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AARC Comments On Salary Equivalency Guidelines

The AARC recently provided comments on the proposed Salary Equivalency Guidelines issued by the Health Care Financing Administration (HCFA). The proposed guidelines, which would cover physical therapy, speech language pathology, occupational therapy, and respiratory therapy, were published in the March 28, 1997 *Federal Register*.

The AARC expressed concerns about three aspects of the proposed rules—

1. The compression of the registered respiratory therapist (RRT) and the certified respiratory therapy technician (CRTT) professionals with non-credentialed workers into one generic category of "respiratory therapy."
2. The methodology and data sources used to determine the proposed respiratory therapy salary equivalencies.
3. The disregard of added costs imposed by respiratory therapy's unique Medicare transfer relationship between a hospital and a skilled nursing facility (SNF).

In a letter to Bruce Vladeck, HCFA administrator, from AARC President Kerry George, the AARC went on record as opposing the adoption of the salary equivalency guidelines.

In commenting on the single level respiratory therapy category, George said, "The single category does not account for the higher level of compensation an RRT receives, nor the propensity for SNFs to utilize the advanced RRT practitioner with experience."

In addition, the methodology used to determine salary equivalency rates for all of the therapy professions does not represent an equitable calculation. "The Medicare transfer agreement requirement limits the efficiency of providers in contracting for respiratory therapy services; a unique set of circumstances not faced by other therapy professions," said George. "This must be addressed in the regulation."

AARC Urges Caution As FDA Proceeds Toward CFC-Free Metered Dose Inhalers

The AARC recently provided comments to the Food and Drug Administration on their Advanced Notice of Proposed Rule Making regarding changes to regulations affecting the propellant in metered dose inhalers (MDIs).

The FDA is seeking to implement the Montreal Protocol, a pact that will ultimately result in a worldwide ban on chlorofluorocarbon (CFC) products. CFC ingredients are the propellants that are used to deliver medications to patients suffering from asthma, emphysema and other diseases through an MDI. Respiratory therapists are in the forefront of health care providers who educate and train patients to properly use MDIs.

The FDA is seeking to phase out current CFC products as CFC-free propellants become available. However, in a letter from AARC President Kerry George, the association warned the FDA about not removing current products from the marketplace until appropriate alternate products are widely available. In his letter to the FDA, George says, "We believe patients and the physicians who prescribe the MDIs must have a wide range of options until an equally wide range of CFC-free MDIs are available. Elimination of a particular active ingredient after 12 months of a CFC-free alternative, will not afford this necessary range of options."

George also stated that Medicare has discontinued large and small volume nebulizers and hand-held ultrasonic nebulizers as covered devices. This policy "has the result of transferring hundreds of thousands of Medicare patients from clinically effective and appropriate MDI alternatives into using MDIs. We believe this will make the FDA's goal of easing the transition to CFC-free MDIs more difficult, because usage and dependence on current MDIs have now tremendously been increased." said George.

He also urged the FDA to work with and educate Medicare policymakers on the inappropriateness of this Medicare regulation.

ARCF "Silent Auction" Offers RC Managers The Chance To Acquire Equipment And Supplies At A Discount

In an effort to increase the amount of funds available for important research projects and other programs aimed at positioning the RCP for success in the managed care environment, the American Respiratory Care Foundation is planning to conduct its first-ever "Silent Auction" during the AARC's 43rd International Respiratory Congress, scheduled for December 6-9 in New Orleans, LA. All AARC members and officially registered attendees at the Congress will be eligible to bid onsite or they may participate in the pre-

meeting bidding that will take place November 1-30.

While many of the items at the auction will be geared toward individual bidders, much of the inventory will consist of respiratory equipment and supplies designed to appeal to respiratory care managers working under increasingly restrictive budget constraints. Since opening bids for all donated items will be set at approximately 25% of retail value, the Silent Auction offers an outstanding opportunity for managers in all care settings to acquire much needed equipment at discounted prices.

RC managers or others with purchasing authority are encouraged to take advantage of this opportunity by working with their purchasing departments now to acquire the necessary purchase requisitions. In most cases, auction items will be shipped directly by the donor to the individual or institution with the winning bid.

A preliminary catalog of items will be included in the October issue of AARC Times to assist bidders in planning for the bidding process and to allow those unable to attend the Congress the opportunity to participate in pre-meeting bidding. A final catalog of items will be distributed at the meeting in December.

All funds raised by the auction will go directly into the ARCF's unrestricted fund supporting educational grants, research projects, practice surveys, consensus conferences, and other philanthropic programs.

The Foundation is currently soliciting items for the auction from a variety of sources and plans to have a wide selection of products in all price ranges available for bidding. The solicitation of items for the auction will continue through September 30. Anyone wishing to donate an item (minimum estimated value of $100) may do so by contacting Brenda DeMayo at the ARCF Executive Office at 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272.

REDUCED HOSPITAL ADMISSIONS AND ED VISITS THROUGH A COMMUNITY HOSPITAL-BASED OUTPATIENT PULMONARY REHABILITATION PROGRAM

by Randy Cox

Randy Cox is respiratory care manager at Lebanon Community Hospital in Lebanon, OR.

Many articles have been published over the last two decades on the varied benefits of pulmonary rehabilitation, including increased exercise tolerance, a reduction in respiratory symptoms, reduced anxiety and depression, enhanced ability to carry out activities of daily living (ADL), and a better quality of life. A few articles have reported a reduction in the number of days of hospitalization experienced by COPD patients following pulmonary rehabilitation. The purpose of this article is to chronicle the experiences of a ten-year-old community hospital-based pulmonary rehabilitation program run by the respiratory care department, and to focus specifically on the last two years and the impact this program has had on hospital admissions and ED visits during that time.

History

In January of 1985, two therapists at Lebanon Community Hospital (LCH), myself and Jim Slusser, identified a need for enhanced education of patients with COPD and started looking for a way to meet this need. We heard of a program developed at St. Charles Medical Center in Bend, OR, and made a trip over the mountains to observe and learn. The staff at St. Charles generously shared their expertise and materials, sending Jim and I home with armloads of information and a hearty recommendation to "Go for it!" In May of that year, the first pulmonary rehabilitation class was offered at LCH for six participants, including a gentleman, John Johnson, who became our "poster patient" when a local newspaper outlined his positive experience during and after the program. From these humble beginnings, the pulmonary rehabilitation program at LCH was born. Since that time, we have served hundreds of patients.

Over the next ten years enhancements and contributions from other staff members at LCH and other rehabilitation programs around the country were incorporated into the program. Crissa Saxton took the program to another level in 1991 by expanding our workbook and incorporating new information and techniques gleaned from research into other rehabilitation programs. In 1993 the program took another step forward through further enhancements and refinements added when Kim Ramp assumed responsibility for the program.

