been about education, but now the organization is ready to take the concept further than it ever has before. If an external fund-raising initiative proves successful, the JCAHO will begin offering a graduate level certificate program for health care professionals aimed at increasing their expertise in the areas of patient outcomes, resource consumption, customer satisfaction, and other health care delivery and management topics.

The Academy for Healthcare Quality, which is being billed as a corporate "university without walls," will operate in cooperation with several yet-to-be-named national universities. The curriculum is currently scheduled to be pilot-tested among surveyor candidates in 1998. Health care professionals and consultants who meet eligibility requirements will be able to enroll sometime after that.

The Joint Commission's stepped-up efforts to provide useful services and programs to its members through the establishment of the Academy are mirrored by its 1997 Action Plan, which was approved at the January meeting of the Board of Directors. Among other things, the JCAHO plans to—

- Pilot-test approaches for the use and transmission of performance data in hospitals and long-term care facilities.
- Improve its responsiveness in answering members' questions, both on the phone and in writing.
- Complete negotiations with other accrediting bodies that will help to streamline the accreditation process and reduce duplication of effort.
- Develop performance reports for managed care organizations and work towards making reports available on the JCAHO website.
- Identify and, where appropriate, modify problematic standards.
- Complete the design for an integrated survey process applicable to organizations that provide multiple services eligible for accreditation.
- Establish up to four additional Orion sites and evaluate results of existing sites.
- Provide field educational support for performance measurement and sentinel event analysis.

E-mail Discussion List Available To RCPs

Indiana University is sponsoring an e-mail discussion group called RC_World. The list, which now has more than 600 members, includes RCP, MD, and RN members from the U.S., Canada, and other parts of the world.

To subscribe, send an e-mail to LISTSERV@LISTSERV.IUPUI.EDU. In the body of the text (not the subject), put "SUBSCRIBE RC_WORLD (your name and credentials). Soon thereafter, you will get a confirmation. Once you receive a confirmation, use you software "REPLY" command and put "OK" in the text. The listserver will follow with a welcome message with instructions. For more information, contact John Hannigan at (317) 463-6765 or (317) 274-7311.

Technical Advisory Committee

Several Home Care Section members have expressed interest in participating on a Technical Advisory Committee for home respiratory equipment. The first item of equipment to be evaluated will be demand or pulse oxygen delivery devices. Anyone using any type of these systems should forward their equipment review to Nick Macmillan, Home Care Section chair. Evaluations should include the following:

- Equipment Name
- Equipment Specifications (height, weight, etc.)
- Battery Information (type, duration, charging options)
- Oxygen Duration Information
- Type of Cylinders Used With
- Carrying Case Options

- Benefits of Using This Specific Brand of Equipment
- Obstacles to Using This Specific Brand of Equipment
- Other Helpful Comments

In addition to this information, a protocol for evaluating a patient's tolerance to this type equipment versus continuous oxygen will be extremely helpful. This protocol will set the groundwork for creating a Clinical Practice Guideline (CPG). All members are welcome to submit equipment evaluations and/or protocols.

THE AARC NEEDS YOUR INPUT

The AARC has formed an Ad Hoc Committee to Develop Age Specific Educational Materials that will identify age specific materials which should be developed and available to RCPs for the education of their patients and caregivers. This committee is looking for input on the types of materials that would be beneficial, as well as the kinds of materials that are already available. Send your input to Nick Macmillan, AGS, RRT at the address/numbers on the back page of this issue. Thanks!

APB ON OMP

An "all points bulletin" is out for "outcome measurement projects" that save money in home respiratory care. Al Wierenga, manager of outcome research at Nellcor/Puritan Bennett, is looking for project ideas with an emphasis on cost savings. Other outcome measurement project ideas are also welcome. Send your ideas to Nick Macmillan, AARC Home Care Section chair.

