Continuing Care & Rehabilitation Bulletin

Jan./Feb. '02

American Association for Respiratory Care

Notes from the Chair

by Mary Hart, RRT, RCP

Happy New Year! I hope you all had a great holiday season and were able to enjoy it with family and friends.

It's hard to believe I have been serving as section chair and editor of the *Bulletin* for a year now. However, I am happy to report that Cara Kraft, RRT, RCP, has graciously volunteered to serve as *Bulletin* editor for the remainder of this year. Cara has many years of experience working in pulmonary rehabilitation and is dedicated to the profession and the AARC. She is truly an asset to our team!

Those of you who attended the AARC International Respiratory Congress in San Antonio in December know what a success it was. It was inspiring to see the incredible number of abstracts presented at the Continuing Care and Rehabilitation Section Open Forum. Not only does the Forum offer us the opportunity to hear about what others are doing in their areas of expertise or programs, but also allows time for networking and identifying ideas for future research. It was a pleasure meeting the presenters and hearing about the exciting research going on in the world of continuing care and rehabilitation. We all should continue to ask these questions about program outcomes, equipment and devices, how to provide pulmonary rehab, and assessment and evaluation tools, to name a few. If more of us do, next year's Open Forum will be even bigger and better.

Although attendance at our section meeting was down, those who did attend submitted many great ideas for future *Bulletin* articles and program topics for this year's AARC International Congress, scheduled for October 5-8 in Tampa, FL. Thank you for your submissions. But rest assured it's not too late for the rest of the membership to submit articles or ideas for articles for the *Bulletin*. Just email either Cara or me at the addresses on page 2. And don't forget about the Open Forum abstract deadline, April 30, 2002! ■

Specialty Practitioner of the Year: *Penny Plouff, RRT*

The Continuing Care and Rehabilitation Section was proud to honor Penny Plouff, RRT, as its Specialty Practitioner of the Year during the Awards Ceremony at the AARC International Respiratory Congress held in San Antonio, TX, in December. Penny is a longtime supporter of the pulmonary rehabilitation field, having worked with patients in a wide variety of settings and served in numerous capacities at the state and national levels of the AARC.

After owning her own business, Respiratory Rehabilitation and Therapy, for a number of years, Penny recently went to work for Unum Provident in Portland, ME, as a disability case manager. She served as president of the Maine Society for Respiratory Care in 2000-2001, and always responds in a timely manner to requests for assistance from the AARC, sharing her knowledge and expertise in the field. Penny has a positive attitude and projects a sense of pride in being a respiratory therapist by attending national meetings and making an effort to continue to learn. She has recently completed a case management certificate program and is now eligible to take the case management exam.

Congratulations, Penny! ■

Tribute to a Pioneer

by Fran Ahel, RRT, RCP

I was an ICU burnout. Fortunately, at the time I realized it there was an opening in pulmonary rehab in my hospital, and my boss, Teresa Davis, agreed, with some apprehension, to let me give the area a try. Apparently, I had been a little crabby, and she had some concerns regarding my ability to be enthusiastic. Well, it didn't take long to be affected by my patients' desires to be healthier, and I soon found myself sitting in Teresa's office for another chat. My eagerness to do the best I could for my patients led Teresa to caution (lecture) me about enabling the patients. She taught me the fine art of guiding rather than leading pulmonary rehabbers.

Some 20-plus years ago, Teresa started a pulmonary rehab trial at Harris HEB Hospital (now Harris Methodist HEB Hospital), with the blessing and encouragement of our medical director, Dr. H. Dhingra. She began by putting ventilator patients in the ICU on a stationary bike and tracking length of stay. The results,

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while not outstanding, were positive enough to begin an inpatient program with more mobile patients. By the time I started at the hospital, she was doing her thing in a small room and in the stairwells. I, on the other hand, was relatively new to the field and did not quite appreciate her happiness in seeing a patient walk up a few stairs. For I was a "real" therapist, taking care of patients with pneumonia and bronchitis, working in the ICU with ventilators, and attending emergencies in the ER and answering codes.

Little did I know then how tough this job is! There are pulmonary rehab programs out there with no involvement from respiratory therapists, let alone under the management of the respiratory department, and they probably function very well. But we, as respiratory therapists, are in a unique position to work with pulmonary rehabbers. It's called a bond of trust. Many of our rehab patients have been on ventilators or in the ER struggling for breath, and we have been the ones to see them through. We have the privilege of following them from the ICU, to the step-down units, to the floor and then home. This is the continuum of care.

But with the pulmonary rehab patient, the process continues to their death. How many of us have been called to the side of a dying patient, or have been asked by a patient's family to be the one to extubate when the decision is made to end life support? It is at these times that the patient is no longer a patient, but a friend. It is at these times that this job is tough. But it is also at these times that this is a job I am humbled to have.