In its current form, the Pulmonary Rehabilitation Program at LCH is comprised of an intake/evaluation process; eight class sessions, each approximately 3 hours long; and follow-up which includes a "Better Breathers Club" that meets monthly at the hospital.

Intake/evaluation

Entry into the Pulmonary Rehabilitation Program is by physician referral only. The intake and evaluation process includes a comprehensive health and lifestyle questionnaire, which the patient completes with the help of a respiratory therapist; a 12-minute walk test monitoring SaO_2, heart rate, respiratory rate, breathing pattern, and perceived dyspnea and exertion; pulmonary function testing; and an ECG. From this information, an action plan is designed for each specific participant.

Education/continuing sessions

Class sessions are three hours long, with the first 1½ hours of each session dedicated to education and the last 1½ hours for conditioning. The education section of the program includes sessions on anatomy and physiology, pulmonary disease, dietary consultation (with recommendations for diet), smoking withdrawal assistance (if needed), bronchial hygiene, medications and their proper uses, breathing retraining, and activities for daily living. The conditioning section of the program utilizes an individualized approach for each participant, with the goal of improving

overall physical conditioning and, specifically, respiratory muscle conditioning to reduce perceived and actual dyspnea with normal daily activities.

Follow-up

At the conclusion of the class sessions, the intake/evaluation process is repeated to measure objective and subjective improvement. Participants are encouraged to come back and audit sections of the program, or even the entire program, at no cost. Monthly "Better Breathers Club" meetings are held to allow participants to get together for further education, discuss common experiences, and support each other. Several times a year the group plans a "field trip." With the help of local home care companies, they have traveled to such places as the Oregon Coast Aquarium, the High Desert Museum, and Silver Creek Falls. Throughout the program the patient's primary care physician (PCP) is kept up-to-date on the patient's progress, and no decisions are made regarding changes in medications or therapies without the consent of the PCP.

Outcomes

In September 1993, we began to compile statistics regarding the outcomes associated with the Pulmonary Rehabilitation Program. At the time these statistics were summarized (September, 1995), 38 participants had completed the program. Of those 38, 18 participants were at least 12 months post program. During the time these 18 completed the program, another 25 people were referred to the program but did not choose to participate or complete the program. Statistics comparing these two groups are presented in the following tables:

Patients referred for pulmonary rehabilitation

Received Pulmonary Rehab	18	42%
Did not receive Pulmonary Rehab	25	58%
Total	43	100%

Comparison of hospital day and ED visits pre & post referral

	Rehab 12 mo/pre	Rehab 12 mo/post	No Rehab 12 mo/pre	No Rehab 12 mo/post
Hosp Pt Days	162	13	198	173
ED visits	14	0	17	18

Comparison of reductions rehab vs. no rehab

	Reductions	Rehab	Reductions	No Rehab
Hosp pt days	149	92%	25	13%
ED visits	14	100%	-1	-6%

Our experience shows a dramatic decrease in hospital patient days and ED visits for the pulmonary rehabilitation group compared to those referred who did not participate. For the 18 participants who completed the program, LCH realized a cost savings of over $150,000. In a managed care and/or capitated environment, these are very significant numbers and they have caught the attention of hospital administration, primary care physicians, and the local managed care provider. In addition to the economic incentives of the program, feedback from participants regarding improvement in exercise tolerance, enhanced daily activity, better control of breathing problems, and a more positive mental outlook—all key factors in what we define as "quality of life"—has been very favorable.

Considerations

In our experience, there are two keys to success in pulmonary rehabilitation. (Please note that our definition of "success" focuses more on outcomes than reimbursement, although we have achieved favorable reimbursement for the program and it continues to pay for itself in terms of therapist salaries and supplies.) Those two keys to success are:

- The people facilitating the program. Your program will only be as good as those teaching it.
- The attitudes of those attending the program. "You can lead a horse to water, but you can't make him drink." This saying holds true for participants in pulmonary rehab as well. If they will not participate fully and make a true conscientious effort, they will not obtain the benefits of the program.

These two keys go hand in hand. If the people facilitating the program have the positive, compassionate attitude necessary to run a successful program, they will, in turn, attract participants to the program and "sell" the idea—even to those with an initial negative attitude.

Conclusions

The Pulmonary Rehabilitation Program at Lebanon Community Hospital has gone through many changes in the last ten years. In its present form, it is making a positive impact on people who have COPD by enhancing their "quality of life." In addition, considerable cost savings are being realized due to reductions in total hospital days and ED visits in the pulmonary rehab group.

LOCAL MEDICAL REVIEW POLICIES: *ONE INTERMEDIARY'S APPROACH*

by J. Michael Thompson, BS, RRT, RPFT, Melvin A. Welch, Jr, MPH, RRT, and Robert C. McCarthy, RRT

The Health Care Financing Administration (HCFA) grants its Medicare Fiscal Intermediaries (FIs) the authority to develop "local medical review policies." These local review policies are used to let Medicare providers know how the FI will interpret the Medicare regulations when processing claims. Although these local medical review policies are only intended for use by the FI that develops them, Blue

Cross of California (BCC) has always attempted to obtain input for its local policies from state and national professional organizations.

One recently published BCC local medical review policy on aerosol therapy is being republished in this issue of the *Bulletin*. The policy was drafted by the BCC respiratory therapy consultants and reviewed by BCC physicians, nurses, and Medicare program administrators.

The policy was also reviewed informally by RCPs and physicians outside of BCC prior to being distributed for comment. This input resulted in a final draft, which was sent out for formal input and review to the AARC, the California Society for Respiratory Care, several BCC Medicare respiratory care skilled nursing facility providers, and HCFA Medicare program administrators.

The final version of the BCC Aerosol Therapy Local Review Policy was published by BCC in its Medicare Bulletin #405 in February 1997 and distributed to BCC providers. It is reprinted below for your information. Although not binding on other Medicare Intermediaries, you may find it useful to review. You will note the reference section cites the AARC's Clinical Practice Guidelines.

Local Medical Review Policy
Aerosol Therapy in a Skilled Nursing Facility (SNF-Part A)
Policy: Medical necessity and appropriateness of Aerosol Therapy

Description

A. Types of Aerosol Therapy
This policy addresses one of the most common forms of respiratory therapy services provided to Skilled Nursing Facility (SNF) patients. These guidelines address two (2) types of Aerosol Therapy.

1.Pharmacologically active aerosols primarily consisting of bronchodilators. These aerosols can be delivered with a variety of devices including:
- pneumatically-powered "jet nebulizers"
- hand-held nebulizers (HHN)
- small volume nebulizers (SVN)
- metered dose inhalers (MDI)
- ultrasonic nebulizers

2.Bland aerosols consisting of water or saline solutions. These aerosols are delivered by:
- ultrasonic nebulizers
- large volume heated jet nebulizers
- large volume cold jet nebulizers

B. Skilled Services
For a respiratory therapist (RT) to provide aerosol therapy services, documentation in the patient's medical record must demonstrate that the unique skills of the therapist are necessary to achieve the predicted medical outcome.

