



Continuing Care & Rehabilitation

May/June '99

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FYI...

American Association for Respiratory Care

Pulmonary Rehabilitation Update

by Trina M. Limberg, BS, RRT

The section continues to be involved in a number of areas critical to pulmonary rehabilitation programs nationwide. Here is a brief status report on the programs we are either working on or tracking for your benefit:

National Emphysema Treatment Trial: All centers continue to enroll patients. Patient recruitment is the main focus. There are approximately 145 rehabilitation programs certified as satellites. Over 1,100 patients have been screened, with more than 300 being randomized to either maximal medical management or lung volume reduction surgery. All patients receive pulmonary rehabilitation treatment.

Program certification by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR): A total of 290 applications were submitted for review. Three were withdrawn. Results included -
Approved applications.....156
Denied applications.....10
Applicants given additional time to provide information.....101
Applications not received from State Review Committees.....23
Total.....290

As of this writing in late spring, a new application filing date has yet to be announced. The implementation and review process is being studied for improvements. AACVPR remains dedicated to offering the membership this requested service.

National policy on pulmonary rehabilitation: The AACVPR Task Force Committee has developed and submitted a recommended policy to HCFA, but HCFA has yet to

respond. AACVPR and the AARC are continuing to hold HCFA to a decision. There are still some states, such as Wyoming and North Dakota, that are not able to obtain coverage from their Medicare carriers. Access to vital restorative treatment is a priority.

Section listserve for members: Although this service has been available since December, the activity remains low. If you have questions to ask your peers or information to share, you might want to consider this alternative. Please e-mail us if you have suggestions or experiences you think we should know about. You can access the listserve by visiting the AARC web site (www.aarc.org) and clicking on "Members Only," then on "Continuing Care & Rehabilitation Section" and following the directions to sign up. ■

Talk Shop Online in Real Time!

- Get to know other professionals from across the country and around the globe
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Don't miss out on this great new feature!

http://www.aarc.org/members_area/chat

Are You Getting Any New Business? Do You Have a Presentation for Payers and Health Care Professionals? Well, You'd Better Get One!

by *Trina M. Limberg, BS, RRT*

To ensure that the patients who could benefit from pulmonary rehab have access to such care, pulmonary rehabilitation programs need to equip themselves with a proactive presentation designed to

convince payers and others to send patients to their programs. The following outline can help you get started. Overheads can be prepared in Microsoft Office's PowerPoint Program. If you have access to a color printer, you can further enhance the look of your materials. Remember, as you are talking to managed care medical directors, nurse practitioners, or primary care physicians, it is important to educate them about your services because most are unfamiliar with rehab and the many proven clinical benefits it can provide.

Pulmonary Rehabilitation Restorative and Preventative Treatment for Chronic Lung Disease Patients

What is Pulmonary Rehabilitation?

- American College of Chest Physicians:

"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."

Program Contents

- Assessment
- Education/skills training
- Supervised exercise conditioning
- Home exercise development and reinforcement
- Psychosocial support

Patient Selection

- Diagnosis of chronic lung disease
- Symptomatic
- Motivated with a desire to improve health status
- Stable (no recent acute episodes)
- Under the care of a physician

- No other interfering or unstable conditions

Patient Evaluation

- Interview
- Medical evaluation
- Diagnostic testing
PFT, exercise tests, ABGs/oximetry
- Psychosocial assessment
Depression and anxiety are common
- Goal setting

Treatment Goals Should:

- Be individualized to the patient's needs
- Include a reconditioning and strengthening element
- Be modified when needed
- Be geared toward self-care enhancement
- Include others (e.g., family and primary physicians)

Program Structure

Describe the number and length of sessions

Proven Clinical Effectiveness

- Reduced:
Dyspnea
Muscle fatigue
Depression, fear, and anxiety
- Improvements in:
Quality of life
Knowledge
Physical activity
Independence

(Cite a few references and have them on hand for attendees to review.)

Cost Effectiveness

- Reduction in hospital admissions:
Several studies demonstrate this outcome. (Be prepared to provide them upon request.)
- Reduced length of stay

Why Refer to Pulmonary Rehabilitation Services?

- Substantial proven effectiveness
- American Thoracic Society: Standard of Care
- Recognition and inclusion as standard treatment in the National

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Emphysema Treatment Trial sponsored by HCFA and NHLBI

- High patient satisfaction ratings

Making a Referral

- Initiated by a patient inquiry call or by direct referral from a health care provider
- Contact the program at: list your phone number

About the Staff

- Medical director
- Respiratory therapists
- Physical therapists
- Social workers
- Exercise specialists

Working with the Primary Care Physician

- Patient evaluations help determine need, establishing appropriate care
- Letters inform primary care physicians of treatment plan

- Direct contact when needed
- Discharge summary of progress and continuing care options
- Utilization review assistance

Pulmonary Rehabilitation Helps Patients Know More, Do More, Feel Better, and Cost Less!!

This outline is only one option. But I have shared it with you to encourage you to expand your skills to include contacting payers and offering presentations on your services. You may want to start internally with your own respiratory care department. Acute and critical care RTs are often unfamiliar with pulmonary rehabilitation services that go beyond pursed-lip breathing, but they are still sources for referrals – and should be making them to your program.