AARC NATIONAL OUTCOME PROJECT UPDATE

Karen Pfaff and Phil Savage, who are coordinating the AARC National Outcome Project, recently distributed a video depicting ten client/caregiver interviews to project participants. Each participant will view the mock interviews and then score them using the standard Assessment Tool for Equipment Management of Oxygen Concentrators (ATEM). The objective is to determine reliability statistics for each project participant. This will help remove personal differences in the project results.

Karen also gave a presentation at the AARC International Convention and Exhibition on the project and the project was featured in the November/December 1996 issue of *Home Health Care Dealer*.

READ MORE ABOUT IT

Recent articles in the Bulletin focused on the use of water in the home for respiratory care. The Association for Professionals in Infection Control (APIC) has a book that addresses this issue. For more information, contact: Patricia Carroll, Educational Medical Consultants, 87 Surrey Drive, Meriden, CT 06451, (203) 238-1723.

TRICKS OF THE TRADE

Editor's Note: "Tricks of the Trade" is a new feature designed to focus on the "little things" that make your life as a home care RCP easier or your patients better. Send your "tricks" to the guest editor listed on the back page of this issue, either by fax or e-mail. This feature will continue as long as we have your input, so call now!

- A most cooperative CPAP patient had been struggling to tolerate the positive pressure. Her complaint was abdominal gas retention after using CPAP. A demand pressure unit was tried and she was most pleased that the gas pains were gone. Several days after using the unit, however, she started to be aroused by the force of air she received. Another type of demand unit/auto adjust unit has been ordered for trial. I will keep you informed on her progress.
- The parents of an infant on an apnea monitor discovered that an elastic head band worked just as effectively as a manufactured belt to hold the electrodes in place.
- A CPAP client who could not keep the chin strap in place tried a self adhesive wrap with satisfaction. The price was affordable.
- Be aware that when using CPAPs which automatically turn themselves off, they may not do so if "back" pressure is sensed and/or the leak alarm may not be triggered. This can happen when using appliances that fit into the nose and some masks.

ARCF AND INVACARE SOLICIT NOMINATIONS FOR THE 1997 INVACARE AWARD FOR EXCELLENCE IN HOME RESPIRATORY CARE

The ARCF and Invacare Corporation are looking for nominees for the 1997 Invacare Award for Excellence in Home Respiratory Care. The award, which was established in 1992 with a grant from Invacare, includes a $500 cash prize along with an engraved crystal sculpture and airfare and

one night's lodging to attend the Awards Ceremony at the AARC Convention.

Nomination Procedure: Please submit a one-page, typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria—

- Must currently be working in home respiratory care.
- Must be a respiratory care practitioner.
- May not be employed by a manufacturer.
- May be involved in education, as well as the management and organization of patient care.
- Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership.
- Preference will be given to individuals who have participated in volunteer community efforts related to home respiratory care, in addition to meeting the medical needs of their patients.

A curriculum vitae is required and supporting documentation should be included, if available.

Nominations will be accepted from January 1 to June 30. Please mail your nominations to: ARCF-Invacare Award, 11030 Ables Lane, Dallas, TX 75229-4593.

AARC ONLINE: *A READILY AVAILABLE RESOURCE FOR BUSY MANAGERS*

by William Dubbs, MHA, RRT
AARC Director of Management Services

The content of the AARC World Wide Web site (http://www.aarc.org) is expanding weekly and may have the information you need readily available for instant downloading. When you reach the site, click on "AARC Online Services and Information." There you will find the following areas, many of which are of particular interest to managers—

Physician Letter of Support: In October of 1996, the American Society of Anesthesiologists issued this statement in support of respiratory care practitioners versus substitute caregivers. The content of this letter is reproduced here along with instructions on how to obtain a signed copy of the letter on ASA stationery.

Conventions, Meetings, and Seminars: Learn about the AARC International Convention and Exhibition, Affiliate Meeting information, and Special Seminars.

Products and Services: Products and services related to respiratory care, and the *1996 Buyer's Guide of Cardiorespiratory Care Equipment & Supplies*, are available here.