Example:
Condition: Many patients require long-term aerosol bronchodilators due to a documented chronic obstructive pulmonary disease (COPD).
Prior Level: When stable at home, these patients self-administer their aerosol medications.
New Problem: SNF admission is related to an exacerbation of their lung disease or the patient's overall medical condition has deteriorated. The patient may not be able to safely and effectively self-administer their medications.
Intervention: The skills of a RT may be necessary to evaluate the patient, administer the aerosol medications, and assess the patient's response to therapy.

Indications Of Medical Necessity

A. Reasonable and Necessary
To qualify for reimbursement under Medicare, the therapy must be "reasonable and necessary for the diagnosis or treatment of an illness or injury." The therapy must meet three (3) criteria to be considered "reasonable and necessary." (Reference: SNF Manual, Section 230.lOB3)

1.Consistent with the nature and severity of the individuals symptoms and diagnosis.
2.Reasonable in terms of modality, amount, frequency, and duration of the treatment.
3.Generally accepted by the professional community as being safe and effective treatment for the purpose used.

B. Medical Necessity of Aerosol Therapy Aerosol Bronchodilator Therapy (ABT)

1.Indications for ABT
Bronchodilators are primarily used as a treatment for bronchospasm and conditions associated with bronchospasm.

a. Conditions/Diagnoses
The following conditions may justify ABT as a skilled respiratory therapy service:
- documented evidence of bronchospasm, (e.g., wheezing with and shortness of breath and decreased peak flows [in patients capable of performing procedure]),
- documented history of bronchospastic disease with evidence of bronchospasm,
- diagnosis of asthma or chronic bronchitis with evidence of bronchospasm,
- documented respiratory distress with or without excessive sputum production.

Note: There are situations when the diagnosis alone may not justify therapist-administered ABT. In these cases, a short trial of bronchodilators may be "reasonable and necessary" for no more than one (1) to two (2) days to observe and document the patient's response to ABT.

b. Clinical Response to ABT
- A documented clinical response to ABT (e.g., significant peak flow response, objective measures of less work at breathing or decreased respiratory distress) would justify continued administration of ABT as reasonable and necessary.
- If the documentation does not show a significant response to ABT after a short trial (1-2 days), continued ABT would not be considered reasonable and necessary.

• Whenever the patient's condition would allow, use of a peak flow as an objective assessment of response to bronchodilators is appropriate.
Note: An auscultation finding of "increased aeration" after ABT may have several potential interpretations. This finding alone would not be considered a significant response.

c. Questionable Use of ABT

• The presence of a productive cough would not justify ABT as reasonable and necessary if the patient has an equally productive cough without ABT.

• A diagnosis alone of pneumonia, atelectasis, or the presence of an infiltrate on chest x-ray does not justify ABT as reasonable and necessary.

• A clinical picture of dyspnea with excessive sputum production along with pneumonia, atelectasis, or infiltrate on x-ray may warrant a trial of ABT.
—The RT must objectively document the patient's response to ABT. If the goal was to aid in mobilizing secretions and decrease the work of breathing, the medical record must reflect increased sputum production above the baseline measurement as well as the signs and symptoms of changes in the work of breathing.

2. Achieving Goals/Discontinuing Skilled Therapy

a. Self-administration of ABT

As the patient's condition improves, he/she should be evaluated and trained, if necessary, for aerosol administration with a Metered Dose Inhaler (MDI). Once a patient demonstrates proficiency in self-administration, the daily supervision by an RT would not be reasonable or necessary.

b. Follow-up by a Respiratory Therapist (RT)

Periodic follow-up to ensure continued appropriate use of ABT. Periodic follow-up to evaluate for potential changes may also be justified.

3. Non-Covered Care

There are conditions when aerosol bronchodilators would not be considered reasonable and necessary.

a. Congestion or a past history of pneumonia or aspiration pneumonia without current significant respiratory distress. These patients would not be expected to respond to bronchodilator therapy.

b. Presence of auscultatory evidence of pulmonary secretions without accompanying respiratory distress. This patient may only require good nursing care to encourage coughing and deep breathing.
Note: Significant retained secretions causing clinical respiratory distress that does not respond to traditional nursing care may justify a trial of ABT as described above.

Bland Aerosol Therapy

Non-pharmacologically active aerosol therapy (bland aerosols) have limited documented usefulness. However, there are conditions that may justify the use of bland aerosols as reasonable and necessary.

1. Indications for Bland Aerosol Therapy

a. Patients with artificial airways often require continuous aerosol to the airway.

b. Patients requiring an induced sputum for laboratory lab analysis may need bland aerosol therapy to produce the sputum sample.

c. A trial of intermittent or continuous bland aerosol therapy may be reasonable and necessary in the following conditions—patients with excessively thick sputum who have been systemically hydrated but are still unable to mobilize the secretions with spontaneous coughing.

d. The RT's daily notes must document the patient's response to treatment that would justify any continuing skilled care.

Physician Orders

A. Specificity of Orders

1. All respiratory therapy services require a physician's order. The orders must state the specific modality, amount, frequency, and duration of treatment.

Example: HHN with 2.5 mg Albuterol + 2.5 cc ns qid x 1 week

2. A complete signed and dated physician's order for respiratory care or a physician signed respiratory therapy protocol must be in the medical record.
Note: Physician "stamped" signatures are not acceptable.

3. Components of a complete physician's order as shown in the above example include;

a. Medication and Dosage (2.5 mg Albuterol) unit dose is acceptable.
b. Frequency (e.g., qid, tid, bid, qid x # weeks).
c. Mode of Therapy (e.g., HHN).
d. PRN orders must include criteria for use (e.g., PRN wheezing).

4. Physician's orders must be legible.

5. The physician's orders must cover the billing period on the UB92.

Example: Orders for respiratory therapy were written July 25, but the billing period in questions is August 1-31. If the July 25th RT orders are not copied and submitted, then all therapy provided in August will be denied.

6. Medical records that are "stickered" with an "order expired" message must be marked "continue" and/or "reorder" and signed and dated by the physician or the order is incomplete.

7. Respiratory services provided without specific physician orders will be denied.

Documentation

A. Respiratory Therapy services that are billed must be documented.
B. The documentation must be legible and include the following:

1. Date and Time
2. Procedure
3. The patient's response to the therapy must be documented. Specific information about the patient's response to therapy is necessary to establish the continuing need for skilled therapy.

C. The respiratory therapy documentation must match what is billed on the itemized ledger.

D. If disposable equipment and/or supplies are billed, they must be documented in the chart (e.g., new circuit or circuit changed).

E. There must be a chart entry for each treatment session. One (1) daily entry for four (4) treatments is not acceptable documentation.

F. If "stick-on" style charting forms are used, all of the entries must be completely visible and inclusive of the above requirement.

