Home Care Bulletin

July/August '98

American Association for Respiratory Care

Notes from the Chair

by Nicholas J. Macmillan, AGS, RRT

I have had the fortunate experience to speak with many RCPs in and out of home care during my tenure as Home Care Section chair. One of the underlying themes of those conversations has been, "why don't RCPs get paid for providing services in the home?"

We all realize the incredible potential cost savings inherent in home care for patients and taxpayers alike—not to mention the marked improvement in patient care and outcomes. Unfortunately, we are burdened with a dysfunctional government payment system (Medicare and Medicaid) in which the right hand does not fully understand what the left hand is doing. Medicare Part A, the hospital side, is doing everything it can to decrease costs by pushing the patient out of the hospital as soon as possible. As of January 1998, Medicare Part B, the home care side, has focused most of its efforts on decreasing costs by various means, including significant home oxygen reimbursement reductions.

As I see it, we have the potential to help reduce costs and improve patient care by two means:

1. The rising costs of home health care will be harnessed substantially when prospective payment systems are introduced. Then, instead of receiving payment for each home health visit, an HHA will receive payment for a diagnosis. Therefore, the HHA will be induced to treat the patient efficiently and "keep them out of their system." With a significant number of respiratory patients, it only makes sense for HHAs to employ RCPs for patient education, rehabilitation, outcomes measurement, and the like. The RCP will also serve as an effective educator and consultant to health care professionals at the HHA.

2. The second means is by continuing to prove, *by study after study after study*, the value of respiratory care in alternate care settings, especially the home. This type of information is vital to helping payers see what we already know: that respiratory care reduces overall patient costs (i.e. Medicare Part A *and* Part B).

The second means mentioned above is our greatest challenge. First, we must look at what we do and realize that somewhere in our organizations' archives are data. Get the data, "massage" it, and start writing your abstract. Even if it doesn't show positive results, it will begin to show you and others what works and what doesn't. The AARC has set aside $1,000,000 to fund worthwhile research efforts of this nature. Your local pulmonologist would be thrilled to help with such a project.

Secondly, we must develop home care-related clinical practice guidelines (CPGs), the precursors to protocols and standards of care. I am therefore asking for volunteers to serve on the following CPG teams:

- Home Oxygen (review and update)
- CPAP/BiPAP
- Compressor Nebulizers
- Apnea Monitors

We will need four to six people on each team, and each team will need a team leader. Having participated in this activity in the past, I can say that it is not as difficult as in may seem. It will involve sharing your knowledge about how you currently perform these tasks, then researching the literature supporting current practices. In many situations there may not be relative literature, so you will be breaking new ground.

Please contact me at the number listed on page two to volunteer. Your support of this project is essential! ■

Selling Disease Management to Managed Care

by Jerry O'Ryan, BS, RRT, chair and CEO of RCOD Home Medical Oxygen, Dayton, OH

Whether you are a hospital-based or home health care-based respiratory care practitioner, it is time to meet your newest customer. Managed care organizations (MCOs) are not new to your local hospital or home health care company. Like physicians, both must routinely negotiate terms and payment rates. With the advent of disease management, however, the RCP must now don the clinical and marketing hat as well, and also be prepared to negotiate rates with MCOs.

This article will serve as a "who, what, when, where, why, and how" primer for the hospital pulmonary rehabilitation program director and his or her home care counterpart, typically the clinical marketing representative.

Pragmatically and realistically, the RCP usually works alongside, or gives direct input to, the chief rates/reimbursement officer (i.e., the hospital or home health care firm's official negotiator), who typically is designated to meet with MCO representatives and sign MCO contracts. This person relies heavily on the RCP's clinical and historical "time and charges" expertise to negotiate a fee. But for illustrative purposes, in this article we'll meld the two — RCP and contract negotiator — into one role. Ready?

What are you selling, and to whom?

Disease management can be defined as a systemic, integrated approach for managing populations of patients who are at risk for, or diagnosed with, a specific disease. For our disease management product, we'll choose Asthma. "Asthma" is capitalized throughout this article because Asthma is the disease management product you are selling to the local MCO.

That MCO has seen a steady climb in emergency room (ER) visits, hospital stays, and pharmaceutical costs in recent years and wants to effect a reasonably low-cost, effective program to thwart this rise.

