HOME CARE SECTION BULLETIN

NO. 4 THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE WINTER 1996

NOTES FROM THE PAST CHAIR

by Allan Saposnick, MS, RRT

For many years the AARC distributed a home care procedure manual that had been prepared by the Pennsylvania Society for Respiratory Care (PSRC) in 1982. However, the manual has been out of print for several years and was very much in need of updating and revision. After about a year of work by a PSRC committee, that job has now been completed. The revised *Home Care Procedure Manual* was reviewed by four home care specialists from around the country, as well as by a professional medical editor. The manual was available in "mock-up" form at both the AARC Convention in San Diego and at Medtrade, the home care exposition in Atlanta, where orders were taken. A mailing announcing and describing the manual will be made at the end of the year. This was a large project and a major accomplishment for the home care practitioners involved.

The section has been involved in several other projects during 1996, including a membership recruitment campaign conducted among Home Care Section members in which we asked our current members to recruit a colleague for membership in the AARC and/or the Home Care Section. We want to thank all of our members who participated in making this a successful venture. As of mid-September 1995 our section had 1817 members. As of October 1, we had 1934, a gain of 117 section members.

Also during 1996:

- An AARC video/teleconference was conducted in July on the subject of Respiratory Home Care Services.
- Work continued on schedule in the outcomes measurement project under the direction of Karen Pfaff. She is well into the data collection and entry stage, which, as of this writing in early October, was slated for completion before the end of the year.
- The October issue of *AARC Times* was devoted almost entirely to respiratory home care topics.
- Multiple symposia and topic suggestions related to home care were submitted to the Program Committee. The 1996 AARC Convention in San Diego included an excellent selection of about 10 hours of home care programming.

My tenure as chair of the section has been very rewarding. I have met personally, as well as spoken by phone, to hundreds of individuals who are either in home care right now or want to be a part of home care in the future. I have learned a lot and I thank you for that. I hope I have given as much as I have received.

I'm confident the section will continue its dynamic growth and activities under the leadership of Nick Macmillan.

NOTES FROM THE CHAIR

by Nicholas J. Macmillan, AGS, RRT

It was good to see so many of you at the AARC Convention in San Diego. But if we didn't have a chance to talk there, I hope you will feel free to contact me this coming year with any issues or concerns you may have.

At the Home Care Section Meeting, I had a chance to share my goals for the upcoming year. For those unable to attend that meeting, I have included them in the

following article. In addition, I have included a short information request form that I ask you to please complete and return so that we can keep in touch and compile our resources.

Finally, a hardy "thank you!" to our outgoing chair, Allan Saposnick. Allan has provided effective leadership for the Home Care Section these last 2 years. He has also provided me with helpful insights regarding my role as chair. Thank you again, Allan!

AARC HOME CARE SECTION MEMBERSHIP MEETING: *AGENDA FOR PROGRESS*

by Nicholas J. Macmillan, AGS, RRT

Here is a list of the section's goals and objectives for the coming year, plus a short information request form that will allow you to provide your ideas for section activities to the chair. Please take a few minutes out of your day to fill out the form and return it to me at the address or fax number listed on the back page of this issue.

Home Care Section Bulletin

- Continue use of "Guest Editor" format
- Increase the number of original contributions from section members
- Include bibliography for further readings on home care topics
- ***Bulletin* DEADLINES**
  Spring Issue: February 1, 1997
  Summer Issue: May 1, 1997
  Fall Issue: August 1, 1997
  Winter Issue: October 1, 1997

Communication

- Create fax network to improve timeliness of communication
- Continue open communication with JCAHO, NAMES, and other parallel organizations

Outcome Studies

- Communicate progress of oxygen and CPAP studies
- Seek results from other such studies

Membership (Membership as of October 1 was 1,934)

- Continue growth of Home Care Section membership—Our goal is to achieve a 10% increase by this time next year

Regulatory

- Use fax network to keep members abreast of potential regulatory and reimbursement changes
- Encourage and facilitate communication with government decision makers regarding regulatory and reimbursement changes

Program

- Solicit input from members for 1997 AARC Convention topics

Encourage Leadership Roles in the Home Care Section

- Provide three names to the AARC president-elect for section chair-elect

Future of Respiratory Home Care

- Who's using "Telecare" and how
- Impact of managed care
- Other innovations

What's on YOUR Agenda?