On Wednesday, November 14, 2001, Teresa Davis died. I not only lost a boss, but a friend. I am sure that if Teresa's early work in pulmonary rehab had been done in a large teaching hospital with a research support staff, her work would have been published. Well, Teresa, this one's for you! ■

Evaluation of a New Demand Oxygen Conservation Device in Patients with Chronic Lung Diseases at Rest and with Exercise

by Trina Limberg, BS, RRT; Andrew Ries, MD, MPH; Roseann Myers, BS, RN; and Lela Prewitt; University of California San Diego Medical Center, San Diego, CA

Editor's Note: *The following abstract was presented at the AARC 47th International Respiratory Congress, Open Forum, Continuing Care & Rehabilitation Section, by Trina Limberg, BS, RRT.*

Background: Oxygen therapy is an important treatment and has been shown to improve survival in hypoxemic COPD patients. Due to potential cost savings and portability benefits, demand oxygen systems have increased in use. Previous studies have demonstrated mixed results of conservation systems during exercise and with activities of daily living. We sought to evaluate use of an O_2Xpress pneumatic device by comparing it to continuous flow during exercise in pulmonary rehabilitation program graduates.

Method: Twenty-one O_2 dependent patients (18 COPD, 3 restricted lung disease) with documented hypoxemia on room air (Sa O_2 <88% or Pa O_2 55mmHg) were studied. All were receiving long-term oxygen therapy. During the one visit testing, patients were provided with either a continuous flow nasal cannula or the Salter Labs demand oxygen conserving device (DOCD). Vital signs and oxygen saturations were assessed at rest and during exercise. While seated, subjects received sequential flow rates of 1, 2, 3, and 4 LPM of supplemental oxygen, once with continuous flow and once with the DOCD, for five minute periods. Oximetry was recorded during the final 15 seconds of each five minute interval. Then subjects were tested while walking on the treadmill, based on workload prescriptions determined during the previously completed pulmonary rehabilitation program. At UCSD, exercise training targets are set to approximate maximum symptom-limited levels reached during an initial incremental exercise test. In obstructive patients, supplemental oxygen was delivered sequentially, at 4, 3, 2, and 1 LPM during treadmill exercise for 3 minutes each. Following each change in flow rate, subjects were required to rest for 10 minutes. Restrictive patients received higher flow rates, sequentially, at 6, 4, 2, and 1 LPM. Ratings of perceived breathlessness and muscle fatigue were also obtained via the Borg scale at the end of exercise. Assessments were terminated if oxygen saturations fell below 85%. COPD patients were analyzed in a group, while the restrictive patients were studied individually. Repeated measures analysis of variance was used to compare oxygen saturation with the two methods of continuous flow via nasal cannula and the Salter Labs DOCD. Separate analysis was performed for rest and exercise with paired-t tests.

Results: For COPD patients, results showed there was no significant difference in SaO_2 at comparable flow rates between the two devices, although with exercise SaO2 was significantly ($p<0.05$) higher at the lowest flow rate with the DOCD (mean SaO2 90.2%). SaO2 was higher for the DOCD in patients (range 1-5%), higher for the nasal cannula in four subjects (range 1-2%), and equal in three subjects. One subject did not exercise on 1 LPM due to a low SaO_2. Overall, there was no significant difference in ratings of muscle fatigue or breathlessness. Individual results for restrictive patients showed that at rest, the DOCD appeared to produce higher SaO2 in one of three patients. During exercise there did not appear to be any consistent difference between continuous flow and use of the Salter Labs DCOD.

Conclusions: This pilot study demonstrated that the Salter Labs DOCD was comparable to continuous flow by nasal cannula at rest and during exercise in patients with chronic lung disease. It is important to note that treadmill speeds in some patients were as high as 2.8 mph. Previous studies appear to have been conducted at much lower workloads. Since respiratory rates increase with higher workloads, it is imperative that patients using conservation devices be assessed with exertion.

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CMS Updates RT Codes for Pulmonary Rehab

Editor's Note: *The Centers for Medicare and Medicaid Services recently published the following updated codes for respiratory therapy in the Federal Register. To access the pertinent section on the Internet, go to: http://www.access.gpo.gov/su_docs/fedreg/a011101c.html. Then page down to: Centers for Medicare & Medicaid Services, RULES, Medicare: Physician fee schedule (2002 CY); payment policies and relative value units five-year review and adjustments. Click on 55295-55344 {TEXT}, and then search for the term "Respiratory Therapy Codes" to locate the following section.*

Respiratory Therapy Codes

Respiratory therapists can deliver services incident to a physician's service or in a provider setting such as an outpatient hospital or a comprehensive outpatient rehabilitation facility. In the past, services delivered by respiratory therapists or other health professionals often have not been clearly described by the existing CPT codes. In order to clarify coding of these services, typically delivered by respiratory therapists, but at times delivered by other specially trained health professionals, we are instituting new G codes to describe these services. We developed three codes for use to describe services to improve respiratory function:

G0237 Therapeutic Procedures To Increase Strength or Endurance of Respiratory Muscles, Face-to-Face, One-on-One, Each 15 Minutes (Includes Monitoring).