Before we get started with the marketing plan, however, first let's quickly review Asthma and its burdensome costs to the MCO and the US economy in general:

• Four billion dollars in annual health care costs attributed to Asthma.

• 13 million persons afflicted with some degree of Asthma.

• Lost work days, due to parents tending to Asthmatic children, is in the millions.

• Asthma is one of the top ten targeted diseases that can be managed proactively.

The "what" in your marketing campaign is a reduction in all the above bulleted costs of Asthma. Since Asthma is one disease which truly can be proactively managed, we can reduce or avoid the old "rescue medicine" approach to this disease (i.e., treating Asthma with beta-agonists only, as has been done historically) and effectively reduce the costs of care.

The "whom" you are selling your Asthma product to are three customers: the MCO of choice, the patient, and the patient's physician. Each will receive benefits in addition to the primary intended benefit: patients won't have Asthma symptoms or nearly so many episodes.

Patients gain knowledge about the disease, medications, and self-management through educational materials, and receive peak flow meters and instruction in their use. Their quality of life and activity tolerance should improve, while the number of missed school or work days and number of symptomatic days should decrease.

Physicians benefit by having their medication and management protocols reinforced by a health care professional. Patients are monitored to decrease frequency of health care system access. Physicians receive assessment reports of the detailed patient and family education. Optimally, patients are referred proactively for MCO partnering.

The MCO benefits by having a better informed, knowledgeable patient and family. Costs for ER visits, hospital admissions, and physician office visits should decrease. The MCO gains a wellness program to offer to the patient while receiving outcome data for National Commission on Quality Assurance reporting. In fact, these benefits become the chief selling features, collectively, in the successful marketing of an Asthma disease management program to your MCO.

Focusing on overall goals of Asthma disease management

In addition to the general goals for an Asthma disease management pro-

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gram presented above, there are two clearly identifiable goals that are mutually agreed upon by all parties. These goals are:

1. Reduce cost and frequency of adverse advents
2. Provide best standard of care by:
   - Early intervention
   - Patient education
   - Appropriate treatment and management

Your report card: Outcomes

An MCO monitors and grades your attempt at controlling its Asthma costs through outcomes reports. Simply put, were you effective (i.e., did you get the job done) while being efficient (i.e., achieving cost control)? A Patient Outcomes Report uses the following benchmarks to gauge the overall effectiveness:

1. Decrease ER visits
2. Decrease hospital admissions /length of stay
3. Decrease physician office visits
4. Increase quality of life
5. Increase activity tolerance
6. Decrease missed school/work days
7. Decrease symptomatic days
8. Environmental changes made (use dust mite covers, HEPA filters, etc.)
9. Peak flow meter management instituted.

Pricing your disease management program

Let's cut to the chase with pricing. The seller (you) wants to deliver top dollar performance for essentially rock bottom prices. MCO's tend to view the more popular and historically successful Asthma disease management programs — those that are home health care based — in terms of home health visits. The MCO understands a $50 home health visit, so when you price your program (a one year program typically runs $400-$600), be prepared to justify your cost-per-patient rate in terms of what it breaks down to per visit, plus phone follow-up and clerical administrative costs.

Selecting and marketing your program

Put down your stethoscope and pick up your briefcase. You're marketing yourself, not your clinical skills. The MCO already presumes you're clinically competent, since your home health care company or hospital is already a provider to that MCO! As far as the product itself is concerned, the MCO doesn't really want to see yet another home-brewed asthma program. Programs of a national origin, especially those with a bona fide history and track record, will achieve a sincere interest level from your local HMO. This is not the time to reinvent the wheel. You will be asked if the program you are using follows National Institutes of Health guidelines and other MCO indices.

Typically, you'll meet with the MCO's medical director, supervisor of disease case management, and possibly someone who will be assigned to help you establish outcome criteria and authenticate your outcome reports.

MCO's do not like to share internal cost reports and other data considered proprietary. There must exist a mutual trust; after all the MCO does want you to succeed. They just do not necessarily want to pay too high a premium for the success. This is not a slam on the MCO, it's a reality check — don't forget that MCO's are almost always publicly held companies responsible to their shareholders. (If you own mutual funds, you may even own some of their stock.)