Yes! I have something to offer.

NAME _____
ADDRESS _____
CITY, STATE, ZIP _____
HOME PHONE _____
WORK PHONE _____
HOME FAX _____ WORK FAX _____
E-MAIL ADDRESS _____

☐ Send me a Section Membership Application
☐ Put me on the Fax Network

I am interested in participating in the following activities:

☐ Submitting an article to the *Bulletin*
☐ Serving as Guest Editor for the *Bulletin*
☐ Submitting a case study to the *Bulletin*
☐ Submitting a product/book review to the *Bulletin*
☐ Submitting speakers/topics for 1997 AARC Convention
☐ Other _____
_____
_____
_____
_____

THANK YOU FOR YOUR INTEREST AND PARTICIPATION!

LINDA ANN FARREN CAPTURES THE 1996 INVACARE AWARD FOR EXCELLENCE IN HOME RESPIRATORY CARE

As director of clinical services at Happy Harry's Health Care, Inc., in Newark, DE, this year's winner of the Invacare Award for Excellence in Home Respiratory Care is responsible for ensuring that internal and external therapies meet JCAHO requirements. Over the past 6 years she has also supervised the respiratory care department at Happy Harry's, overseeing patient assessment and care plans as well as coordinating the schedules of RCPs and the clerical staff, and has served as a staff therapist administering to home bound patients of all ages.

What sets Linda Ann Farren, CRTT, RRT, apart from the crowd, however, is her ongoing dedication to her patients. "Linda has always been active in both promoting patient advocacy and through her involvement in community activities," says Lee A. Simon, vice president of health delivery services at Happy Harry's. "She truly embodies excellence in the field of home respiratory care."

Unlike many practitioners, Linda's day doesn't stop at the end of the shift. She regularly volunteers her time to numerous community organizations engaged in strengthening respiratory health programs in Delaware. Since moving to Newark from Harrisburg, PA, in 1990, Linda has been a constant source of support for groups ranging from the American Heart Association to the Delaware National Guard. She has served as instructor manager trainee for the AHA since 1990 and has assisted in certifying or re-certifying 475 National Guard members and others from the area in CPR. Linda is also active in her local chapter of the American Lung Association, where she has participated in asthma education through camp "Super Stuff" and acted as a resource for the Sleep Apnea Support Group.

Linda has been a member of the Delaware Society of Respiratory Care since 1990 and a board member of the Delaware Tobacco Coalition since 1995. She also serves on the Delaware Technical & Community College respiratory school board.

Linda received her AS degree in respiratory therapy from Harrisburg Area Community College in 1985 and recently completed her BS degree in health management at California College for Health Services. When she isn't busy with her respiratory care-related activities, she is an active volunteer at the Pike Creek Valley Running Club, where she was named "Volunteer of the Year" in 1995. She received the "Outstanding Employee Award" from Happy Harry's in 1992 and was presented with the "Harry Levin Award" in 1992-93 for employee of the year. Congratulations, Linda!

UNIT DOSE MEDICATION CHANGES SLATED FOR DECEMBER 1 IMPLEMENTATION

by Nicholas J. Macmillan, AGS, RRT

The Durable Medical Equipment Regional Carriers (DMERCs) recently published a revised medical billing policy, effective December 1, 1996, that would prohibit all entities except for licensed pharmacies from billing Medicare for medications used with durable medical equipment. While organizations are scrambling to find alternatives to providing these much needed medications, the National Association for Medical Equipment Services (NAMES) has been in regular communication with Health Care Financing Administration (HCFA) officials to address many of the unanswered questions regarding the policy change.

At issue is the fact that HCFA has not adequately addressed the operational problems this change will bring about with industry members, let alone their own internal operations. NAMES members have been asked to fax their questions to NAMES officials so that they can be passed on to HCFA.