AARC Clinical Practice Guidelines: All 46 of the AARC's Clinical Practice Guidelines are available online.

$1,000,000 Fund Grant Application: The AARC has established a fund of $1,000,000 to promote research into the clinical and economic value of respiratory care practitioners. Details on how to apply can be found here.

Links to Other Respiratory Care Related Sites: Links to other sites of interest—

More information for managers can be found in the "Member's Only Section." In this section (members get their unique password through e-mail) you will find—

The AARC Help Line: In this area members can pose their questions or respond to the questions of others. You can review the responses others have made to the questions posted. Some of the questions under discussion this month related to management issues are—

- Extended/advanced practice
- Institutions using TDPs without a respiratory care information system
- Patient assessment skills
- Inpatient pulmonary rehab
- Criteria for discontinuing RC services
- Outsourcing respiratory care in acute care settings
- Charting by exception
- Cardiac rehabilitation
- RCPs as case managers
- Differences in duties (CRTT and RRT)
- Joint Commission experiences
- Therapist-driven protocols
- Respiratory therapists starting IVs

Position Statements: The AARC has advanced a number of position statements and guidelines regarding the provision of services or the practice of respiratory care. These statements are presented here.

CRCE: The AARC approves respiratory care educational programs for CRCE credit, which many states use as the basis of continuing education. A month-by-month listing of the courses approved by the AARC is posted here.

Resources: This is a particularly rich area for managers. Information here includes the following—

- **Post-Acute Care Contracting Resource List:** A list of AARC members who are engaged in contracting post-acute care services.
- **Restructuring Resource List:** This is peer counseling network of AARC members who have been involved in hospital restructuring initiatives.
- **Model Transfer Agreement:** This is a sample of a transfer agreement between a hospital and skilled nursing facility.
- **Model Management Agreement:** This is a sample of a respiratory therapy program management agreement between a hospital and a SNF.
- **Overview of the Medicare Program:** A white paper providing a general description of Medicare.
- **Utilization in Respiratory Care:** A white paper describing utilization review in acute and post acute settings.
- **Recentralized Respiratory Care:** A list of organizations that have recently recentralized respiratory care services.

There is much more to come, so I encourage you to check the site frequently. For example, in the near future we will be posting the AARC's JCAHO Cross Walk document. This identifies the 1997 Standards that managers of respiratory care services in acute care facilities should be familiar with when preparing for an accreditation site visit. Also, those who visit our site in the future will be able to quickly determine the current adjusted hourly salary equivalency amounts and standard travel allowances for respiratory care practitioners providing services to residents in skilled nursing facilities covered by Medicare Part A.

FYI...

FUND APPLICATION CHANGE

In 1994, The National Board for Respiratory Care/Applied Medical Professionals (NBRC/AMP) established an endowment to the American Respiratory Care Foundation (ARCF) to provide support up to $3,000 for educational or credentialing research, a Master's thesis, or Doctoral dissertation with practical value to the respiratory care profession. This educational research endowment is named for H. Frederic Helmholz, Jr., MD, in recognition of his outstanding contributions to the respiratory care profession.

The ARCF has approved a more "user-friendly" application that can be submitted at any time during the year. The ARCF trustees feel the new, simplified application is more relevant to education research and is tailored to assist individuals applying for credential-related research grants. The Helmholz award will include registration, round-trip airfare and one night's lodging to the 1997 AARC International Respiratory Congress in New Orleans, LA.

Applications may be obtained through the ARCF Executive Office at 11030 Ables Ln., Dallas, TX 75229-4593, (972) 243-2272.

OIG investigations to target home care

The Office of the Inspector General has released its list of investigations for the coming year and 15 HME items made the cut. Of most concern to RCPs is a planned investigation into the lease-purchase option for oxygen concentrators, an issue that has been on the hot list since a 1995 report indicated that monthly payments to HMEs were too lucrative. The new study will try to determine if another payment method could be used to replace the current plan.