What exactly do you present at that first meeting? A word from the world of sales and marketing gurus: don't divulge every bit and piece of information you have on your first visit. What would be left for successive visits? And you will most assuredly be required to attend several meetings (it's a Dilbert thing in managed care — don't try to figure it out).

Here are some overall suggestions for your first meeting:

Be punctual and dress as if you're applying for a job and this is your initial interview.

Have a 3-5 page (maximum) description of your program, how it works, who makes the home visits and their qualifications, your medical advisor (hopefully a provider to the MCO), and a few samples of your patient education literature.

No need to get into price during the first visit. If pressed with, "What's the cost?" try to find out what they may have paid for other disease management programs. Another approach is to ask what they feel their cost savings will be (a primer for future risk-sharing negotiations).

Again, remember that this is an initial business meeting. Don't try to wow anyone with "clinical terminology overload"; after all, most of the people sitting across the table from you have prior clinical backgrounds too — plus they have a business acumen you don't possess. (Again, leave the mental stethoscope at home.)

Future meetings and number-crunching will reveal more details about the actual contract (yes, you'll be asked to sign a contract or pass it on to someone in your organization with fiduciary responsibilities). A final word on pricing: remember that, "You don't get what you deserve. You get what you negotiate."

Post contract signing

Congratulations! You now, effectively speaking, are working for, and on the behalf of, the MCO. Your organization's name will appear along with the MCO's name in press releases, pamphlets, and official memos sent to physicians, other hospitals, and even competing home health care providers and pulmonary rehabilitation programs. You essentially have a legal responsibility to represent the MCO (not necessarily your own interests) at all times.

Benefits of disease management to the contractee

"If I'm working for the HMO and can't blatantly, publicly, thumb my

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nose at the competition, why am I doing this?" you may ask yourself. A good question, and a good way to wrap up this discussion on disease management. Think l-o-n-g term and you'll see inherent benefits, which include several very important short and long-term factors:

Medicare is slowly but surely turning the reins over to privatization via MCOs.

MCOs are unlikely (and it would not be pragmatic anyhow) to license all their providers to do disease management, so you get to come in on the ground floor.

Given the current (and probably, future) Medicare cuts, disease management, if priced properly and performed effectively and efficiently, can be a future product line for you.

This can be your initial foray into risk-sharing.

Lastly, it presents your organization as more than just "one more" oxygen company or rehab department. You now give added value and get paid for it!

In summary, disease management is an additional product line that the HME company or business-savvy pulmonary rehabilitation department can look at as an additional niche for business. It is an important niche, because you are desiring to maintain a long-term relationship with MCOs, whose very core philosophy is to treat the member's health care needs proactively and avoid or delay long-term reactive care products whenever possible. The entrepreneurial clinician will be able to bridge the gap between expensive "rescue medicine" treatment and the more cost and health care effective proactive benefits of disease management.

Please contact the author, Jerry O'Ryan, at (937) 299-6999 to obtain more information on disease management programs. The author uses the SafeHarbour disease management programs in his own company in Dayton, OH. ■

Know Your Numbers: NLHEP Set to Revolutionize Diagnosis of Lung Disease

All AARC members recently received a copy, via publication in the March issue of RESPIRATORY CARE, of the National Lung Health Education Program's (NLHEP) resource document calling for greater use of spirometry to diagnosis COPD in physicians' offices. The program's chief aim: to make spirometry as routine in the physician's office as blood pressure checks are today.

"We are hoping that the program will grow the same way that cholesterol screening and blood pressure checks have grown," says Ray Masferrer, RRT, associate executive director of the AARC and the Association's representative on the NLHEP executive committee. In addition to the AARC, the program is being sponsored by the American Association for Cardiovascular and Pulmonary Rehabilitation, the American College of Chest Physicians, the American Thoracic Society, the American College of Physicians, and the Society of General Internal Medicine. Government sponsors include the Lung Division of the National Heart, Lung, and Blood Institute, the National Cancer Institute, and the National Institute of Occupational Safety and Health. By joining forces through the NLHEP, these organizations believe they can revolutionize the diagnosis of COPD and other smoking-related illnesses.

