Continuing Care & Rehabilitation Bulletin

March/April '02

American Association for Respiratory Care

Notes from the Chair

by Mary Hart, RRT, RCP

As you probably know, we are already planning for this year's AARC International Respiratory Congress. The AARC Program Committee met in January to review the proposals and consider topics and speakers for the 2002 meeting. Thanks to those of you who submitted ideas for topics and speakers related to continuing care and rehabilitation. As always, I think the meeting will have much to offer; I hope you will be able to join us this October 5-7 in Tampa.

Since reimbursement continues to be our primary area of concern, I am interested in hearing from pulmonary rehabilitation programs in states with a Local Medical Review Policy (LMRP). How has your program changed? Do you have any outcomes to share? Are you being reimbursed? I would like to collect this information and publish it in a future *Bulletin* article. If you have information to share, please contact me at the addresses/numbers listed on page 2. I look forward to hearing about your programs and sharing the information with leaders in the AARC. I am sure it will generate a lot of good discussion and many ideas.

Indeed, I always enjoy hearing about what you are doing in your programs, whether it's asthma disease management, support groups for seniors, asthma camps for children or pulmonary rehabilitation. It's important to our profession that we all network and share ideas. We can learn from the experiences, successes and challenges of others. One good way to do this is through articles in this *Bulletin*, I hope more of you will consider submitting your stories to our new editor, Cara Kraft, RRT, RCP. Cara's contact information also appears on page 2.

Lastly, it's not too early to begin thinking about nominations for this year's Practitioner of the Year. Nomination forms can be found on the AARC website.

Until next time, I hope you all have a safe and happy spring. ■

Upcoming Conferences

ATS 2002
98th International Conference
Atlanta, GA
May 17-22

AACVPR 2002
Charlotte, NC
September 26-29

AARC 2002
48th International Respiratory Congress
Tampa , FL
October 5-8 ■

The Patient Perspective

by Cara Kraft, RRT, RCP

I would like you to meet Frank Simoni, a World War II veteran and former Army sergeant. If you ask me or any one else who knows Frank, he looks at least a decade younger than his 80 years. And he gives some of the credit to exercise. Staying active has always been important to Frank but had been difficult for many, many years because of a variety of lung problems. Then his physician referred him to the Baylor Asthma and Pulmonary Rehabilitation Center (BAPRC).

Frank found out about the BAPRC summer water exercise program and enrolled. "Staying motivated to exercise regularly is tough, especially when it is so hot outside!" says Frank.

Now, if you have ever been to Dallas in August, you know "hot" doesn't just mean hot. It means SO HOT and HUMID that you can fry an egg on the sidewalk and take a bath without going into the tub. Anyone with breathing problems will have breathing problems in the summer in Dallas. That is, anyone except for a happy, wet group of individuals with COPD.

"Getting to exercise in the water was outstanding, not only because it was cool, but also because I was able to increase my upper body strength, have fun and even lose four pounds," says Frank. He adds, "I did have to wear oxygen at times, but I felt that I could exercise longer and easier in the water than on land!"

The best part is that Frank showed great improvement. Today, he is still "full of zip," now exercising on land with other graduates of our pulmonary rehabilitation programs.

Editor's Note: *Do you have a special patient you'd like to share with the section membership? If so, email your story to Cara Kraft at the address found on page 2 and we'll include it in an upcoming issue.* ■

FYI . . .

An apple a day . . .

A new study from British researchers finds that eating two or more apples per week and increasing intake of the essential metal selenium can protect against asthma in adults.

Their population-based, case-control study was undertaken to determine whether asthma is less common and less severe in adults who consume more dietary antioxidants. The study involved 1,471 individuals, including 607 asthma patients and 864 controls without asthma. Patients ranged in age from 16 to 50. Complete information about their usual diet was obtained through food frequency questionnaires.

The investigators found that asthma was less common in adults who consumed more apples and had a higher intake of selenium. There was also some evidence that asthma was less severe among some asthmatics who drank more red wine.

Dietary selenium is found in meats and other animal products and is necessary for the synthesis of an essential antioxidant enzyme. The study was published in the second November issue of the *American Journal of Respiratory and Critical Care Medicine*.

