



Continuing Care & Rehabilitation

May/June '00

Bulletin

Notes from the Chair

by Trina M. Limberg, BS, RRT, FAACVPR

The most important event that has occurred in the continuing care and rehabilitation area since our last issue is the draft of a template for coverage of pulmonary rehab across the U.S. A committee of medical directors from the various fiscal intermediaries, which contract with the Health Care Financing Administration for Medicare business, put forth a policy template that could be voluntarily used by any of the fiscal intermediaries in the nation.

As we all know, there is no national policy for pulmonary rehab. This has led to inconsistent coverage – or no coverage at all – for pulmonary rehabilitation services for Medicare beneficiaries in some geographical regions. The medical directors on the committee conducted three conference calls to discuss and debate the contents of the draft. The conference calls were arranged and facilitated by Phil Porte and Pat Booth from GRQ and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

Phil and Pat also compiled the comments of appointed representatives from the AARC, AACVPR, American College of Chest Physicians, American Thoracic Society, and National Association of Medical Directors of Respiratory Care into a document and submitted it to the committee in mid-March. The next step is to receive feedback from the committee. As of the first week in April, this had not occurred.

Once it is finalized, the template will be posted on the Internet for public comment for a period of 45 days. However, a specific date for posting to the web has yet to be announced. But we do know that the Fev₁ requirement is likely to be set at less than 60% of predicted. When we

learn of the posting date and web site address, an e-mail announcement will be posted on the section list-serve.

On another note, we are still looking for nominations for our section's Specialty Practitioner of the Year. Please take the time to nominate a colleague who you feel goes above and beyond the call of duty to support his or her profession and patients. (You know who we're talking about!) For your convenience, a nomination form appears in this issue. The AARC would like to recognize an outstanding pulmonary rehabilitation clinician at the Annual Respiratory Congress in October.

As always, if you have comments about the *Bulletin* or would like to contribute to it, please contact me. We are always in need of article submissions and will do everything we can to assist you in contributing.

Resources Available

The California Thoracic Society (CTS) has several resources that can assist pulmonary rehab professionals in their jobs. The newest include:

- Pulmonary Rehabilitation HMO and Insurance Approval Strategies
- Pulmonary Rehabilitation Coordinator (a companion piece to the American Thoracic Society Pulmonary Rehabilitation Statement)

To find out more about these and other position statements, e-mail a request for information to the CTS at ctslung@aol.com. You may also contact the CTS by phone at (714) 730-1944 or Fax at (714) 730-4057. A number of lung disease prevention and patient care items can also be ordered by calling 1-800-LUNG-USA. n

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Specialty Practitioner of the Year

American Association for Respiratory Care

Pulmonary Rehabilitation Administration: How Many Hats Do We Wear?

How many “hats” do those of us in pulmonary rehab administration wear? More than most of us probably think! The following is a listing of the different roles and functions we are

often expected to carry out as part of our jobs. Does your current job description reflect these functions? Should it?

1. Clinician

- Screening referrals and evaluating potential candidates
- Completing necessary documentation
- Communicating with referring physicians
- Securing funding (protecting reimbursement)
- Scheduling necessary tests
- Acting as a resource for colleagues
- Facilitating weekly clinical team meetings
- Teaching and training chronically ill patients

2. Program Director

- Supervising staff, providing feedback about performance, and completing evaluations
- Drafting staffing and performing time keeping tasks
- Working with the medical director, keeping him/her informed about the business, and assisting with projects when needed
- Working with administration to set prices
- Cultivating and maintaining a healthy relationship with billing department representatives
- Maintaining policies and procedures
- Supervising and taking responsibility for pulmonary rehab ser-

vices

- Facilitating meetings to establish goals and objectives
- Planning, facilitating, and recording staff meetings
- Supporting hospital policies (i.e., JCAHO requirements, safety plans)
- Reviewing and authorizing expenses and preparing an annual budget
- Marketing the program internally and externally
- Developing and modifying job descriptions; working with human resource representatives
- Screening job applicants and hires
- Attending supervisor and hospital meetings to stay informed
- Tracking referral and program activity levels
- Working within the system to get what the program needs (i.e., new equipment or supplies)
- Staying informed regarding Medicare and health care issues
- Growing the business (i.e., HMO contracts, etc.)

3. Leader

- Continually working on leadership skills
- Striving to set an example for others
- Working at the art of delegation
- Remaining active with professional organizations. n

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UCSD Pulmonary Rehabilitation Scope of Services

Editor's Note: The following is a scope of services document developed by our program at the University of California at San Diego. I offer it here for any program in need of such a document. Please feel free to use and/or adapt it to your particular pulmonary rehab program or setting.