It is not uncommon for policy changes to be published, then postponed until objections are reviewed and details are worked out. However, as of this writing in mid-fall, HCFA is still determined to implement these changes on December 1. What is most disturbing about this policy change is that it is financially motivated instead of a true "medical policy" issue. Most organizations utilize a regular follow-up program to prevent over-utilization and stockpiling of medica-

tions, and assess treatment compliance. It would seem that a more prudent approach would include a thorough investigation into this service, including patient input, to determine relevant issues.

As this policy change unfolds, all of us in home care could benefit from knowing how our colleagues around the country are changing their organizations to maintain patient services. Please consider voice-mailing or faxing your comments and/or "solutions" to me at (812) 334-0626 so they can be compiled and shared in the next *Home Care Section Bulletin*.

PRINCIPLES OVER PROFIT: *CAN YOU SUCCEED WITH BOTH?*

by L. Jack Clark, RRT

L. Jack Clark is principal and founder of MGR (Mid-Georgia Respiratory) Homecare in Griffin, GA.

As I was waiting to board a flight recently to visit with two of my colleagues on the West Coast who share my belief that operating a home medical equipment and service firm with principles *does* produce profits, I picked up an *Entrepreneur Magazine* at the airport newsstand. While flipping to the table of contents, Fanean Chun's article, "Code of Honor," caught my eye. Reading along, my thoughts turned to the differences in honor that can be seen and heard in our predominantly independent, entrepreneurial (60%+ of market share) home medical equipment management industry.

Being human, it is our nature to flirt with compromising our principles. Certainly, we all do this from time to time. As reports of misdeeds and abuse in our industry continue to mount, however, some of us wonder why others choose to believe that it is cheaper to cut corners, go against their honor, or cast their principles to the winds of fate rather than ensure the integrity of their operations.

Due to the less bureaucratic and more dynamic nature of our services, small, entrepreneurial home care firms generate an interesting set of ethical questions, particularly since, in closely held firms, the standards depend almost entirely on the principals' beliefs and personalities. No one has more freedom to refuse to compromise when the pressure is on than the entrepreneur. Indeed, given the ever-increasing levels of investigation into suspected abusive behavior by the large home care firms, succumbing to peer pressure from the major players in our industry is hardly a good idea.

Today we are expected to manage risks to meet the expected outcomes. Foregoing principles is a very real risk. Although the use of social responsibility as a selling feature is receiving a lot of attention today, there appears to be a wide gap between "do good" hype and "feel good" performance. Yet as we look around, we see many who *are* holding on to their principles, standing firm, and enjoying success.

Ethics can't be re-engineered or copied. They are unique to your firm's value-added benefits. With the managed-cost mania so prevalent today, what will likely separate one firm from the next is its personal integrity. Given today's hard choices, the smaller, independent providers must come to grips with what they are really made of. The line between compromise and risk is very thin, and you'll occasionally stumble across it. After nearly a half century of gathering information, knowledge, and experience, I see that line more clearly than ever.

Although it is likely that a principle-centered provider's moral choices may at some time or another cost the firm money, over the long run there appears to be no dichotomy between running a firm that is both principled and profitable. (If that weren't true, there would be nothing wonderful about those who choose to be moral!) Profits *and* principles are a reality in many firms. Just remember, the more you do it right, the more likely you are to keep doing it right. Repetition works! You'll reap the benefits over the long haul. And also remember this: if you *are* doing things for good reasons, there is nothing wrong with letting patients, payers, and referral sources know about it so that they can respect you and use your firm's services and products.

WRITE OR WRONG: *YOUR INPUT IS IMPORTANT*

by Nicholas J. Macmillan, AGS, RRT

Now that the elections are over, the oil in the political machine has been changed. However, the engine is still moving in the same direction and will need fine-tuning as the new year begins. Okay, so the metaphor stinks, but my point is still valid: write your legislators or wrong your patients.

The following issues remain in the political forefront when it comes to patient care. Please keep a watchful eye and respond quickly and appropriately with letters and/or phone calls to your elected representatives in Washington, DC, and/or your state legislature.

- DISPROPORTIONATE CUTS IN MEDICARE REIMBURSEMENT FOR HOME OXYGEN SERVICES
- COMPETITIVE BIDDING PRACTICES
- MEDICATION BILLING POLICY

NEW CAMHC FOCUSES ON "USER-FRIENDLINESS"

The 1997-1998 edition of the Joint Commission's *Comprehensive Accreditation Manual for Home Care* (CAMHC) contains several new features designed to improve the "user-friendliness" of the publication.