Continuing Care & Rehabilitation Bulletin

is published by the
American Association for Respiratory Care
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair
Mary Hart, RRT, RCP
Baylor Asthma and
Pulmonary Rehab Center
3504 Swiss Ave., Ste. 303
Dallas, TX 75204
(214) 820-3500
FAX (214) 841-9799
mc.hart@baylordallas.edu

Editor
Cara Kraft, RRT, RCP
(214) 820-9791
denkraft@yahoo.com

Are seniors up to the task?

The Centers for Medicare & Medicaid Services (CMS) wants to find out if senior citizens have what it takes to play an active role in the care of their health. Earlier this year, the federal agency proposed a survey of 16,000 households aimed at determining whether or not Medicare beneficiaries possess sufficient communications skills, motivation and basic knowledge of their own health care status necessary to participate in medically-related decisions.

Reports outline problems with Medicare+Choice

Two new reports from The Commonwealth Fund reveal that Medicare+Choice enrollees paid nearly 50% more in out-of-pocket costs for their health care in 2001 than they did in 1999, and those in poor health had even greater cost increases. Enrollees faced increased premiums and cost-sharing burdens as well as reduced coverage of prescription drugs during the three-year period.

Both reports point to weaknesses in the Medicare program that have a disproportionate impact on the sickest beneficiaries, who are also more likely to have low incomes. In "Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999-2001," investigators analyzed the effect of shrinking managed care benefits on enrollees by examining trends in estimated out-of-pocket costs from 1999 to 2001. Enrollees in poor health not only paid more out-of-pocket than those in good health, they also experienced the highest rate of growth in out-of-pocket costs — 62% — in the three-year period. In marked contrast, those in good health experienced a 43% increase in out-of-pocket expenses between 1999 and 2001. In 2001, enrollees in poor health spent about three times as much as those in good health ($3,578 vs. $1,195 annually).

Differences in out-of-pocket costs for those in poor health were also striking in prescription drug spending. In 2001, Medicare+Choice enrollees in poor health spent an average of $2,088 out-of-pocket for prescription drugs — a 56% increase from 1999. In comparison, those in good health spent an average of $158, a 47% increase from 1999.

Despite the increases in costs, Medicare+Choice plans are still a good value for beneficiaries when compared with Medigap supplemental insurance, says the report. Previous studies of costs for beneficiaries in traditional fee-for-service Medicare have estimated average out-of-pocket costs were $3,142, considerably higher than the 2001 average estimate of $1,438 for Medicare+Choice beneficiaries. However, the report concludes that limitations in the Medicare benefit package — especially the exclusion of drug coverage and the absence of a catastrophic limit on total out-of-pocket spending — will mean even greater cost burdens as market forces continue to pressure health plans to increase premiums and reduce benefits.

In the second report, "Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums," researchers analyzed trends in benefits and premiums from 1999 to 2001. They found that average monthly premiums went from $14.43 in 2000 to $22.94 in 2001, while the proportion of enrollees with prescription drug coverage fell from 78% in 2000 to 70% in 2001. Rural beneficiaries had fewer options, higher premiums, and less-generous coverage. Many Medicare+Choice enrollees also experienced increases in copayments in 2001: one-third were charged a copayment for an outpatient visit in 2001, compared with just 13% in 2000.

Health plans that left the Medicare market in 2001 were also more likely to have had lower enrollments, higher premiums (on average about twice as high) and less-generous benefit packages than those that remained in the market, indicating possible competition problems. The findings support previous studies concluding that plans withdrew from markets where they had failed to attract enrollees or where they faced larger competitors.

The enactment of the Benefits Improvement and Protection Act of 2000 (BIPA) has not shored up the Medicare+Choice program. Plans that remain have reduced benefits while slightly increasing premiums and cost-sharing. BIPA did not achieve its goals of reducing the geographical disparity in benefits between low- and high-payment counties, encouraging plans to reenter the program or rolling back reductions in benefits.

Only four plans that had dropped out of the market (covering about 13,000 enrollees) reentered as a result of BIPA. Most plans used the BIPA payment increase to enhance provider networks. Only 6% of enrollees were in managed care organizations that used the funds only to reduce premiums and/or cost-sharing.

The report concludes that while Medicare+Choice provides affordable supplemental coverage for some beneficiaries, it is not the only solution to Medicare's problems. Policymakers seeking to ensure that Medicare fulfills its mandate to provide affordable and equitable access to health care for older Americans cannot rely on Medicare+Choice, but must focus on reforming the entire benefit package.