Based on findings from the Lung Health Study—which noted that spirometry could effectively predict not only COPD but early death from all causes — the NLHEP is directed to all primary care professionals, respiratory care practitioners included. The objective is to reach all smokers and patients with common respiratory symptoms of dyspnea, cough, sputum, and wheeze by putting spirometers in the hands of all primary health providers and promoting their use. The program's theme—"test your lungs/know your numbers"—will attempt to convince patients that knowing their FEV1 and FVC is just as important as knowing what their blood pressure is or knowing their cholesterol levels.

At least three companies have developed spirometry devices so far capable of meeting the needs of the primary care physician. These devices give direct readout of FEV1, FVC, and the ratio between the two, along with the option of printing out volume-time and flow-volume curves. All meet American Thoracic Society standards.

"We needed devices that were inexpensive and easy to use," says Masferrer, "and companies have come up with those devices." The next step is to develop a Spirometry Statement that will help guide primary care physicians in the appropriate use of the test. He and the other members of the executive committee, says Masferrer, are currently working on such a statement and they hope to have a final version ready soon. "The NHLEP process," he says, "has been one of coming up with ways to facilitate the use of spirometry in physicians'offices."

What will the wide spread use of simple spirometers in primary care practitioners'offices mean to respiratory care practitioners? "RCPs will be called upon to actively participate in screening efforts," says Masferrer. As the only allied health practitioners with specific knowledge and training in spirometry, hospitals and doctors' offices alike will also look to RCPs to assist in training primary care practitioners—physicians and nurses—in the proper use and interpretation of spirometry.

Finding patients early in the course of their disease will create more treatment opportunities for practitioners in the profession as well. "One of the biggest benefits for respiratory care," continues Masferrer, "is that the program will identify more people with lung disease earlier on. So we will not only be part of the screening, we will also be involved with therapeutics—treating people with early disease to help them avoid major problems later on."

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He also believes the program will encourage managed care companies to increase their investment in smoking cessation programs and other efforts aimed at prevention and wellness in this patient population. RCPs can play a role in these efforts as well, by lending their expertise in the diagnosis, treatment, and prevention of respiratory disease to companies who want to set up large scale screening and intervention programs for their enrollees. ■

Medicare Launches Pilot Project for Competitive Bidding

The Medicare program is launching a pilot competitive bidding project in Polk County, FL, aimed at helping beneficiaries pay more reasonable prices for medical equipment and supplies.

The project will use competitive bidding for oxygen supplies and equipment; hospital beds and accessories; surgical dressings; enteral nutrition products and supplies, and urological supplies. Starting this fall, suppliers serving Polk County will be required to submit bids to Medicare if they wish to provide beneficiaries with these types of durable medical equipment and supplies.

Polk County was selected for the demonstration because it has a relatively small population of about 450,000, including 92,000 Medicare beneficiaries, high expenditures per Medicare enrollee for equipment and supplies, and a large number of suppliers servicing the area. In 1997, about 4,500 of the county's beneficiaries received Medicare reimbursements totaling about $6.6 million for the equipment and supplies in this demonstration.

Bid proposals will be evaluated on price and quality. Those companies that bid too high or do not demonstrate that they provide quality equipment and service will not be able to bill Medicare for the covered items. Medicare will select enough demonstration suppliers to meet the needs of beneficiaries in Polk County. Actual payment on new rates will start in April 1999.

Medicare will pay 80 percent of the selected bid price following a comprehensive education and outreach campaign to beneficiaries, physicians, and suppliers. The program will provide a directory of the demonstration suppliers and the new price for every item covered under the demonstration to each beneficiary. Winning demonstration suppliers must agree to accept assignment, which means beneficiaries will have to pay no more than the standard 20 percent copayment.

Medicare recognizes that some beneficiaries may want to maintain their long-standing relationships with oxygen suppliers or continue their rental agreements for nutrition pumps and hospital beds. Those beneficiaries will be able to do so for as long as the medical service is needed.

Beneficiaries will have a number of additional protections — first among them an emphasis on quality, not just price. An ombudsman will be based in Polk County to handle any beneficiary complaints, and site visits will be conducted for all demonstration suppliers, who will have to meet quality standards which are not currently monitored by Medicare. (Source: HHS)

HCFA Delays Medicare Changes

Several of the Medicare changes outlined in last year's balanced budget act (BBA) might have to be delayed according to HCFA administrator Nancy-Ann DeParle.