SECTION 1. PURPOSE

To establish guidelines for defining the various programs included within pulmonary rehabilitation/conditioning services.

“Scope of Services” continued on page 3

“Scope of Services” continued from page 2

SECTION 2. DEFINITIONS

The American College of Chest Physicians (ACCP) and the American Thoracic Society (ATS) have both accepted the following definition of Pulmonary Rehabilitation:

“Pulmonary Rehabilitation may be defined as an art of medical practice wherein an individually tailored multidisciplinary program is formulated which, through accurate diagnosis, therapy, emotional support, and education, stabilizes or reverses both the physio and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by his pulmonary handicap and overall life situation.” – From the ATS Position Statement on Pulmonary Rehabilitation.

SECTION 3. SERVICES

For reference, pulmonary rehabilitation services will be described in five categories: (1) Clinical Rehab Program, (2) Medical/Surgical Rehab Services, (3) Individual Teaching, (4) NETT Services, and (5) After Care and Support Services.

3.1.1 CLINICAL REHAB PROGRAM

This program is designed for ambulatory patients with moderate to severe chronic lung disease. The program includes a comprehensive evaluation prior to training to assess appropriateness of care and develop individual training goals. Candidates for service are limited by dyspnea, and possibly, fear of dyspnea. The current treatment plan, the patient’s level of understanding with medications, his disease, and his symptoms are also assessed. The goals of the program are to: (1) Reduce symptoms of breathlessness, coughing, sputum production, and panic episodes; (2) Reduce the use of acute care resources by improving the patient’s

ability to self-assess and report symptoms early on to the primary care physician; (3) Increase functional ability to do self-care activities; (4) Increase ability to perform activities of daily living; and (5) Increase exercise tolerance.

The major components of the sessions include: (1) Skills training in various respiratory and self care techniques; (2) Supervised exercise sessions with breathing retraining reinforcement and monitoring of vitals and oxygen saturations with implementation of home exercise programs; and (3) Emotional support through weekly group support sessions. The exercise sessions and educational/training components are designed to assist the patient and family in becoming familiar and comfortable with rehabilitation techniques and able to implement these techniques into their everyday lives. Once patients have completed the program they are encouraged to attend free monthly education/training sessions to support learned behaviors.

3.1.2 MEDICAL/SURGICAL REHAB SERVICES

The primary goal of these services is to restore the patient to the highest possible functional ability with supervised exercise, monitoring oxygen saturations and symptom changes during the waiting period (period before transplantation surgery) and following surgery and reporting any clinically notable changes to the pulmonary physician. A pre-rehab evaluation is required to establish appropriateness of care and to develop an individual rehab care plan. Transplant rehab services are delivered before and after transplantation surgery.

Candidates for lung transplantation generally have a 12-18 month life expectancy. During the waiting period, respiratory symptoms (i.e., dyspnea, respiratory infections) may progress, oxygenation may worsen, and functional abilities may deteriorate. Monitoring and exercising patients prior to surgery reinforces

learned behaviors and promotes conditioning to the best possible level preoperatively.

The philosophy of the transplant team has been that pulmonary rehab before surgery helps patients to prepare physically and emotionally and improves the recovery rate postoperatively. It is believed that rehab intervention often shortens the length of stay. In the postoperative phase, patients are monitored for infection and rejection. They are exercised and supervised for up to 12 weeks. Post-op symptoms change, and patients are often limited by muscle weakness and fatigue as opposed to the dyspnea they experienced preoperatively. Comprehensive evaluations are offered to the transplant team as a resource for patients who are listed and reside out of the San Diego area. The rehab team can offer information about programs in other geographical regions upon evaluation.

3.1.3 NATIONAL EMPHYSEMA TREATMENT TRIAL

These services are offered in support of a NHLBI and HCFA contract to research lung volume reduction and maximal medical management in moderate to severe emphysema Medicare beneficiaries. This multi-center clinical trial is expected to run from November 1997 through 2002. Over 2500 emphysema patients are expected to enroll and be randomly assigned to either surgery or maximal medical management.

3.1.4 INDIVIDUAL TEACHING/OTHER

These services are reserved for use on an as needed basis for patients whose needs differ from the goals of other services and programs. The training goals and frequency of visits may vary depending upon the needs of the patient.

