Home Care Bulletin

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

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NOTES FROM THE CHAIR: ADVOCACY BEGINS WITH EDUCATION

by Nicholas J. Macmillan, AGS, RRT

As the President and Congressional budget committee members again begin to take a hard look at home oxygen reimbursement, we must take a hard look at what we are doing to ensure that they and our customers are aware of the impact of proposed reductions. One question we must ask ourselves is, "What have I done to educate government decision makers about the service we provide with our product?" Even more, 'What have I done to educate my referral sources (i.e. physicians, discharge planners, respiratory department directors) AND my patients on the impact of proposed reductions?"

Here are a few suggestions for educating legislators about the service you provide—

- When you and your coworkers draft your letters to Congress, be certain to explain the services provided along with your equipment.
- Send a letter to your oxygen patients explaining the proposed cuts and ask them to contact their legislators with their concerns.
- The next time you make a call on your referral sources, explain the proposed reductions and what the impact may be to service levels, and ask them to write their legislators.

Generally, referral sources and patients are not made aware of proposed reimbursement changes until it is too late. Therefore, it is incumbent on us to make them aware.

One other imminent change involves the use of "stable state" blood gases/saturations for qualifying patients for home oxygen. This change is not necessarily conveyed to the individuals responsible for obtaining these results. So again, it will be up to us to educate the appropriate parties so they will understand how and when qualifying tests may be done.

As we embrace the role of patient advocate, we become responsible partners in the education of the individuals involved. Now, let's get busy!

NOTES FROM THE GUEST EDITOR: *WHY YOU SHOULD WRITE A* BULLETIN *ARTICLE*

by Heidi Weston, RRT

Once again it has been my privilege to serve as guest editor for the *Bulletin*. I would like to thank all of the contributing authors for their time and effort. You did a great job as usual. Thanks for making my job as editor easier.

Since I did not have the pleasure of having any new participants in this newsletter, however, I would like to once again challenge all of my home care colleagues to become contributing authors to the *Bulletin*. As I listened to the home care section meeting in San Diego, I realized that all of you have plenty of ideas and do not appear shy about expressing them. So I challenge all of you to share those ideas by writing a short (1-3 typed, double-spaced pages) article for an upcoming issue.

What might you write about in these articles? Our section chair, Nick MacMillan, has given me some great ideas for topics. One is "Tricks of the Trade." Surely all of us have, at one point in our home care careers, found ourselves short on time and uncovered some shortcuts that made our jobs easier and more efficient. Or, perhaps you have discovered a new piece of equipment that is efficient, and cheap, too. Let all of us hear about it. Another topic that may inspire some of you to pick up a pen is a technical review of a certain product that you may have found terrific. Alternatively, you may wish to review a new product on the market for effectiveness and cost containment. Of course, it goes without saying that ANY information you have regarding outcomes would be much appreciated. As we all struggle to deal with the changes taking place in health care today, sharing data on what works and what doesn't will be paramount to our ability to continue to offer our services to patients.

Lastly, I want to emphasize that you need not be a Pulitzer Prize-winning writer to submit an article to the *Bulletin* (editing assistance is available), and having an article with your byline under it is a great feeling and a wonderful way to demonstrate your professional commitment to your superiors and peers alike! To find out more about submis-

sion guidelines, turn to the end of this issue—they will tell you everything you need to know to participate.

AARC Raises Concerns On Conditions of Participation That Restrict Home Respiratory Care Services

The AARC recently provided comments on proposed revisions to the Medicare Home Health Agency Conditions of Participation, applauding the Health Care Financing Administration (HCFA) for the proposal's flexibility, but admonishing them for allowing only nurses or physical therapists to provide skilled respiratory care as a home health benefit.

"The Conditions continue to ban the one professional who possesses documented competency to deliver such services, the respiratory care practitioner," said AARC President Kerry George in a letter to HCFA administrator Bruce Vladeck. "This is tantamount to providing a nursing benefit and prohibiting nurses from delivering it, or a physical therapy benefit prohibiting the physical therapist from providing the service."

According to the Medicare Home Health Manual (the implementing guidelines for the Conditions of Participation), intermittent skilled respiratory therapy visits are a covered service, but only if provided by a nurse or physical therapist.