Billing

A. Covered Charges

1.Supplies

a. Respiratory supply items are ancillary charges in a SNF if the charges meet the following requirements:

They are direct, identifiable services to individual patients, and they are not generally furnished to most patients, and they are furnished at the direction of a physician for special medical needs, and one (1) of the following;

—are not reusable (e.g., oxygen, medications)

—represent a cost for each preparation

—involve complex medical equipment (e.g., ventilators).

b. If the above criteria are met, the supplies may be billed.

• If the physician has ordered a specific respiratory therapy procedure, the necessary disposable supplies would be covered. Some of the most common items include disposable nebulizers, oxygen masks, and nasal cannulas.

• The supplies must be itemized on the financial ledger by date. Documentation in the respiratory therapy records must show that the supplies were issued to the patient on each date the item is billed.

• Failure to document the supplies as issued to the patient will result in a technical denial of the supplies.

• A medical device, such as a peak flow meter, may be billed if it is ordered by the physician and the medical records document that the device was actually used on the patient.

2. Skilled Respiratory Services

• Respiratory services must be billed by procedure.

• The respiratory therapy daily documentation must match the billed charges on the itemized financial ledger.

B. Revenue Codes

(Medicare code that identifies the category of a chargeable service, used on HCFA Universal Billing Form 92 [UB92])

270 Supplies

947 Complex Medical Equipment (ancillary)

410 or 412 Respiratory Services

Routine Therapy

A. Non-Billable Charges

Non-disposable, multiple patient use devices are not billable. These devices include:

• a compressor used to power the nebulizer during aerosol therapy administration.

• a percussor as an aid to perform chest physiotherapy.

Note: These items are considered part of the administrative cost of providing skilled respiratory services.

Comments

The Draft Policy was developed and sent to State/National Respiratory Care Organizations, providers, HCFA, Medicare Carriers and Intermediaries on November 18, 1996. Comments, when appropriate (i.e., met HCFA guidelines) were incorporated into the Policy.

Effective Date of Policy: Services on or after March 1, 1997

References

Respiratory and Critical Care Manual, Volume 152, #5 (November, 1995).

Standards for the Diagnosis and Care of Patients with Chronic Obstructive Pulmonary Disease. New England Journal of Medicine, 328:1017 - 1022 (April 8, 1993).

Management of Chronic Obstructive Pulmonary Disease. G.T. Ferguson, MD, R.M. Cherneack, MD.

American Association for Respiratory Care, Respiratory Care, (September 1991) Volume 36, #9, Aerosol Consensus Statement, 1991.

American Association of Respiratory Care, Respiratory Care, AARC Clinical Practice Guidelines, (December 1993).

American Association of Respiratory Care, (Respiratory Care 1992:37: 891-897), AARC Clinical Practice Guidelines, Selection of Aerosol Delivery Device.

Respiratory Care (December 1995) Volume 40, #12, AARC Clinical Practice Guidelines, Assessing Response to Bronchodilator Therapy at Point of Care.

Blue Cross of California, Asthma Consensus Statement, 1995.

Blue Cross of California Medicare Bulletin #398, March 29, 1996. Coverage of Respiratory Therapy in a Skilled Nursing Facility.

Health Care Financing Administration (HCFA) HIM-12 Extended Care Facility

Manual, Section 230.10B, Respiratory Therapy Provided by Hospital with which Skilled Nursing Facility has Transfer Agreement.

Medicare Intermediary Manual HIM-13-3, Section 3101.10. Respiratory Therapy Furnished by the Hospital or by Other Under Arrangements with the Hospital and Under Supervision.

BLUE CROSS OF CALIFORNIA'S "PEER REVIEW" AUDITS OF MEDICARE SKILLED NURSING FACILITY CLAIMS: *1997 UPDATE*

by Melvin A Welch, Jr., MPH, RRT
and J. Michael Thompson, BS, RRT, RPFT

This article is an update of a previously published paper (see *Subacute Care Section Bulletin*, Vol. 1, No.1) that describes the process used by Blue Cross of California (BCC) in performing its review of skilled nursing respiratory therapy claims. Blue Cross is one of a number of "Fiscal Intermediaries" (FI) used by the Medicare program to review and pay claims. Each FI has its own process of medical review and may use somewhat differing approaches. Blue Cross's approach to the review of allied health claims has, for many years, utilized the "peer review" approach, i.e., physical therapists review PT, occupational therapists review OT, and respiratory therapists review RT. The allied health consultants at Blue Cross review each claim with the objective of finding the information in the medical record required by Medicare to approve payment, i.e., the BC philosophy is to find the supportive documentation to pay the claim, not to try and find a reason to deny payment.

Based on the experience gained in performing these reviews (audits), the following discussion highlights the critical role played by the therapist who works in the skilled nursing facility (SNF) and, in particular, the pivotal role that RT documentation plays in establishing the medical necessity and skilled nature of the services provided. We will start with an overview of the two "phases" of claim review (Technical and Medical Necessity), then briefly highlight some of the more common "problems" identified during the review process.

Review Process Step 1: *The request for records*

When a SNF claim is to be audited, the provider is sent an Additional Development Request (ADR) form informing the provider of the audit and requesting the patient records for review. The ADR lists the records that the provider must submit to the FI. These records typically include—

- Physician's orders
- Progress notes
- Respiratory therapy and/or pulmonary function notes and documentation
- Laboratory and radiology reports (if available), and
- An itemized financial ledger

Typical "problems" related to requested records

Problem number one: Requested records are not submitted! Unfortunately, it still is not unusual for no physician orders, no itemized financial ledger, or no actual RT documentation to be submitted! The importance of insuring that complete records are submitted cannot be overstated. The FI is forced to deny payment if requested records that are needed to perform the review are not sent by the provider of the service.

Review Process Step 2: *The "technical" review of records*

The itemized financial ledger is reviewed to determine the specific respiratory services being billed. At BCC an itemized accounting of all the RT charges must be provided to allow the review process to proceed, as the next step in the technical review is to verify that each charged service or disposable supply is accounted for by an appropriate physician order. After confirming the order for the service, the actual RT records are evaluated to ensure that all billed services were documented in the medical record. Note: Many FIs do not request the above described "itemized ledger," but instead use the total number of "visits" by RT as the basis for reviewing the charges. For example, if one-half of the RT services are not documented or determined to be medically necessary, then one-half the number of billed "visits" would be denied on the claim.

Typical "problems" at the technical review level

Since the review process at BCC starts with the identification of the specific services or items that are being billed, the importance of the itemization of charges should be apparent. The most common problem seen with financial ledgers is that some are not itemized, or they only identify "units" of service (time). These types of ledgers do not permit BC to perform as thorough an audit as required, and hence cause the claim to be denied. "Service logs" with time units are the basis for the acute institution's billing to the SNF, but the provider (SNF) is then required to establish its own charges based on its costs, and to create an "itemized ledger" (bill) that is then submitted to the FI for payment processing.