While standards requirements have not been substantially changed from last year's version, chapters in the new CAMHC have been rewritten for better clarity and streamlined to provide home care organizations with a better understanding of the Joint Commission's expectations. Standards are also more patient-focused, centering on those functions that most significantly affect patient care.

In addition, the new manual contains a question and answer section in the introduction and an "Examples of Implementation" section that illustrates practical strategies, activities, and processes that can be used to meet the intent of the standards. Other new features include

- Up-to-date ideas about performance improvement in the "Improving Organization Performance" chapter.
- Medicare Conditions of Participation for Medicare-certified home health agencies and Medicare certified hospices.
- "Suggested Readings and Other Resources" sections at the end of each chapter.

All currently accredited home care organizations will receive one complimentary copy of the manual. Additional copies may be ordered through the Joint Commission's Customer Service Center at (630) 792-5800 using order code CAMHC97. Copies sell for $170 each.

SHUTTER-BUG ALERT: *THE AARC WANTS YOUR HOME CARE PHOTOS*

They say that one picture is worth a thousand words, and in these days of "information overload," often that is true. Especially when it comes to patient care, a well-composed photograph of a caring practitioner providing services to a patient in need can make an immediate—and lasting—impression. The AARC regularly uses such photographs in everything from promotional brochures to meeting displays. Unfortunately, our supply of good photos depicting respiratory home care practitioners in action leaves something to be desired. If you or any of your colleagues have any photos of home care RCPs and/or patients (black & white prints, color prints, or slides) that you would be willing to share with your professional organization, please send copies to: AARC, Attention: Marsha Cathcart, 11030 Ables Lane, Dallas, TX 75243. The next time you see a home care practitioner in an association publication, it just might be someone you know!

FOR YOUR INFORMATION

STUDY DOCUMENTS PROBLEMS WITH MDI USAGE IN OLDER PATIENTS

Greater use of metered dose inhalers (MDIs) has been touted as a way to reduce the costs of care for those with chronic lung diseases. The devices are simple and easy to use, allowing patients to self-administer their medications.

RCPs and other clinicians who see how this philosophy plays out in real life, however, may beg to differ. While it doesn't take a rocket scientist to use an MDI properly, neither is correct usage a given. For elderly patients with lower cognitive abilities and/or poor hand strength, in fact, it may be just the opposite. In a study involving 71 COPD patients over the age of 51 who had no prior experience with MDIs, researchers found that even extensive instruction in the use of the device does not always guarantee success when it comes to these patients.

Each of the patients in the study was assessed by a mini-mental status exam and hand strength exam prior to receiving education in the use of an MDI. After 1 week, two new evaluators returned to reassess the patients' MDI usage. Only about half (56%) were found to be using the devices correctly. An analysis using logistic regression statistics revealed that lower scores on the mini-mental status and hand strength exams correlated with incorrect MDI usage. Being male also made a difference. They were more likely than females to use the devices improperly. The study appeared in a recent issue of the *Archives of Internal Medicine*. (Source: *Clinical Briefs in Primary Care*, September 1996)

PERTUSSIS SHOULD BE CONSIDERED IN ADULT CASES WHERE COUGHS PERSIST

Pertussis is not generally considered a disease that affects adults, but the results from a recent study published in *JAMA* suggest otherwise.

Researchers who conducted a prospective study of 153 people over 18 years of age with chronic cough persisting beyond 2 weeks were surprised to find that 12.4% had pertussis as an etiology for their cough. They reached their findings by measuring the IgG antibody levels to toxin and using a cutoff of two standard deviations of the mean, then comparing the results to those from a group of 100 randomly selected adults. When they factored in the incidence for other patients in their database, they concluded that the incidence of adult pertussis is 176 cases per 100,000 person-years.