As part of its comments, the AARC provided Mr. Vladeck with information about the lack of any formal education or competency documentation in respiratory care for any other health providers, and also provided data showing the positive economic and clinical benefit of respiratory care practitioners. Statements from the American Society of Anesthesiologists and the National Association for Medical Direction of Respiratory Care also endorsed the need to use respiratory care practitioners to render respiratory care services.

In addition, the AARC raised the following concerns—

- That the Medicare guidelines are contradictory. The Medicare Hospital Conditions of Participation clearly recognize the critical nature of respiratory care services by establishing a standard of care that requires that there be adequate numbers of respiratory therapists and respiratory therapy technicians to provide these services. Yet Medicare is contradicting itself by not requiring this same standard outside of the hospital.
- That the current Medicare regulations are working against the dynamics of integration of care across all care settings. And at a time when higher acuity patients are being discharged from the hospital, patients must continue to have access to qualified health care providers in the post-acute settings.
- That HCFA is permitting Medicare beneficiaries to receive complex respiratory care by nurses and physical therapists who do not have to demonstrate any respiratory care competency.

The AARC did praise HCFA for turning their focus to providing care in the most appropriate setting, thereby incorporating a flexibility and coordination of services heretofore missing from Medicare standards.

Budget Proposals: *What They Mean For You*

by Cheryl West, MHA

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

The Clinton Administration and Congress continue to debate changes in the payment and structure of the Medicare program. This federal program is the key to bringing the federal budget into balance by the year 2002.

While the home health benefit is catching most of the proposed budget cutting bullets, the Medicare HME benefit is not likely to survive unscathed either. Both the President and a group of conservative Democrats dubbed "the Blue Dog coalition" have released their own proposed budgets. The Republican Congress has yet to come up with its version of a budget bill, but the outlines of the final budget have taken shape.

The President's budget proposal calls for the institution of a competitive bid process for all Part B services (except for physician services and the home oxygen therapy benefit). This is a radical departure in that previous plans had only included competitive bidding for DME. Furthermore, President Clinton's budget is proposing that if a 20% reduction in reimbursement has not occurred due to competitive bidding by the year 2002, payments would be reduced until the 20% decrease has been reached. Worse yet, because President Clinton's budget was short $18 billion of its $100 billion reduction goal, new budget proposals now include a 40% reduction in home oxygen payments, for a savings of $1.3 billion over four years. Needless to say, other non-physician Part B providers and suppliers are lobbying hard against this proposal.

House Republicans are lukewarm on the issue of competitive biding and may drop it in its entirety. Also, the Blue Dog coalition is omitting competitive bidding in its proposal. However, the Blue Dog coalition has proposed reductions, including a 10% decrease in home oxygen therapy payments, and a freeze on DME annual updates for the year 2002, with a 2% reduction in future CPI adjustments for subsequent years.

The AARC is part of several Capitol Hill coalitions that are vigorously lobbying against many of these proposed measures. Because the Democrats and Republicans continue to be at an impasse, final budget decisions remain many months away.

HOME NOCTURNAL VENTILATION IN COPD

by Alan L. Plummer, MD

Last week a good friend and colleague called me from a city on the coast of Georgia. He was quite perplexed because he had seen three patients with COPD from separate areas of our state who were receiving nocturnal nasal ventilation with a device which provides inspiratory and expiratory pressures. He felt that the patients were coerced into buying these units, either by a DME or by unsuspecting primary care physicians who had been influenced by the company selling this product to place their COPD patients on it. None of the devices had been recommended by a pulmonologist or anyone knowledgeable in home mechanical ventilation.

Is there a role for home nocturnal ventilation in the stable COPD patient? Studies in patients with stable COPD were performed in the '80s utilizing a poncho wrap negative pressure ventilation unit for nocturnal ventilation. The short term studies seemed to demonstrate an improvement in blood gases and respiratory muscle strength, but prospective, controlled studies showed no apparent improvement in pulmonary function or respiratory muscle function. Even an NIH-sponsored 12 week trial in 184 patients with stable COPD who were treated with a poncho wrap or sham ventilation failed to show any improvement in exercise tolerance, ABGs, respiratory muscle strength, shortness of breath, or quality of life.