A second common problem is that physician orders are sometimes incomplete, or they expire and the service continues. Third, some providers improperly bill for services that are not covered by Medicare, such as equipment standby charges, or charge for each use of a device that is used on multiple patients (e.g., a "percussor" or "compressor/nebulizer"). Lastly, the RT documentation often does not substantiate all of the billed services in terms of number of billed procedures or number of disposable items issued.

Review Process Step 3: *Determination of Medical Necessity*

The final phase of the review is the evaluation of the medical necessity of the respiratory services provided to the patient. This is where the RCP's assessment and documentation skills become critical. Although the auditor will be looking at all the submitted medical records to determine where the medical necessity is documented, RCPs who practice in the subacute setting know that the physician's opportunity to evaluate and document the patient's "pulmonary status" in his/her progress notes is often not nearly

as frequent as in the acute care setting. This places tremendous importance on the quality and detail of the RCP's assessments and daily documentation. Many physicians rely on "RTs to assess and recommend" types of admitting orders. Although this is perhaps the "ideal" order professionally speaking, it places a tremendous responsibility on the RCP to do a thorough, scientifically valid plan of care. With this caveat in mind, the medical records are reviewed to evaluate the medical necessity of the ordered therapy.

To establish the "medical necessity" for therapy, Medicare has identified that the therapy must meet the following three criteria. The therapy must be—

- "consistent with the nature and severity of the patient's complaints and diagnosis"
- "reasonable in terms of the modality, amount, frequency, and duration of the treatments"
- "generally accepted by the professional medical community as being safe and effective treatment for the purpose that it is used"

Finally, in addition to meeting the above criteria, the documentation must establish that a "skilled service" was provided (i.e., show that the skills of a respiratory care practitioner (RCP) were required to deliver the service to the patient to obtain the desired medical outcome).

To assist providers in determining the medical appropriateness of various therapy(s), the FIs have the authority to create "local medical review polices" that are used as criteria for determining the acceptance or denial of billed services. BCC recently created and published one such policy on "Aerosol Therapy in a Skilled Nursing Facility." The text of that policy is reprinted in this newsletter as a service to Subacute Section members. Keep in mind when reviewing the policy that it is a local medical review policy (BCC) and it is not binding on other FIs.

Typical "problems" at the establishment of medical necessity step

The three "Medicare criteria" listed above are sufficiently vague and can result in considerable problems in determining whether the medical records prove that these criteria have been met. As discussed earlier, the typically sparse physician progress notes frequently do not provide adequate information to establish current specific pulmonary problems needed to meet criteria number one. The auditor then must rely on RT documentation and any other data available (PMH, CxR, PFTs, ABGs, nursing notes, etc.) to aid in identifying the patient's current pulmonary status and, hence, current pulmonary needs. Unfortunately, this frequently presents a problem, especially if the RT documentation is formatted in a more "task performance" oriented manner.

Most providers of SNF RT services do perform some form of "RT patient assessment" and periodic "re-evaluations," but, typically, the difficulty is in the very general nature of the identified problems or established goals. For example, it is extremely common to establish that the patient needs to "mobilize secretions," but the assessment often does not establish that 1) there is any evidence of retained secretions, or 2) the patient is having any significant problem related to the secretions they may have (e.g., the patient may have an adequate cough and simply needs to use it!). Often goals are very general in nature (e.g. to "decrease work of breathing," "increase alveolar ventilation," or to "provide bronchodilation"), and the medical record does not establish that there is a problem with any of these issues. The bottom line is that performance of "patient assessments" is still a relatively new responsibility for many RCPs, and although we do see excellent quality from some, many others are not documenting specific patient problems to support the identified goals.

The last potential "problem areas" lie in the daily RT documentation and establishing that the "skilled service" was a necessary component of the care. In previous times it was adequate to note that the patient "tolerated the procedure well and had no adverse effects" (we refer to this as "task oriented" documentation). Now that we are relying on the daily documentation to establish the very need for the therapy, it is critical that we carefully document the patient's respiratory problems and response to therapy. It is interesting to note how often "mobilize secretions" is identified as a major goal in the initial assessment, yet no discussion of secretions or cough occurs for days, or even weeks, in the daily documentation! Then, on the next "weekly re-evaluation" it may again be noted that the patient is "improving in his or her ability to cough and is making progress toward the goal of mobilizing secretions." It is difficult to determine how the periodic assessments can make the conclusions they often do without the daily documentation substantiating the findings. Sometimes it is not even apparent that these weekly evaluations are on the same patient as the daily documentation! If the daily documentation does not substantiate the need for the therapy, the medical necessity of the therapy will be questioned.

For the documentation to establish that a "skilled service" was provided, it should be readily apparent why the presence of the therapist was required to ensure the outcome. For example, observation of a patient who already properly self-administers a metered dose inhaler does not require the skills of an RCP. However, initial instruction and follow-up supervision, if clearly documented as medically necessary (i.e., the patient cannot properly self-administer and this is well documented), could be considered a skilled RCP service. The key to establishing if the service is skilled is adequate documentation of the patient's problem(s) that require the skills of the RCP to ensure the desired outcome. In other words, why is the RCP there? Just watching the patient to make sure he/she takes the medication is not adequate justification. This clearly could be done by other health care personnel.

We certainly recommend that the AARC Clinical Practice Guidelines be used to assist in the establishment of appropriate utilization, but even when using these guidelines one must clearly document the patient's status and response to therapy in order to evaluate the appropriateness of the therapy for each individual patient.

Outcome of the audit process

After the review has been completed, there are several possible results. The entire claim may be accepted for payment, some or all of the billed services may be deleted for technical reasons (e.g., no orders, incomplete documenta-

tion, etc.), or payment for some or all of the services may be denied because of lack of medical necessity. It is also possible for a single claim to have some services accepted, other services deleted for technical reasons, and still other services denied for lack of documented medical necessity.

Technically deleted services, and services denied for medical necessity, now both result in the immediate deduction of dollars from the provider's bill. This policy is relatively new for medical necessity denials, resulting from the elimination of provider "waver status" by HCFA in 1995. Technically deleted claims can be resubmitted to BCC with a complete set of the initially requested records and a request for a "reopening" of the claim. While HCFA does not require its FIs to perform reopening reviews, BCC performs them as a service to its providers. They have a low priority, however, because initial claims selected for audit must be reviewed first. Hence, it may be a long time before requests for reopenings are processed.

Claims denied for lack of documented "medical necessity" have a more formal review process. These claims are resubmitted, with an accompanying letter from the provider requesting that a "reconsideration" review be performed. The provider should identify, in the cover letter whenever possible, specifically where in the medical record the medical necessity is documented for the denied therapy and/or the specific reasons why the therapy is appropriate. This type of claim would then be independently reviewed by a different therapist/auditor and another determination made. The outcome of the reconsideration review may result in complete or partial reversal of the initial determination, or it may uphold the initial auditor findings.