Industry leaders took the news calmly, but cited concerns about the oxygen concentrator issue. Specifically, the Health Industry Distributors Association questioned the advisability of changing the way patients pay for their oxygen concentrators, noting that those who purchased their equipment outright would no longer have access to routine service on the device.

Also included on the OIG's HME list are investigations into—

- Questionable billing practices for air-fluidized beds
- Questionable billing practice for orthotic supplies
- Medical necessity issues associated with the coverage of portable oxygen
- Appropriate utilization and medical necessity issues involving enteral nutrition therapy
- The usefulness of CMNs for DME to the DMERCs
- The physician's role in controlling non-physician services and supplies
- Discharge planning
- Dually billable HME codes
- Recovery of carrier overpayments for incontinence supplies in Florida
- Home health care eligibility reviews
- General and administrative costs of HHS
- High cost HHAs
- Home health in HMOs
- The physician's role in home health

(Source: *Home Care*, 1/97)

ARCF ANNOUNCES HELMHOLZ RESEARCH
Operation Restore Trust hits hospices

Despite the fact that a 1994 Lewin study found that Medicare saved $1.52 cents for every dollar it spent on hospice care for patients with terminal cancer, the hospice industry is having to go on the offensive to maintain its place in the continuum of care. A recent government investigation of hospices in California, Texas, Florida, Illinois, and New York conducted under the Operation Restore Trust program is targeting cases where patients did not die in the prescribed amount of time and auditors are now seeking to recover millions of dollars in improper Medicare payments.

The National Hospice Organization (NHO), which represents over 2,200 hospice programs and 4,100 hospice professionals, is concerned that although "the OIG's efforts related to beneficiary eligibility for hospice care are well intended, the process is seriously flawed, with potentially devastating impact on appropriate patients seeking hospice care." The government investigation, which began with two hospices in Florida, is focusing on patients who outlive the standard time allotted for hospice care.

Under Medicare rules, patients must have a prognosis of six months or less to live in order to qualify for hospice care. In question are those cases in which patients who were referred to hospice care with that prognosis were still alive after six months. At one of the Florida hospices, nearly 300 such cases were uncovered, but operators say they have reviewed all the cases and almost all involve patients who were, indeed, terminally ill. Says the NHO, "The reviews in Florida fault the hospice for not being flawless in establishing the prognosis of the patient... it is disconcerting that OIG reviewers, with a lack of generally accepted or established criteria, are 'second-guessing' the prognosis determined by other physicians." (Sources: Reuters Medical News, PRNewswire)

More fraud and abuse initiatives

Is the government serious about curtailing fraud and abuse in health care? Consider the following—

- In an attempt to ferret out so-called "nomad" providers who constantly move from location to location, the DMERCs will begin using "Do Not Forward" envelopes when mailing checks to providers. Not only will these providers fail to have their cash returned, the DMERCs will also forward all returned envelopes (with new address label) to the National Supplier Clearinghouse for investigation. (Source: *HomeCare Monday*, 1/20/97)

- A Florida Medicaid program rule requiring DMEs to post a monetary bond to participate in the program may soon be adopted by the Health Care Financing Administration for the Medicare program. HCFA officials believe such a rule would dissuade shady DME dealers from seeking participation in the Medicare program and would also help in recovering at least some of the funds lost to fraudulent billing practices. Indeed, the idea is so appealing to the federal agency that it is considering expanding the bond proposal to include home health agencies, medical transportation firms, and other providers. The suggested price of the bonds? $50,000. (Source: *Medicine & Health*, 1/3/97)

Canadians call for more home care

Is home care a costly option that payers need to minimize or is it a potential money saver that ought to be utilized more often? U.S. payers might want to look to their neighbors to the north for an answer to that question. A Canadian panel appointed by Prime Minister Jean Chretien in 1994 has concluded that increased government funding for home health care could cut costs overall by preventing, delaying, or substituting for more expensive long-term care services in hospitals and nursing homes. The National Forum on Health released its report in early February. (Source: Reuter, 2/4/97)

NAMES, HIDA, develop HME industry standards

Reacting to growing concerns regarding fraud and abuse in the HME industry, the National Association for Medical Equipment Services (NAMES) and the Health Industry Distributors Association (HIDA) have both been hard at work on national standards for the HME industry.