Most alarming, however, was the fact that not one of the charts among the study group or other database patients that comprised their possible pertussis group ever even mentioned the possibility that pertussis was the cause of the patient's cough. The researchers conclude that clinicians should be more aware of the incidence of pertussis as an etiology of cough and the prevalence of the disease in the adult population. (Source: *Clinical Briefs in Primary Care*, September 1996)

MEDICARE COVERAGE OF FLU SHOTS HAVING A POSITIVE IMPACT

Statistics show that older Americans account for 90% of all deaths from influenza each year, but new Medicare rules allowing for the coverage of flu shots may be reducing the actual number of those who succumb to the disease. According to the Centers for Disease Control and Prevention in Atlanta, more people over the age of 65 are receiving the flu shot than ever before. About half of all senior citizens were vaccinated in 1993, the latest year for which figures are available. Another 28.7% also were vaccinated against pneumonia. Both figures are a considerable improvement over the 20% rates noted before 1985. (Source: AOL NewsProfiles, 10/10/96)

THE HEIMLICH MANEUVER FOR ASTHMA?

The Heimlich Maneuver has been a proven lifesaver in cases of choking, but can it also treat asthma? Yes, say patients who are participating in a study at the Heimlich Institute. They say that

performing the maneuver on themselves, or having someone else perform it on them, helps to expel trapped air and mucous plugs, clearing the airway and ending — or even preventing — an asthma attack.

The Heimlich Institute decided to study the effects of the maneuver on asthma patients after numerous patients and their families contacted the institute to report successful use of the procedure on asthma patients. Although final results won't be available for some time, researchers at the institute say that at least some of the patients who are performing the maneuver on themselves on a regular, preventive, basis (several times a day) have found that it can diminish or eliminate the need for asthma medications. They caution, however, that the procedure must be performed more gently on asthma patients — particularly children —than it is on those who are choking. (Source: PRNewswire, 10/7/96)

GUIDE TO PEAK FLOW METERS AVAILABLE FROM AAN/MA

Home care RCPs who want to help their asthma patients make better use of their peak flow meters may want to take advantage of a new publication from the Allergy and Asthma Network/Mothers of Asthmatics, Inc. (AAN/ MA). *The Peak Flow Meter Book: A Guide for People With Asthma* includes step-by-step explanations designed to guide patients and families through the use of this important assessment tool. The publication, co-authored by Nancy Sander, Guillermo R. Mendoza, MD, and Martha White, MD, also includes sections on interpreting the peak flow measurements and the importance of keeping a daily symptom diary. To order a copy ($5 each) of this publication, call AAN/MA at (800) 878-4403.

AHCPR RELEASES GUIDELINE ON DEMENTIA

Health care professionals who view the problems that their elderly patients have with absorbing new information, handling complex tasks, or spatial orientation as just a normal part of the aging process may be selling them short, says a new clinical practice guideline developed by the Agency for Health Care Policy and Research.

According to the recently published guideline, many of the so-called "inevitable" problems of aging are not inevitable — or normal — at all. About one in five cases of dementia are really due to treatable disorders such as depression or drug interactions and should be handled as such. Even in the case of Alzheimer's, say the guidelines, early diagnosis and treatment are advisable. "Early recognition of Alzheimer's disease or identification of other types of dementias," says Paul Costa, a representative from the National Institute on Aging who co-chaired the panel that drew up the guideline, "can prevent costly and inappropriate treatment and give patients and family members time to address the complex financial, legal, and medical conditions these conditions present." (Source: Reuter, 9/25/96)

CHRONIC BRONCHITIS PATIENTS RUN GREATER HEART ATTACK RISK, SAYS STUDY

Chronic bronchitis patients have more to worry about than just a persistent cough, say results of a Finnish study that followed 19,000 people for up to 13 years. They also run an increased risk of heart attacks.

Researchers from the National Public Health Institute in Helsinki found that men who reported a cough with phlegm for 3 months out of the year were 52% more likely to suffer a heart attack than those with less frequent coughs. They were 74% more likely to die of the heart attack. Women in the study fared a little better, but still ran a 49% greater chance of dying from a heart attack if they suffered from chronic bronchitis. Researchers say the results held true even when other known causes of heart disease were factored in. Since infections are known to cause blood clots or damage to the blood vessel walls, they believe the increased risk likely stems from the regular bronchial infections and inflammation suffered by those with chronic bronchitis. (Source: Reuter, 8/29/96)

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