Summary

As can be seen from the preceding overview of one Fiscal Intermediary's Medicare audit process, the role of the RCP in the subacute setting is certainly not that of "just there to follow physician orders," but can be one of the most challenging and, hopefully, rewarding of RCP roles. The quality of your work can make a tremendous difference, not only in ensuring that the patient receives the most appropriate respiratory care, but also in ensuring that appropriate reimbursement occurs for this care. Since there are many different FIs that process claims for respiratory care services in SNFs, and each has its own process and criteria for claim review, we recommend that you communicate with your Fiscal Intermediary to determine its claim review process.

THE ORDER: *"PATIENT, FAMILY, AND CAREGIVER TRAINING AS NEEDED" WHAT DOES THIS MEAN?*

by Cheryl Vial, RRT, RCP

Cheryl Vial is manager, alternative site program, at the Oregon Health Sciences University.

We have all seen this order in skilled nursing facility (SNF) charts. What does it mean? Or better yet, what should it mean? What modality should we teach, what method of documentation is required, how much do we train, and who do we train? All good questions to explore.

On admission, most SNF patients are not candidates for full pulmonary rehabilitation and, if they are, they should be referred on to a qualifying program at discharge. Still, simple, yet time intensive and specific teaching is most appropriate as long as the care plan, taking into consideration the proposed discharge site and available caregiver help, is initiated.

Modalities such as proper MDI delivery with spacer utilization, oxygen delivery with or without exercise, nebulizer medications and usage, PEP therapy and/or inspiratory muscle trainer, peak flow meter, trach care, trach suctioning, and non-invasive ventilation techniques are all appropriate examples of teachable self care. In some instances, more extensive training in conjunction with physical therapy, occupational therapy, or speech therapy is important, as well as appropriate.

Several important concepts should be kept in mind when evaluating potential training—

- Will the training help prevent future exacerbations?
- Is the patient physically able to perform the modality?
- Will self administering portions of his/her therapy enhance the patient's quality of life?

If the patient can learn to better control his or her disease process by using prevention and proper intervention, he or she can gain a new sense of control over activities of daily living. Once this is achieved, the only limitations are physical or mental capabilities. At this point, self esteem and quality of life can improve significantly.

Also important to remember is that with prevention and intervention comes the secondary benefit of decreased medical cost. Therefore, we should train each patient until he or she has reached a plateau of learning and accomplishment. Goals should be specific: "self administer MDI medications with spacer to include knowledge of ordered medication with time parameters on when to administer," or "know when to self administer prn medications based on peak flow meter values or symptoms."

We reach these goals by providing patients with the physical tools to perform at their maximum level. If that level is short of full self-administration, we should evaluate their available caregivers and train them appropriately to assist. Our overall goal should be to give each patient as much control as he or she can handle.

When we first initiate the care plan, the proposed discharge site should be known and our training of patient, staff, and family should reflect that environment. If the proposed site is identified as inappropriate when compared to the abilities of those involved in care, then recommendations for changes need to be made. However, one pitfall that we all need to avoid is our natural tendency to jump to the conclusion that "they can't do it." Trainers have to step out of their "acute care environment" mentality and adjust to the post acute care setting where rehabilitation takes time.

Consider this example: We had a patient who, over a period of two to three years, had multiple SNF and hospital readmissions due to her end-stage emphysema. She was read-

mitted once again to a SNF, which contracted OHSU for RT services. On talking with her, we found out that she had a desire to return to her own apartment, which was in a building where her sister also lived. But the consensus of all involved with her care was that she was "too ill" to do it.

A care plan was developed by the RCPs which incorporated teaching the patient as much of her care as possible. It soon became evident that she had an extremely strong will to achieve her goals, even though her progress was slow.

On admission, she was unable to transfer from her bed to the bathroom without assistance due to dyspnea and paralyzing fear. Our first goal was to stabilize her status by developing an optimum level of bronchodilation via nebulizers and MDIs. Oxygen was titrated to appropriate levels at rest and with exertion. Next, we evaluated her prn MDI needs and she was started on an inspiratory muscle trainer. During this time, PT and OT worked to optimize her physical capabilities, and RC, as part of the team, managed her oxygen consumption during activities.

This brought us to the realization that her dyspnea was so acute during activity that she would actually become "paralyzed," unable to move or use her purse lipped breathing effectively. She would have someone rush to turn up her O_2. We convinced her that with a high expiratory setting, the inspiratory muscle trainer (IMT) would help her compensate by lengthening her exhalation. She soon had the ability to become acutely dyspneic, grab her IMT from her pocket, use it, and continue on with her activity. No longer was increased O_2 needed. Her walker was fitted with a small basket by OT to carry her "emergency" needs, including MDI and spacer. Getting her to this level took approximately four to five weeks.

However, she was still apprehensive about being alone while attempting her activities, and the RCPs were still administering medications. Slowly, she was trained on how and when to use all of her inhalers and nebs (the latter being eventually eliminated). Over another period of approximately four to five weeks, she was weaned from having to have an RCP present during treatments.

While the RCPs were administering nebs or MDIs, they would talk about how to arrange her apartment for ease of retrieving things (shoulder height storage vs. bending or reaching), where to keep an extra MDI canister (bathroom or bedroom, etc.), or how to eat smaller, more frequent meals for energy conservation. Her sister was present during a lot of these sessions, and they devised an emergency call system. Both sister and patient became well versed in exacerbation prevention and proactive behavior. If she was having a bad day, that was okay—no pushing. If she felt really good and wanted to extend her activities, they both learned how far to go.

As you can guess, none of this happened overnight, but the patient was, after a little over three months, discharged to her own home. Her sister checked on her daily, and during the ensuing year she only had one overnight readmission to the hospital.

The cost of this rehabilitation process was significant, but the savings in hospital and SNF admissions compensated for the expense. The patient and family were very happy with the clinical outcomes, and the insurance company appreciated the savings achieved.

Because of the team concept used in the above case, chart documentation supported levels of achievement in the notes of each therapeutic discipline. Weekly summaries showed level of progress and changing needs. The insurance provider was able to see the treatments and training being done in the RC notes, and the effects of that treatment and training were noted in the PT, OT, or nursing notes. Both forward progress and "back slides" were noted, all supporting each other. The care plans were updated and changed as the patient's condition and abilities changed. What the patient said and felt was also recorded as part of the team communication. This helped all of us understand our patient and her needs.

In the acute care setting, this type of teaching and training is impossible. But at the subacute level, "patient, family and caregiver training as needed" orders are both cost effective and outcome oriented, and can provide our patients with their optimum level of ability and quality of life.