A few short-term studies have looked at the use of nasal nocturnal ventilation in the home in the stable COPD patient and have suggested favorable results. However, with one exception, long term studies performed over 3-6 months did not show any significant improvement in pulmonary function or respiratory muscle strength. The exception was one study performed in 14 stable, hypercarbic COPD patients, which showed that nasal nocturnal ventilation plus oxygen improved daytime P_{aCO_2}, P_{aO_2}, and quality of life, compared to oxygen alone.

These studies were disappointing, because in patients with hypoventilation due to progressive neuromuscular disorders, uncontrolled studies have shown an improvement in daytime P_{aO_2} (lowering daytime P_{aCO_2}), and elimination of symptoms of hypersomnolence and morning headaches. It is possible there may be a role for nasal nocturnal ventilation in stable COPD patients with severe hypercarbia or severe nocturnal oxygen desaturation, but further research is necessary to determine if nasal ventilation in these patients will be effective.

Thus, it appears that nasally-administered nocturnal ventilation is of limited value in stable patients with COPD. Certainly any attempt to use this modality in the COPD patient should be under the aegis of a pulmonologist within a research setting. Nasal nocturnal ventilation should not be used in an unsupervised fashion in the community, since there is no evidence that it is efficacious.

The indiscriminate selling of nasal positive pressure devices to unsuspecting COPD patients is unconscionable and must be avoided. It is up to each of you to be certain that your home care company is not involved in this practice. We don't want nocturnal nasal ventilation to become in the '90s what home IPPB therapy was in the '60s and '70s.

Suggested Reading

1. Strumpf DA et al. Nocturnal-positive-pressure ventilation via nasal mask in patients with severe COPD. Am Rev Respir Dis 1991; 144:1234-1239.
2. Hill NS. Noninvasive ventilation. Does it work, for whom, and how? AM Rev Respir Dis 1993; 1050-1055.
3. Meecham Jones, DJ et al. Nasal pressure support ventilation plus oxygen compared with oxygen therapy alone in hypercapnic COPD. Am J Respir Crit Care Med 1995;152:538-544.
4. Wunderink RG, Hill NS. Continuous and periodic applications of noninvasive ventilation in respiratory failure. Resp Care 1997; 42:394-402.

CLINICAL RESPIRATORY: *SHOULD I OR SHOULDN'T I?*

by Kathleen Brition, RRT, MPH

Kathleen Brition is the associate director of home care accreditation services at Joint Commission on Accreditation of Healthcare Organizations.

There are few days that go by at the Joint Commission without at least one question from customers about clinical respiratory services.

- What is it and am I doing it?
- Why should I provide clinical respiratory services if I don't get reimbursed?
- How will clinical respiratory services impact my survey?

Eligibility

Before the Joint Commission began to accredit home care organizations in 1988, the phrase "clinical respiratory services" did not exist, and the professional services provided by respiratory therapists outside of the hospital setting were largely unrecognized. During the initial development stage of the "Equipment Management" standards in 1986, research identified that professional services were being provided by some home medical equipment organizations. These organizations were using respiratory therapists, not only to monitor the equipment, but also to assess the patient or provide therapeutic treatment. It was quickly obvious that these services were similar to the services provided by other health care professionals such as nurses, and were clearly outside the definition of equipment management. The Joint Commission realized the significance of the professional component provided by the respiratory therapist and the necessity of recognizing these services as more than equipment management, and thus classified the professional involvement of respiratory therapists as "clinical respiratory services."

Clinical respiratory services (CRS) are performed when a professional gathers clinical data (physical or respiratory assessments, ongoing oximetry, PFTs, etc.) in order to make judgments about the patient's condition, or administers

therapy or treatment to a patient. Any organization that employs health care professionals to monitor or treat respiratory patients in their homes will be surveyed for clinical respiratory services. The professional can be an RRT, CRTT, RN, or other qualified health care professional, as long as the professional is competent to perform the designated care.

Although most organizations that provide CRS do so in conjunction with the provision of the equipment management services, this is not always the case. There are organizations that are accredited for CRS that do not provide equipment to patients. These organizations are typically home health agencies. However, there are several organizations that are accredited for no other home care service except CRS; for example, a hospital respiratory therapy department that obtains arterial blood gas samples from patients at home.

Organizations sometimes assume they are providing CRS if they provide an oxygen delivery system to a patient. Some organizations consider that employment of respiratory therapists constitutes CRS. Other organizations believe that they are required to provide CRS if the organization has ventilator-dependent patients. In reality, none of these situations is actually the case. Rather, it is the type of services provided by the health care professional that constitutes CRS, not the type of equipment provided to a patient or the specific occupation of the health care professional.