"Increasing payments to health plans alone will not solve the problems of the Medicare program," says Karen Davis, president of The Commonwealth Fund. "We should consider modernizing Medicare's basic benefit package to meet the health care needs of our growing population of older Americans in the 21st century."

The Commonwealth Fund is a private foundation supporting independent research on health and social issues. ■

Study looks at patient perception of dyspnea

For most asthmatics, dyspnea is usually a sign that they are experiencing an asthma attack. In a new study published in CHEST, researchers found that patients with a low "perception of dyspnea," or POD — defined as the identification, evaluation and interpretation of discomfort of breathing — had significantly increased emergency room visits, hospitalization, near-fatal asthma and death as compared to those with normal or high POD.

"Preventing a life-threatening attack and certainly death is a major concern in the ongoing treatment of asthmatic patients," says Paltiel Weiner, MD, head of the department of Internal Medicine A at Hillel Yaffe Medical Center in Hadera, Israel, where the study was conducted. "POD is not readily measured in the treatment of asthmatics today, but with a simple test, we can identify patients with low POD; i.e. those with risk for fatal asthmatic attack. By carefully monitoring them, we can prevent death from asthma."

The study measured the POD in 113 patients with stable asthma, then related the measurements to the incidence of near fatal and fatal attacks within a two-year period. Results were compared with the PODs of 100 healthy matched subjects.

About 26% of the subjects had low POD, 59% had normal POD and 15% had high POD. Researchers found that asthmatics with low POD, even those without a history of near fatal asthma, were more likely to suffer life-threatening attacks. As compared to the other groups, low POD subjects tended to be older, female, long-time asthma sufferers and to have severe asthma.

"This study has important implications for our role as clinicians and for the prevention of death from asthma," says American College of Chest Physicians President Sidney S. Braman, MD, FCCP. "Impaired perception of dyspnea should be considered in all high risk asthmatics, and if found, such patients can be monitored more closely." ■

Depression may lower disease-fighting abilities in the elderly

Previous research has estimated that 15%-57% of older adults experience some form of chronic depression at some time during their later years. Now a new study from investigators at Johns Hopkins and Ohio State University suggests this may compromise their ability to fight off infections and cancers.

According to a report on the research in a recent issue of the *Journal of Abnormal Psychology*, even chronic, sub-clinical mild depression may suppress an older person's immune system. The 18-month prospective study involved 22 older adults who suffered from chronic depression and 56 who didn't. Forty of the participants were caring for spouses with dementia and 38 others were not caregivers. The non-depressed group included 25 caregivers and 31 non-caregivers, while the depressed group included 15 caregivers and seven non-caregivers. Females accounted for 64% in both the depressed and non-depressed groups. The depressed and non-depressed groups were compared for their ability to generate enough white blood cells to fight off an infectious agent.

No significant difference was found for risk of depression according to marital status, education or income levels. All the depressed participants reported clinically relevant depressive symptoms at the beginning of the study and 18 months later, but fewer than half of these participants met formal diagnostic criteria for depression.

This information, along with previous research findings, suggests that depressive symptoms can exacerbate and accelerate the immunological declines that typically accompany aging. "Changes in the immune response, including dysregulation of the proinflammatory cytokines and endocrine functions has been associated with depression as well as aging, especially in adults over 60," say the authors. They also note that other factors in addition to aging can have a role in lowering older adults' immunity. For example, lack of social support has been reported as a risk factor for depression.

The researchers postulate that age-related changes in cell-mediated immunity caused by mild depression is linked to the increased risk and severity of infections and cancer found in older adults. They believe these findings suggest that detection and treatment of even mild depression may be crucial for better health in older adults, since the prevalence of mild depression is high in this age group. ■

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. ■

Continuing Care Section Survey

We want to provide you with the information and service you desire for your specialty section membership. Please take a minute to fill out this small survey and fax it back to: 972-484-6010

Why did you join this specialty section?

___ To receive information about my specialty area of practice.
___ To participate in designing programs and information about my specialty.
___ To network with and learn from others working in my specialty.

How many times a year do you want to receive a newsletter?

___ 6 times a year
___ 4 times a year
___ 2 times a year
___ No opinion

Would you prefer to receive this newsletter by reading it on the website?

___ Yes
___ No
___ No opinion

Would you rather receive a printed newsletter or more timely and more frequent email updates of news and information?

___ Newsletter
___ Email
___ No opinion ■

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

Non-Profit Org.
U.S. Postage
PAID
Permit No. 7607
Dallas, TX