MANAGED CARE: *HOW DOES IT AFFECT YOUR ROLE AS A HEALTH CARE PROVIDER?*

by Tami Carter, RRT, and Jan Haneberg, RN, CCM

How does managed care affect your role as a health care provider? If you ask therapists who are experienced in managed care, you may get different answers. That's because health plans and organizations adopt different methods to manage resources that may, for example, affect access to services and the degree to which costs are controlled. Managed care is a complex collection of interdependent systems that integrates the financing and delivery of health care services. Thankfully, it's not impossible to sort through the muddle to gain an understanding of a few basic managed care concepts that can help you survive and prosper in the rapidly evolving subacute, managed care environment.

Types of managed care

Managed care organization: A managed care organization, or MCO, is any form of health plan that initiates selective contracting for the medical care of patients. As a result, the number of providers within a given network is limited. For example, if you're insured with an MCO you will be given a list of providers to select from when choosing a physician. If you select a network physician, you will remain eligible to receive the maximum coverage available.

Health maintenance organization: A health maintenance organization, or HMO, is an organized health care system that is responsible for the financing and delivery of a broad range of comprehensive services that are delivered to a specific, enrolled population for a pre-paid, fixed fee. If you enroll in an HMO, your choice of health care services may be more limited. Your acute care needs, for example, will likely be met by an HMO employed physician in an HMO owned and operated health care facility.

The success of managed care

Although managed care may be feared or abhorred by some, it's difficult to dispute its overall success. The following statistics reveal a rapidly growing managed care population—

- 63% of the employees at nation's largest corporations are HMO members.
- 20% of the nation's population are enrolled in HMOs.
- It is projected that by the year 2000, 125 million people will be enrolled in HMOs.
- Seniors age 85 and older represent the fastest growing segment of the managed care population.
- The American Medical Association estimates that 56% of all physicians now participate in HMOs.
- It's important to note that the growth of managed care isn't simply a question of economics. Client satisfaction is also a determining factor—
- A national study of 25,000 health care consumers sponsored by Xerox, Digital Equipment Corp., and GTE showed that employees enrolled in HMOs are substantially more satisfied with their overall care than those with fee-for-service insurance plans. The study found that 86% of employees who belong to group HMOs were satisfied with their health plans, compared with 74% of those with fee-for-service.
- A 1994 poll of 606 Massachusetts residents found that 70.9% of HMO members would recommend their health plan to a friend or relative. This compared with 69% of the residents covered under fee-for-service plans. The study also found that 84% of HMO members, compared to 73% of fee-for-service beneficiaries, believe the benefits and services they receive for their premium payment represent a good value.
- A statewide poll released in December 1994 by the Massachusetts Hospital Association showed that 86% of HMO members were satisfied with their coverage, compared with only 78% of those with fee-for-service insurance. In addition, 72% of HMO members said they were satisfied with the cost of their HMO premium, compared with only 63% of people in other types of health plans.

(Source: Massachusetts HMO Association Internet/ Mahmo.org March 14, 1996)

Objectives of managed care

Although managed care health plans and organizations vary by type, they share common objectives that are critical to their success. Each of these objectives, in turn, presents an opportunity for you and your subacute respiratory program.

- *Seek alternatives to expensive inpatient hospital care and reduce inpatient hospital costs and stays.* This objective presents a great opportunity for the development of respiratory treatment programs in subacute nursing facilities.
- *Improve quality of patient care and customer satisfaction*. Many respiratory patients are in a revolving door cycle between the emergency room, hospital, and home. Hospital diversion and disease management programs implemented by subacute facilities can positively impact clinical outcomes and customer satisfaction, while reducing the overall cost of care.
- *Use of case managers to control health care expenses, especially in high cost cases.* As a respiratory care practitioner in a subacute facility, you will interact extensively with case managers in obtaining authorizations for treatment. This authorization process may appear, at first, as an obstacle. Case managers are, however, important members of the health care team and can become a valuable resource. Their goal is to develop individualized treatment plans that implement services at the appropriate level and intensity to achieve the client's clinical and discharge goals.
- *Minimize administrative costs.* At first glance, it's difficult to see how a subacute program can assist in minimizing administrative costs. Creative programs can, however, capture these opportunities. Efficiencies in the authorization process and contract rates that reduce claim processing time are just a couple of examples.
- *Develop risk sharing, managed care partnerships.* As a provider of respiratory care in a subacute facility, you may be asked to contribute to the development of capitation, or modified capitation, contracts. This type of contract places the provider of care at risk to meet the needs of managed care clients at a specific dollar amount per member per month rate.

Strategies for success

Tailoring your respiratory program to meet the objectives of managed care is an important start on the road to success. But beware! The road may be rocky. Here are a few strategies that will help you survive and prosper in a managed care environment—

- Be prepared to make a paradigm shift. Health plans will set clinical criteria based on care at the lowest cost setting appropriate. More is not better. Outcome study and analysis will be used to determine optimal approaches in the delivery of care. Fee-for-service plans will become a thing of the past. Practitioners won't function independently, but as members of an interdisciplinary team.
- Medicare guidelines are simply guidelines, and some will be waived by managed care organizations if doing so will improve outcomes and reduce cost. For example, some MCOs may allow direct admissions to subacute programs, thus avoiding the Medicare required three day hospital stay.
- Services must be of therapeutic value. Outcome studies will prove valuable in this determination.
- Maximize the benefits of treatment while ensuring cost containment. Again, the proof is in the outcome study results.

- Carefully evaluate the severity of illness and deliver an intensity of service to match.
- Stay in tune with the managed care dynamics in your area. The market changes quickly.
- Develop services that meet existing patient needs and will provide a foundation for true development. Anticipate market needs and plan today for tomorrow. For example, a COPD management program designed to avoid costly exacerbations and hospital admissions may be based at the subacute setting and include outpatient education and wellness classes.
- Develop strong relationships and gain the trust of managed care organizations and members of the medical community.
- Create quality minded, cost effective care plans.
- Do not over treat.
- Upgrade your clinical image by learning more about reimbursement issues, health care financing, and the MCO's authorization process. Develop your understanding of capitation, market share, and cost caps. Develop a business side that complements your clinical side.
- Accept responsibility for developing your business and professional skills. If you "just want to take care of patients," you may find yourself on the outside looking in.

Embracing a managed care future

Based on the statistics and studies conducted to date, managed care has arrived and is expected to stay a long while. In many regions of the nation, it has dramatically altered the health care delivery system through careful integration and management of resources. The objectives of managed care introduce new opportunities for RCPs in the subacute setting. In order to capture these opportunities, you must adopt a strategy for success, one that incorporates the concepts of managed care and applies them in the treatment and management of respiratory disease. It's the future—embrace it!

References

Dolin, Leigh, MD, "Quality Assurance and Utilization Review in the Group Practice Setting," Sept. 25, 1993.

Feuer, Louis, "Upgrade Your Clinical Image by Learning Business Skill," Continuing Care, Feb. 1995, p. 16-29.

Formisano, Roger, PhD and Susan Van Duyne, EdD, "A Cost Containment View of Subacute Care: 'What the Case Manager Should Know,'" Inside Case Management, Vol. 2, No. 11, Feb. 1996, p. 1-4.