“Scope of Service” continued on page 4

"Scope of Service" continued from page 3

3.1.5 AFTER CARE AND SUPPORT SERVICES

After care can be described as care delivered after completion of rehabilitative services. We offer monthly

alumni training sessions for patients and their families in an effort to support learned self-care behaviors and to continue training and education. Weekly exercise maintenance sessions are offered to patients who indicate a need for continued support. Newsletters are distributed at a mini-

um of twice a year to provide information and encourage patients and their families to continue to practice healthy living techniques. Two annual social functions are offered: the Walk for Wellness and the Holiday Gathering. n

FYI . . .

Statement urges office spirometry

A just-released consensus statement calls for more widespread use of office spirometry to detect chronic obstructive pulmonary disease (COPD) in its most treatable stage, particularly in smokers over 45 years old.

The statement was released by the National Lung Health Education Program (NLHEP) in the peer-reviewed journal, CHEST in April and in RESPIRATORY CARE in May. The NLHEP is sponsored by several medical professional groups, including the AARC and the American College of Chest Physicians (ACCP), which publishes CHEST.

According to the statement, COPD is currently the fourth leading cause of death in the United States. Of the top ten causes of death, only COPD mortality continues to rise, increasing by 22% in the last decade. Its prevalence is now rising faster in women than men. Every year it causes 100,000 deaths and 550,000 hospitalizations, as well as \$13 billion in medical costs.

The consensus statement notes that the widely accepted definition of COPD progression is an abnormal rate of decline in lung function. Prevalence rates of low function increase with age and are highest in current smokers, intermediate in former smokers, and lowest in never smokers. Data from the multi-center Lung Health Study (LHS) showed that an intense smoking cessation effort can lead to a quit rate of 35% in asymptomatic smokers and that the rate of decline of FEV₁ following cessation is very similar to that seen in healthy nonsmokers.

The LHS was the first study to demonstrate prospectively that early intervention in smokers identified to be at risk of COPD could modify the natural history of the disease. However, primary

care physicians rarely use spirometry to detect COPD early in smokers.

In an effort to increase the use of spirometry among primary care physicians, the consensus statement calls for the widespread use of the new office spirometers, which differ somewhat in specifications from the more traditional spirometers used for diagnosis. The new office spirometers are less expensive, smaller in size, require less effort to perform the test, have improved ease of calibration, and have an improved quality assurance program. While traditional diagnostic spirometers currently cost about \$2,000 each and require about \$10 of health care professional time and disposable supplies per test, office spirometers will cost less than \$800 and require less testing time.

The consensus statement called on primary physicians to use office spirometry on all patients 45 or older who smoke. Discussion of the spirometry results with smokers, they add, should be accompanied by strong advice to quit smoking and referral to local smoking cessation resources. Office spirometry was also recommended for patients with respiratory symptoms such as chronic cough, sputum production, wheezing, or dyspnea on exertion in order to detect COPD or asthma. (CHEST, 4/00)

Blood Pressure numbers escape seniors

Nearly half of all Americans aged 50-plus do not know their own systolic and diastolic blood pressure numbers, according to a survey conducted by The National Council on the Aging (NCOA). The survey of 1500 Americans over the age of 50 also found that people in this group, who are at great risk for complications from uncontrolled blood pres-

sure, do not understand the factors that contribute to high blood pressure or the dangers of untreated high blood pressure.

More than two out of three of those surveyed had not discussed the physical consequences of high blood pressure with a doctor or nurse in the past 12 months, and only 27% knew the importance of the systolic number as an indicator of high blood pressure. Alarming, one third of those affected were unaware that they had high blood pressure, and only 27% were being treated to the recommended goal of 140/90mmHg as identified by the Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. (NCOA)

Alzheimer's disease and folic acid

Folic acid, also called folate, has been shown to reduce the risk of disease throughout the lifespan, preventing birth defects; warding off coronary heart disease, stroke, peripheral vascular disease, and atherosclerosis; and possibly reducing the risk of breast and colon cancer, dementia, and Down syndrome. Now researchers believe it may also help to prevent the brain degeneration that causes Alzheimer's disease.

In a study of elderly Catholic nuns, low serum folate levels in blood samples collected in 1993 were strongly associated with atrophy of the cerebral cortex in women who had a significant number of Alzheimer lesions in the brain when they died a few years later.

The Nun Study was completed before folic acid fortification became mandatory in the United States, and investigators say it remains to be seen whether folic acid fortification will result in a lower incidence of Alzheimer's disease. (ASNS/ASCN) n

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