In an internal memo written by DeParle, she says the "year 2000" computer problems may cause HCFA to postpone implementation of some of the BBA required changes. The agency might have to ask Congress to let it delay implementation of the prospective payment system for home health agencies (HHAs) and outpatient facilities.

Other developments in HCFA's handling of the Medicare modifications include the agency's agreement to drop the antifraud surety bond rule. HHAs had been required by the new law to obtain by July 31 surety bonds of $50,000 or %15 of annual billings, whichever was greater. After strong protests from HHAs and threats from Congress to repeal the rule, HCFA decided to suspend the rule pending a General Accounting Office review. Future bond rules may not go into effect until February 15 next year. ■

FYI . . .

Japanese study assesses peak flow meters

A Japanese comparison of four different brands of peak flow meters found that "the limit of agreement between each (was) so wide that we do not recommend the use of the readings of each meter interchangeably." Still, investigators say that the devices gave similarly valid values and are accurate enough for day-to-day use.

The study involved 294 respiratory patients who tested the Mini-Wright, Assess, Pulmograph, and Wright Pocket peak flow meters. Readings were then compared to peak expiratory flow rates obtained via spirometry. (Respir Med 1998;92:505-511)

Study gauges childhood disability

Respiratory diseases were among the top causes of childhood disability identified by a telephone survey of 100,000 children younger than 18 that was conducted by University of California at San Francisco researchers.

According to the group, about 6.5 percent of the nation's children suffer from some type of disability. Together these disabilities cause 66 million days of restricted activity each year, includ-

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ing 24 million missed days of school. Children with disabilities also experience 26 million more physician contacts than their peers and spend about five million additional days in the hospital annually.

The study also found that socially and economically disadvantaged children suffer disproportionately from disabilities when compared to their better-off counterparts. (American Journal of Public Health 1998;88:610-617)

Do better, say Americans polled about government health programs

For years now health care organizations and health plans have been subjected to customer satisfaction surveys aimed at determining their worth. Now the federal government has gone under the microscope as well—and the results indicate plenty of room for improvement.

A new survey that looked at how Americans view government-sponsored health plans and initiatives found that just 18 percent believe the government is doing a good job of providing high quality, affordable care. Forty-five percent rated government programs as "fair" and 35 percent said they were "poor."

Who does the public blame for this poor performance? Interestingly, not the government itself. Just 45 percent of those who issued a "poor" rating said the government was to blame. Forty-nine percent said the poor performance was more due to the complexity of the health care issue itself.

The feds could be doing a better job, however, say respondents. Only 15 percent said that the government has placed enough emphasis on health care; 75 percent said health care should be bumped up the priority list.

The survey was part of a larger survey conducted by Pew Research Center for the People & the Press to gauge the nation's opinion on a variety of government-related issues. (Hospitals & Health Networks, 4/20/98) ■

Call for Articles

Through our Home Care Section meeting at the AARC Respiratory Congress in New Orleans, you have come up with some topics you would like to spotlight in upcoming issues of the *Bulletin.* Our fourth issue of the year will cover JCAHO and regulatory affairs and compliance. Our fifth issue will focus on disease management (including noninvasive ventilation) and the CQI process. Our final issue is still without a topic, so any suggestions would be greatly appreciated.

I have a list of those who volunteered to write articles in New Orleans, and rest assured that all of you will hear from me during the year. But you don't have to wait for me to contact you! If you have something to contribute, please feel free. ANYONE may contribute an article at any time! See the following article on "Submission Guidelines" for instructions on how and where. ■

Submission Guidelines for Articles Written for the Home Care Section Bulletin

Article length: Bulletin articles should be between 500 and 1000 words (about 1-3 typed, double-spaced pages).

Format: In addition to a paper copy, all articles should be submitted on a 3 -inch floppy disk saved in Microsoft Word or TEXT ONLY (ASCII) formats, or e-mailed to the editor in one of those formats.

Deadlines: The remaining 1998 deadlines are August 1, October 1, and December 1.

Article Review: All authors may review a copy of their article before it goes to press. If you would like to review a copy of your article, please include a FAX number when you submit it to the editor. **It is the responsibility of the author to 1) request the opportunity to review the article before it goes to press and 2) contact the editor by the stated deadline if any changes need to be made before the article goes to press.** ■