Reimbursement

Typically, clinical respiratory services have not be reimbursed by third party payers. The common perception by both HME providers and payers has been that the clinical respiratory services were related to the equipment, and were used to monitor the equipment and the patient's response to the use of the equipment. However, with the advent of managed care, the cost-effectiveness of managing a patient's respiratory condition at home has opened the door to reimbursement. Many HME providers are being contracted to render both clinical evaluations and therapy, in addition to equipment management services. Although it is not a giant step forward, it is at least a step in the right direction towards recognition of respiratory therapy as a credible professional service.

However, the Joint Commission does not correlate eligibility of services with reimbursement. Consequently, organizations that provide clinical respiratory services will be surveyed for those services, and will be granted the additional accreditation award denoting the provision of a higher level of care accordingly.

Standards compliance

Most organizations that employ qualified respiratory therapists or other health care professionals are already well on their way to complying with the Joint Commission standards for clinical respiratory therapy. Indeed, one of the most commonly cited standards is lack of a qualified, competent individual. This occurs when the individual has not been appropriately trained to provide the required care.

For example, one organization hired a respiratory therapist without prior neonatal/pediatric experience. The therapist was asked to set up a ventilator on an infant in the hospital prior to discharge. Rather than confirming the physician's orders, the therapist took a verbal order from a hospital employee, who stated that the tidal volume should be set at 1200 cc's. The therapist, unable to distinguish the inappropriateness of the order, set up the ventilator at the stated volume, and did not evaluate the patient following the set up to note the patient's alarming condition.

Another problematic area for organizations providing CRS is lack of physician's order to provide the additional care. As with all health care disciplines, the professional services delivered under the guise of clinical respiratory services must be provided under the direction of a physician, necessitating an authenticated order from the physician.

Beyond these two problematic areas, organizations providing clinical respiratory services find that CRS constitutes nothing more than respiratory therapists practicing what they have been trained to do; with that realization, the trepidation with which CRS is often approached seems to disappear. Additionally, improved patient outcomes frequently provide the organization with decreased costs of care for third party payers, thus increasing contract potential for providers. More and more, organizations providing CRS have stated that they market their outcomes with great success to managed care organizations.

Each home care organization must individually determine the merit of providing clinical respiratory services. Unfortunately, the respiratory therapist is caught in the conflict between cost of care and quality of care. However, by continuing to push for respect and credibility through our state and national associations, and by seeking accreditation of the professional role of the respiratory therapist, the cost of care provided to the respiratory patient may someday be considered a direct reflection of the quality of care resulting from the professional services of the respiratory therapist.

TELEMEDICINE

by Nancy Brown

Nancy Brown is with the Association of Telemedicine Service Providers.

Telemedicine has been defined as the use of telecommunications to provide medical information and services. (Perednia and Allen, 1995). It may be as simple as two health professionals discussing a case over the telephone, or as sophisticated as using satellite technology to broadcast a consultation between facilities in two countries using videoconferencing equipment. The first is used daily by most health professionals, and the latter is used largely by the military and some large medical centers. It is the practice of telemedicine that lies somewhere in-between those two which will be described in this article.

Two different kinds of technology make up most of the telemedicine applications in use today. The first, called store-and-forward, is used for transferring digital images

from one location to another. A digital image is taken using a digital camera, ("stored") and then sent ("forwarded") to another location. This is typically used for non-emergent situations, when a diagnosis or consultation may be made in the next 24-48 hours and sent back.

The image may be transferred within a building, between two buildings in the same city, or from one location to another anywhere in the world. Teleradiology, the sending of x-rays, CT scans, or MRIs (store-and-forward images) is the most common application of telemedicine in use today. There are hundreds of medical centers, clinics, and individual physicians who use some form of teleradiology. Many radiologists are installing teleradiology equipment in their homes, so they can have images sent directly to them for diagnosis instead of making an off-hours trip to a hospital or clinic.

Telepathology is another common use of this technology. Images of pathology slides may be sent from one location to another for diagnostic consultation. Dermatologic images are also a natural for store-and-forward technology. Digital images may be taken of skin diseases and sent to a dermatologist for diagnosis. A National Library of Medicine-funded project at Oregon Health Sciences University is developing a low-cost teledermatology system for use by clinics in three different rural areas in Oregon with poor access to dermatologists. Skin conditions which a general practitioner may not feel confident about diagnosing are digitally photographed and forwarded by computer to a dermatologist in Portland for consultation.