This service is to be billed when the therapist works with the patient to perform specific exercises aimed at strengthening the main and accessory muscles of respiration. We have provided a specific value for this code based upon the time that a respiratory therapist, who we believe will be the typical professional providing this service, will spend performing this service and practice expenses crosswalked from other similar services. This code will have no physician work.

G0238 Therapeutic Procedures To Improve Respiratory Function, Other Than Ones Described by G0237, One-on-One, Face-to-Face, per 15 Minutes (Includes Monitoring)

G0239 Therapeutic Procedures To Improve Respiratory Function, Two or More Patients Treated During the Same Period, Face-to-Face (Includes Monitoring)

Codes G0237 and G0238 are billed in 15-minute increments. The method for "counting'' the 15 minutes will be consistent with the method for counting minutes in many of the 97000 series CPT codes (see PM-01-68 for details). These codes would describe activities, such as monitored exercise, that improve respiratory function. Both G0238 and G0239 would be carrier-priced. The carriers have the authority to request information about the specific nature of the services delivered. CPT codes G0237-G0239 may not be billed with codes G0110 and G0111, which are restricted to services in the National Emphysema Treatment Trial (NETT), since they represent the same services. These codes are designed to provide more specific information about the services being delivered. The availability of codes for services to improve respiratory function will make billing of CPT codes 97000-97799 inappropriate for professionals involved in treating respiratory conditions, unless these services are delivered by physical and occupational therapists and meet the other requirements for physical and occupational therapy services. We recognize that speech and language pathologists also occasionally treat patients to improve respiratory function as part of their treatment of speech and language disorders. Because the primary goal of these services is not to improve respiratory function, but to restore speech and communication, these services should be coded with 92507, "treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation, individual).'' (Source: Federal Register, vol. 66, no. 212, page 55311) ■

FYI . . .

Study highlights medication problems

A new study from the Agency for Healthcare Research and Quality (AHRQ) highlights the problem of inappropriate prescribing in elderly patients in the United States. According to the findings, which were published in a recent issue of *JAMA*, about one fifth of the approximately 32 million elderly Americans not living in nursing homes in 1996 used at least one or more of 33 prescription medicines considered potentially inappropriate. Nearly one million elderly used at least one of 11 medications which a panel of geriatric medicine and pharmacy experts advising the researchers agreed should always be avoided in the elderly. These 11 medications include long-acting benzodiazapines, sedative or hypnotic agents, long-acting oral hypoglycemics, analgesics, antiemetics, and gastrointestinal antispasmodics.

Missed opportunities

Investigators from the Minneapolis Veterans Affairs Medical Center believe health care providers are not making the most of their opportunities to give influenza and pneumococcal vaccinations to their elderly and high-risk patients. In a study published in the December 10 issue of the Archives of Internal Medicine, they found that of 1,874 doctors responding to a survey, approximately one in seven generalists and one in four subspecialists failed to very strongly recommend flu shots to their elderly patients. Since more than 60% of all elderly persons receive their flu shots at the doctor's office, they believe that doctors need to do a better job of making the most of the immunization opportunities that occur on a daily basis.

CT scan encourages smokers to kick the habit

Smokers who undergo low-dose helical computed tomographic (CT) scanning for lung cancer may be more motivated than others to quit smoking, say researchers at Memorial Sloan-Kettering Cancer Center and elsewhere. The study, which was published in the December issue of Preventive Medicine, found that 23% of smokers who had the scans reported quitting and another 27% reported decreased smoking.

The retrospective, self-reported study looked at 134 active smokers, all of whom were enrolled in the Early Lung Cancer Action Program (ELCAP). ELCAP screens high-risk active and former smokers with low-dose CT scanning, a procedure which preliminary evidence has shown to have increased sensitivity in the detection of early stage lung tumors. Individuals who enrolled in the study, which did not provide any formal smoking cessation advice or counseling, completed a brief telephone interview following their screening. Eighty-seven percent of enrollees stated that the screening process had been a major influence in increasing their motivation to quit smoking.

Twenty-three percent of the study participants reported that they had quit smoking following screening (markedly higher than the expected annual quit rate of about 7% estimated for the general population of smokers). Twenty-six percent reported decreased smoking and 48% reported no change in smoking status or rate, while just under 3% reported increased smoking after ELCAP enrollment. The median time between screening and quitting was six months. ■

Get It on the Web

Want the latest news from the section in the quickest manner possible? Then access the *Bulletin* on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would get it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html. You can either read the *Bulletin* online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the *Bulletin* over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section *Bulletin*, send an email to: mendoza@aarc.org. ■

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