Fowler, Frances J., "Direct Admission is Bright Under Managed Care," Subacute Care, Nov.-Dec. 1996, p. 21.

FRONTLINE ADVANTAGE, Source: InterStudy Competitive Edge; Industry Report 6.1.

Gerson, Vicki, "HMO Case Management," TCM, Jan./Feb./Mar. 1995, p. 79-88.

Hegland, Amme, "Moving Ahead in a Managed Care Environment," American Association of Homes and Services for the Aging, 1995.

Johnson, Sharon K., "The State of Disease State Management," Case Review, Fall 1996, p. 53-57.

King, Angela, "Respiratory Success," Continuing Care, May 1996, p. 28-31.

Lee, Sharyn, "New Trends in Disease Management," Continuing Care, July/Aug. 1996, p. 37-39.

Masso, Anthony R., "Managed Care and Alternative-Site Health Care Delivery," The Journal of Care Management, Vol. 1, No. 1, June 1995, p. 45-51.

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES: 1996 Oregon Consumer Guide to Medicare Supplement Insurance and HMOs, 1996.

Powell, Suzanne K. and Mary Ellen Dalton, "Shifting Roles," Continuing Care, Feb. 1996, p. 20-30.

Schaffer, Carol, "Moving Toward National Integration," Continuing Care, Sept. 1995, p. 17-18.

Smith, Rich, "RCPs in Case Management," Case Review, Winter 1996, p. 71.

Todd, Warren E., "New Mindsets in Asthma: Interventions and Disease Management," The Journal of Care Management, Vol. 1, No. 1, June 1995, p. 37-43.

Wade, Judy, "Patterning the Care Partnership: The Payor-Provider Coalition," Case Review, Fall 1995.

Wiedeman, Greg T., "The Growth of Respiratory Care at the Skilled Facility," AARC Times, May 1994, p. 54-56.

FYI...

Editor's Note: FYI . . . is a regular feature of the Subacute Care Section Bulletin devoted to short news items that may be of interest to members of the section.

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)

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)

Many hope to cash in on boomers' old age

Add venture capitalists to the list of folks anxious to profit from the baby boomers' transitions into old age. U.S. Census Bureau figures showing the over-65 age group will consist of 70.1 million people and 20.1% of the population by 2030 (up from just 33.2 million and 12.5% of the total population in 1994), are creating a boom in markets designed to serve the needs of this burgeoning group. Merrill Lynch, for example, predicts that the demand for nursing home beds will exceed supply as early as 2007 and the $12 billion assisted living industry will grow by 30% by 2005. Home care and rehabilitation will see large increases as well, increasing by 15% each over the next decade. (Source: *Modern Healthcare*, 3/10/97)

Blood pressure measurements may help skilled nursing residents avoid falls

Fainting spells and falls among elderly nursing home residents often occur more frequently early in the morning, and now a new study from the Hebrew Rehabilitation Center for the Aged in Boston, MA, explains why.

Researchers who studied 911 long-stay nursing home residents age 60 or older to assess the patterns of blood pressure fluctuation throughout the day found that 51.5% experienced orthostatic hypotension (OH), a drop in blood pressure upon standing and 13.3% experienced the condition at least four times during eight position changes. OH was most common before breakfast and least common after lunch, which researchers say may be due to the fact that hypotensive medications usually begin with breakfast.

They recommend that nursing home staff pay greater attention to their patients as they rise in the morning to help them avoid falls and fainting. They also suggest that measuring blood pressure early in the morning or after meals should be avoided, as those times may lead to either overly aggressive antihypertension management (in the case of early morning measurements, which tend to be higher) or overlooked hypertension (in the case of after meals measurements, which tend to be lower).

Say the authors, "Multiple supine and standing measurements throughout the day are necessary to determine whether hypertension or hypotension are persistent or variable and to gauge the response to therapy. Future studies should address whether overnight antihypertensive therapy might prevent the early morning hypertension and OH that we have observed."(Source: *JAMA*, 4/23/97)

ACHCA to offer certification exam for subacute care administrators

The American College of Health Care Administrators has several programs that may be of interest to subacute care managers, including a new certification examination for subacute care administrators which is open to licensed and/or credentialed RCPs who meet certain eligibility requirements. Here is their upcoming calendar—

Assisted Living Administrator Instruction Program
(20 CE hours)
December 5-7
Harrah's Casino & Hotel
Las Vegas, NV
September 12-14
The Embassy Suites Hotel
Palm Beach Gardens, FL

Certification Exams for Assisted Living, Nursing Home and Subacute Care Administrators
October 13, 1997, February 21, 1998, May 1, 1998
Locations to be announced in the following cities:
Atlanta, GA
Boston, MA
Charlotte, NC
Chicago, IL
Cincinnati, OH
Dallas, TX
Des Moines, IA
Denver, CO
Detroit, MI
Los Angeles, CA
Memphis, TN
Minneapolis, MN
New York, NY
Orlando, FL
Philadelphia, PA
San Francisco, CA
Seattle, WA
St. Louis, MO
Washington, DC

ACHCA's 32nd Annual Convocation
May 2-5, 1998
Hyatt Regency Atlanta
Atlanta, GA

For more information about these programs, contact: ACHCA, 325 South Patrick Street, Alexandria, VA 22314, (703) 739-7900, Fax: (703) 739-7901, http://www.achca.org. (Source: ACHCA)

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)

_____

_____

_____

SPECIALTY PRACTITIONER OF THE YEAR

Don't forget to make your nominations for the Subacute Care *Specialty Practitioner of the Year*. This honor is given to an outstanding practitioner from this Section each year at the AARC's Annual Meeting.

The recipient of this award will be determined by the Section Chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the Section.

Use the following form to send in your nominations for this important award—

I would like to nominate _____ for *Subacute Care Specialty Practitioner of the Year* because

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Nominee Your Name

_____ _____

Hospital/School Hospital/School

_____ _____

Address Address

_____ _____

City, State, Zip City, State, Zip

_____ _____

Phone Phone

Mail or FAX your nomination to the Section Chair at the address/number listed on the last page of this issue.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Subscute Care Section
11030 Ables Lane • Dallas, TX 75229-4593
(972) 243-2272 • Fax (972) 484-2720

Chair and Bulletin Editor
Kevin Cornish, BS, RRT
Ernst & Young
100 N. Tampa St., #2200
Tampa, FL 33602
(813) 225-4788
FAX (813) 225-4713
e-mail: kevin.cornish@ey.com

Chair-elect
To be appointed

Medical Advisor
James K. Stoller, MD
Pulmonary-Critical Care Medicine, A90
Cleveland Clinic Foundation
9500 Euclid Ave.
Cleveland, OH 44195-5038
(216) 444-1960
FAX (216) 445-8160

American Association for Respiratory Care
11030 Ables Lane
Dallas, TX 75229-4593

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