The *HME Services Industry Standards*, which were developed by NAMES from current Medicare DME standards, standards previously developed by NAMES for its "Operation Build Trust" fraud and abuse prevention initiative, and standards proposed by NAMES members and others, will be presented to Congress and other government and private organizations in the near future. Says the organization, "By meeting basic business standards, a legitimate HME services provider establishes a solid base on which to operate a quality HME business. Quality HME businesses deliver a product and/or service to the customer in the most cost-effective and appropriate way, while ensuring that each individual customer's needs are met."

The 12 standards, which cover everything from the physical facility to clients' rights, state that delivery personnel must be appropriately trained to—

- Conduct an environment/equipment compatibility assessment;
- Appropriately and safely set up the equipment;
- Instruct patients and their caregivers in the safe operation and client maintenance of the equipment;
- Recognize when additional education and/or follow-up patient compliance monitoring is appropriate; and
- At the time of the initial delivery set up any appropriate follow-up HME services schedule as needed for such items including, but not limited to, periodic maintenance, supply delivery, emergency services, and other related activity.

In addition, the standards state that "The equipment needs of the patient, the physician's orders, the economic and environmental situation of the patient and caregiver, and the requirements of any third-party payer source must be considered by the provider in providing HME services for a patient/client. When special requirements exist, the provider shall provide trained individuals to assess and help select the appropriate product for a patient."

The HIDA standards will take a more operational and procedures focus and be tailored specifically for the HME, respiratory, and infusion markets. The association plans to incorporate an extensive array of rules governing the provision of these services, including everything from the types of information that should be collected by Medicare to the provision of product information and resources to customers. As of this writing in early February, HIDA expected to have its standards ready in draft form by mid-winter. (Sources: NAMES, *HomeCare Monday*, 1/20/97))

AARP, others join in fight for quality care at the end of life

A coalition of more than 40 national medical and consumer organizations, including the American Geriatrics Society, the American Association of Retired Persons, the American Nurses Association, and the American College of Physicians, is calling on the government to establish quality measures to ensure adequate and compassionate care for the terminally ill.

The group, which has come up with ten principles to guide the medical community in measuring quality care for the dying, is urging the National Institutes of Health to increase research in the area. The coalition also wants Medicare and other insurers to establish minimum care standards for the terminally ill, and is asking that the Joint Commission on Accreditation of Healthcare Organizations and National Committee for Quality Assurance include such quality measures in their performance standard sets.

Among the ten principles supported by the group are—

- Ensure that the patient's physical and emotional symptoms are addressed
- Make better functioning and autonomy a key objective
- Encourage patients to plan their death wishes in advance
- Limit the overuse of machinery in futile cases
- Promote provider continuity and skill in end-of-life care

(Source: Reuters Medical News, 1/8/97)

New website focuses on elder care

As the elderly population grows from about 33.5 million today to 70 million in 2030, the provision of services to Americans over the age of 65 is expected to skyrocket. Now the National Technical Information Service has established a new online service designed to get the word out about elder care issues to those catering to this growing market. The website features abstracts of research reports, along with guides on elderly nutrition, housing, transportation programs, long-term care, legal assistance, elder abuse prevention, and volunteer networks. Visit the site at http://www.ntis.gov/health (Source: PRNewswire, 1/21/97)

More managed care choices for Medicare beneficiaries

Medicare patients in Orlando, FL, Philadelphia, PA, Houston, TX, and rural southern Virginia who want to give managed care a try now have more to choose from. Through a HCFA demonstration project started in January, beneficiaries in those four communities can opt for one of four provider-sponsored networks, a preferred provider organization, or a "triple option" hybrid that allows participants to use a physician in the plan, go to another provider in the plan's network, or go to a provider outside the network. The pilot program has been dubbed "Medicare Choices." (Source: *HomeCare Monday*, 1/20/97)

Nursing home population fails to keep pace with elderly population for the first time

Although the nursing home population increased by four percent between 1985 and 1995, the over-65 population grew by 18 percent, making it the first time since records have been kept that the nursing home population has not grown at the same rate as the elderly population, says the National Center for Health Statistics. The decline is being attributed to medical technology advances and the rapid growth in home care, which together are enabling many would-be nursing home residents to remain in their homes longer than they could in the past.