The other widely used telemedicine technology, two-way interactive television (IATV), is used when a consultation between the patient, primary care provider, and specialist is necessary. Videoconferencing equipment at both locations, typically one urban and the other rural, allow a "real-time" consultation to take place. This means that the patient does not have to travel to an urban area to see a specialist, and in many cases, provides access to specialty care where none has been available previously. Almost all specialties of medicine have been found to be conducive to this kind of consultation, including psychiatry, internal medicine, rehabilitation, cardiology, pediatrics, and obstetrics and gynecology.

There are many on-going IATV projects and several new ones are springing up as well, both nationally and internationally. In Oklahoma, a mobile telemedicine unit operating from the Konawa Community Health Center is taking health care to five rural counties. After updating with video cameras and video-equipped medical instruments, the unit took in over $40,000 in September 1995. (Kincade 1996) The system has been used for consultations from physicians assistants and nurse practitioners at the outlying clinics, who consult with the primary care physicians when they need help.

Several telemedicine programs are being initiated in correctional facilities, eliminating the costs and danger of transporting prisoners to health facilities. A prison telemedicine program at the University of Texas Medical Branch at Galveston sees over 350 patients per month.

Home health care is another booming area of telemedicine. A program in Japan allows home bound patients to communicate daily with physicians, nurses, or physical therapists. Telemedicine does not have to be a high-cost proposition. Many projects are using low-end technology to provide valuable services to those with no access to health care. The Memorial University of Newfoundland project has been using low-cost store-and-forward technology to provide quality care to rural areas for many years.

The military and some university research centers are involved in developing robotics equipment for telesurgery applications. A surgeon in one location can remotely control a robotics arm for surgery in another location. The military is developing this technology particularly for battlefield use, and it will likely eventually filter to domestic use as the technology is perfected.

The use of telemedicine can provide several advantages. It can make specialty care more accessible. Video consultations between a rural clinic and a specialist can alleviate sometimes prohibitive travel for patients. Videoconferencing also opens up new possibilities for continuing education for isolated or rural health practitioners who may not be able to leave a rural practice to take part in professional meetings or educational opportunities. While studies have yet to confirm this, it appears that the use of telemedicine can also cut costs of medical care for those in rural areas.

There are still several barriers to the practice of telemedicine. Many states will not allow out-of-state physicians to practice unless licensed in their state. The Health Care Financing Administration (HCFA) will reimburse for teleradiology and telepathology, but not specialty consultations for Medicare patients; many private insurers also will not reimburse. Fear of malpractice suits is another consideration for physicians, as is acceptance of the technology and lack of "hands-on" interaction with patients.

Many telemedicine projects have been hampered by the lack of appropriate telecommunications technology. Regular telephone lines do not supply adequate bandwidth for most telemedical applications. Most rural areas do not have cable wiring or other kinds of telecommunications access required for more sophisticated uses, so those who can most benefit from telemedicine may not have access to it. However, Congress recently passed the Telecommunications Reform Act of 1996 which, among other things, will allow rural education and health care networks to pay connectivity rates similar to those charged in urban areas.

Telecommunications companies are also jumping on the bandwagon, by either providing funding and technology for telemedicine programs, or by improving telecommunications access in many states. This should greatly enhance the availability of telemedicine technology to those who can most benefit from it.

Many of the current telemedicine projects side-step these problems by seeking grant funding. However, as federal funding has become less available for telemedicine, many private corporations and telecommunications companies are stepping in to fill the void. Pressure on the appropriate government and legislative agencies needs to increase to move the field forward.

The Association of Telemedicine Service Providers (ATSP), a comprehensive membership organization, was formed to address the current barriers preventing the success of telemedicine. Reimbursement and licensure advocacy efforts will be taken on behalf of the ATSP membership base to ensure the advancement of the field. Additionally, access to information, practice guidelines, and standards

will enable member organizations to develop and sustain successful telemedicine programs.

Once the current barriers are resolved, the practice of telemedicine will likely undergo a radical change. Telemedicine will transition from its current state of grant-funded projects, military demonstration projects, and a few self-funded programs, to become a major industry within the health care field.