According to the report, the number of nursing homes fell by 13 percent between '85 and '95, but the number of beds increased by nine percent, suggesting consolidation in the field. About 1.5 million people received care in 1.8 million beds in 16,700 nursing homes in 1995. Nine out of ten residents were over 65 and 35 percent were 85 or older. For-profit facilities accounted for 66 percent of all homes and over half of all facilities were part of a chain (up from 41 percent in 1985). Occupancy rates in 1995 ran about 87 percent. (Source: National Center for Health Statistics)

DeVilbiss and Respironics enter agreement on sleep apnea technology

In what industry insiders term a move to enter the bi-level therapy market without risk of being sued for patent infringement, DeVilbiss Health Care recently entered into an agreement with Respironics to pay royalties for the right to sell Respironics' patented bi-level positive airway pressure technology in its product sales throughout North America. Respironics currently holds two types of patents for its technology: a technological patent covers all intellectual property and a methods patent covers the application of all types of bi-level therapy for obstructive sleep apnea. The company recently filed a patent infringement suit against Buffalo, NY-based AirSep Corp., claiming that AirSep's "Remedy" device violates the proprietary intellectual property incorporated in Respironics' BiPAP systems. (Source: *HomeCare Monday*, 1/20/97)

Apria debuts electronic data interface program for respiratory therapy

Apria Healthcare Group, Inc., has launched a new electronic data interface program with Kaiser Permanente in Northern California that allows for near instantaneous order intake and confirmation of respiratory therapy and home medical equipment for 2.5 million Kaiser Permanente members.

Through the new system, orders are entered into the computer system and then transmitted to the Apria branch located nearest to the patient's home, where a customer service representative is alerted via an interrupt message on his or her computer screen. Once the order had been filled, the Kaiser Permanente office receives an electronic confirmation of delivery. The system, which Apria believes to be the first of its kind in home health care, also handles electronic billing and utilization reporting, as well as other operations and reporting functions. (Source: Business Wire)

Fledgling organization focuses on telemedicine

Telemedicine has been touted as the wave of the future, but most providers not only don't know how to catch the wave, they don't even know where it find it. A new organization called the Association of Telemedicine Service Providers wants to change all that. This support group aims to provide advice and education not just for those already involved in the area, but for those who would like to get involved as well. You can access the organization at its website: http://www.atsp.org or call (503) 222-2406. (Source: *HomeCare Monday*, 1/27/97)

JCAHO Accreditation Visit Report Form

The following survey form is provided to enable the reporting of recent JCAHO accreditation site visits. Compiled results will be published regularly through select section newsletters and the *AARC Times*. Please return your completed survey to:

William H. Dubbs, MHA, RRT
AARC Director of Management Services
11030 Ables Lane
Dallas, TX 75229-4593
Phone # (972) 243-2272 Fax # (972) 484-2720

Inspection Date: _____

Name: _____

Facility: _____

Address: _____

_____

_____

Phone: _____

If you are willing to discuss your accreditation visit with others check this box ☐ and this information will be added to a list that is available to AARC members. If you do not check the box your response will remain anonymous.

Please check the type of accreditation visit you are reporting:

Pathology & Clinical Laboratory Services ☐

Hospitals ☐

Home Care ☐

Long Term Care ☐

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

What areas were cited as being exemplary?

What suggestions were made by the surveyors?

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

Please offer any additional comments about the site visit that will be helpful to others. (use additional sheet if necessary)

_____

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_____

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