Technology manufacturers and telecommunications companies are already vying with each other to produce the low-cost equipment and bandwidth needed. Many states are creating networks which link education, government, business, and health care. Education by videoconferencing is commonplace today. Employees of many kinds of businesses are meeting by video rather than traveling many miles to get together.

It's not too much of a stretch of the imagination to realize that telemedicine will soon be just another way to see a health professional, just as the technology that will allow us to see our grandchildren while talking to them on the phone is only around the corner. Farther down the road, some theorize that we may all have a "Personal Diagnosis System" as part of our home entertainment center. This system will monitor our daily health status and automatically notify a health professional if we become ill. (Kurtz 1994)

Ten years ago we had no idea we would rely heavily on faxes, answering machines, and e-mail—tools which are now considered low-tech and taken for granted. Ronald C. Merrell, from Yale University School of Medicine, says, "The innovations we will encounter as we step beyond feasibility are dazzling in their potential." (Merrell 1995) The future of telemedicine in the next ten years is left to our imaginations.

The Association of Telemedicine Service Providers is now accepting applications. Visit the ATSP Web site at www.atsp.org for more information about membership offerings, or phone (503) 222-2406.

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FYI...

Asthma disease management program outcomes show savings

Preliminary data collected from the asthma disease management program operated by the National Jewish Medical and Research Center's Lung Care Communications Services division in Denver, CO, indicate significant savings for the health care system.

Medicaid patients in the program have experienced a 50% reduction in work/school absences, 74% reduction in hospitalizations, 60% reduction in office visits, 75% reduction in ICU utilization, and 79% reduction in ER visits. Patients from the commercial population have noted a 78% drop in work/school absences, 90% drop in hospitalizations, 84% drop in office visits, 94% drop in ICU utilization, and 91% drop in ER visits.

The two-tiered program, based on disease severity, provides four scheduled calls by a nurse case manager to patients enrolled in Level I care and six calls, five home visits, and a written Asthma Action Plan for patients in Level II care. An electronic home monitoring device is also being used to allow selected patients to monitor their peak expiratory flow and other lung functions at home and send the values via computer modem to the nurse case manager, who can then intervene quickly when the situation warrants. (Source: Reuters Medical News, 3/20/97)

JCAHO president addresses the issue of performance measures

Like the rest of health care, the accreditation process seems to be in a steady state of evolution. What's the next big step for the Joint Commission on the Accreditation of Healthcare Organizations? According to a recent article in *Joint Commission Perspectives*, the integration of performance measures will be the greatest area of concern for organizations in the coming years. How will this integration impact organizations? JCAHO President Dennis S. O'Leary, MD, offered some insight into what organizations can expect. Here are the highlights—

- The use of performance measure data will shift the focus of attention from compliance with standards to actual results, leading to more frequent interactions between the Joint Commission and accredited organizations. In the long term, this may evolve into what some are calling a "continuous accreditation process." In the short term (by the end of the century) outlier data may trigger communications, and site visits will become increasingly data-driven.
- Since outcomes and performance measures are backward-looking tools, however, they will not replace the Joint Commission's current standards-based process, which consists of essential forward-looking tools that look at what organizations should be doing to effectively service their

communities.
- Organizations should start now to gather outcomes and performance measures, beginning with their high volume, high risk, and problem prone services, as well as those that are of particular interest in their communities.
- The current paucity of data on the reliability and validity of performance measures will make the task of collecting such data difficult, but that should not stand in an organization's way. While prior testing of the measures may be one factor in the selection of measures for the initial program, the lack of such testing need not eliminate the measure from the group.
- Starting this year, the Joint Commission will try to alleviate the problem by initiating a systematic review of the performance measures in the measurement systems that contract with the JCAHO. Measurement systems that contract with the Joint Commission will be expected to validate the integrity of the performance data submitted to the JCAHO through periodic data audits.
- Organizations reporting performance data to the Joint Commission will be expected to use and report data on selected measures for at least one year.
- A hospital with a low inpatient census and large ambulatory care population may select ambulatory care measures to report.
- Given the number of measurement systems currently available to organizations for the collection of performance data (150-200), it is likely that some of these systems will either cease to exist or fail to meet current or future criteria established by the Council on Performance Measurement. Organizations should exercise caution in selecting a system, looking for stability, a good track record, adaptability, and ability to service the needs of the organization. However, if the system fails, the Joint Commission will assist the participating organization in its transition to a new measurement system.
- Don't expect to save money by measuring performance—at least not in the short term. Initially, it will add cost. Over the long haul, however, performance measures will have to live up to the same value barometer applied to all other factions of health care. If they don't lead to cost saving improvements in patient care, then they may go the way of other innovative, but quickly passing, trends in health care.

(Source: *Joint Commission Perspectives*, Sept./Oct. 1996)

New FDA labeling requirements will assist elderly in taking OTC medications

The Food and Drug Administration is set to help consumers—particularly the elderly—better understand and use their over-the-counter medications. New and simpler labeling requirements are expected to make it easier for older Americans, who make up just 12-17% of OTC drug buyers but consume some 30% of all OTC medications today and are projected to consume 50% of all such medications by the turn of the century, to take drugs properly. Among other things, the proposed regulations will—

Call for uniform, standardized headings and subheadings, and a standardized order of information.

Promote simplified language for certain words or phrases, such as "throw away" instead of "discard," "lung" instead of "pulmonary," and "hole in" instead of "perforation of."

Require that drug manufacturers utilize an easier-to-read format with minimum type size and standardized type style.

(Source: Department of Health and Human Services)

Home care accreditation resource available

If your organization is getting ready for a Joint Commission survey, here's a publication that can help you prepare for the visit—

The *Joint Commission Home Care Survey and Accreditation Process Primer* is an excellent resource for organizations considering or preparing for home care accreditation. It is available free of charge by calling the Joint Commission at (630) 792-5754.

Study says vitamin E, Parkinson's drug, may slow Alzheimer's

Researchers from Columbia University have found that large doses of vitamin E and the Parkinson's drug selegiline can both delay the progression of Alzheimer's disease by about seven months when compared to a placebo.

In their study, a group of 341 patients with Alzheimer's was divided into four groups. One received 2,000 IU a day of vitamin E, one received selegiline, one received both vitamin E and selegiline, and one received a placebo. Interestingly, the group that received both vitamin E and selegiline actually fared worse than the groups that received either vitamin E or selegiline alone. Patients who took both vitamin E and selegiline noted a five month delay in progression of the disease. The study was published in the *New England Journal of Medicine* last spring. (Source: USA Today)

Hospital-based home care agency wins favorable ruling

Chalk one up for hospital-based home care agencies. A senior U.S. District Court Judge in Wilmington, DE, dismissed a lawsuit earlier this year claiming that the Medical Center of Delaware had unfairly leveraged its strong presence to monopolize the area's home care market. Delaware Health Care, the home care and infusion company that brought the suit, had also charged the hospital with denying its patients access to home care providers other than the hospital-based agency. The court disagreed on both counts,

ruling that other referrals were available to the home care company and that the patient discharge process at the medical center was not critical to Delaware Health Care's survival. (Source: *Modern Healthcare*, 3/10/97)

Add your name to the list: *RCPs can assist AHCPR by signing up to review grant applications*

Since its inception in the late 1980s, the Department of Health and Human Service's Agency for Health Care Policy and Review (AHCPR) has provided important funding and oversight for a wide range of research efforts aimed at identifying best medical practices. Every year, hundreds of health professionals across the nation assist the agency in that goal by serving as reviewers in the peer review of research grant applications. If you would like to add your name to the list, please forward a current curriculum vitae to: AHCPR, Office of Scientific Affairs, Attention: Bonnie Edwards, 2101 East Jefferson Street, Suite 400, Rockville, MD 20852, or fax your CV to Bonnie Edwards at (301) 594-0154. (Source: *Research Activities*, 3/97)

Submission Guidelines For Articles Written For The *Home Care Section Bulletin*

Article length: *Bulletin* articles should be between 500 and 1,500 words (about 1-4 typed, double-spaced pages).

Format: In addition to a paper copy, all articles should be submitted on a 3.5 inch floppy disk saved in Microsoft Word or TEXT ONLY (ASCII) formats, or e-mailed to the editor in one of those formats.

Deadlines: All articles must be submitted to the editor according to the following schedule of deadlines—

- Spring Issue: February 1
- Summer Issue: May 1
- Fall Issue: August 1
- Winter Issue: October 1

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