In the managed care arena you may want to consider contacting a plan to arrange a presentation. At

UCSD we are fortunate to work with one of the largest health plans in California. When we contacted this plan, it did not have a pulmonary rehab program to which it referred its members. We submitted a proposal to contract these services to the plan, and we also arranged to make a few presentations to plan administrators. The response and acceptance was not immediate, but in the long run it resulted in the addition of a referral population that we previously could not service or obtain access to.

Program coordinators must accept the burden of educating health care providers about the value and benefits of pulmonary rehabilitation treatment to patients and their families. Developing presentations and materials can help to further the education of these providers and increase referrals. ■

Maintenance Exercise for Pulmonary Patients

by Chris Garvey, RN, MPA

Retained physical function and symptom management are primary reasons to offer follow-up or maintenance exercise to chronic lung disease patients. Functional abilities, disease severity, and symptoms are expected to worsen over time. Although disease progression is quite variable, most pulmonary rehabilitation professionals recognize a clinical need for continued monitoring and guidance following completion of initial restorative rehabilitation treatment.

A primary value of offering maintenance exercise programs is the opportunity to monitor symptoms, modify exercise workloads, and adjust oxygen therapy prescriptions. Pulmonary rehabilitation professionals can continue to reinforce learned behaviors, including early symptom recognition and reporting to the primary care physician. Maintenance sessions also offer patients and their families social support.

Health professionals are concerned that the physical benefits of pulmonary rehab will decline if routine exercise is not continued.

Long-term studies evaluating exercise tolerance are fewer in number than studies evaluating training achievement immediately post rehabilitation intervention. More studies are needed to demonstrate clinical benefits and educate payers. At the present time, Medicare and most insurers do not cover maintenance sessions, which means that patients must self-pay.

Individualized maintenance exercise programs often include components of aerobic, endurance, strength, and flexibility training. These programs typically provide clinical monitoring, supervision, and communication with the patient's physician as well. Many programs provide a progress note to the patient's physician, which may include:

- A summary of exercise achievements
- Clinical findings
- Compliance concerns
- Changes in symptoms
- Exercise tolerance
- Oxygen saturation and oxygen needs
- Weight changes

- Mental status changes

A secondary benefit of maintenance exercise programs is the supportive environment they create in which staff can foster compliance with therapies. Staff provide enthusiastic, supportive encouragement, interesting exercise options, and creative distractions to combat the anxiety and boredom associated with routine exercise. Distractions from unpleasant dyspnea and fatigue include conversation, varying exercise routines, TV, and music. Many maintenance exercise programs include forms of group, social, psychological, and educational support. Some groups also develop relationships outside of the exercise sessions, arranging social outings such as race track events, cruises, luncheons, or picnics.

In an effort to learn about the type of maintenance services being offered in California, an informal survey was created and distributed to several programs. Twenty-one programs responded. The results are summarized in the table on page 4.

“Maintenance Exercise” continued on page 4

| Survey Questions | Yes | No |
|--|--------------|----------------|
| Do you have a maintenance program? | 18 | 3 |
| Are you hospital based? | 15 | 3 |
| Do you offer resistance training? | 15 | 2 |
| Do you offer circuit training? | 6 | 10 |
| Is there regular communication with MD? | 12 | 5 |
| Can spouse/partner join maintenance? | 8 | 10 |
| Is there a limit to the program length? | | 20 |
| | Range | Average |
| Hours per day classes are offered | 1 to 12.5 | 3.5/day |
| Days per week classes are offered | 2 to 6 | 3/wk |
| Length of exercise session | 1 to open | 1 |
| Number of treadmill(s) | 2 to 10 | 4 |
| Number of bike(s) | 0 to 10 | 5 |
| What is the charge for maintenance exercise? | | \$42/mo |
| What is the staff-to-patient ratio? | 1 to 3-13 | 1 to 6.5 |

Most programs are hospital based and offer classes for 1-4 hours per day, 2-6 days per week. Treadmills and stationary bikes are used for training. Some programs use additional equipment, such as arm ergometers, wall pulleys, step-type machines, Theraband®, rowing machines, Nautilus®, circuit weights, Nordictac®, and recumbent bikes. Most offer strength or resistance training, and many offer circuit training. Charges vary from free or donation, to \$3-\$8.50 per visit, or \$25-\$133 per month. Patients pay in the department, pay the hospital cashier, or are billed by the hospital billing department. Most programs communicate with

the patient's physician, generally by progress note when changes in clinical observations indicate. A few programs extend the option to spouses or partners; charges are generally the same as for the patient. Professional credentials of staff are typically RCP, RN, exercise physiologist, PT, and/or PTA. Staff ratios vary from 1 (and up to 2) staff to 3-20 patients. Most programs do not formally measure productivity; however, if programs are billing through their hospital billing department, visits or sessions may be tracked. Tracking productivity related to maintenance session staffing should be a priority for rehabilitation coordinators, as fiscal

solvency and accountability remain important.

Some programs encourage patients to be responsible by having them log their own workloads; others use creative themes for different days, e.g., "Theraband® Thursdays." Some program coordinators offer the first session free to encourage participation. Some concerns expressed by program staff include not having enough classes and difficulty in making the program cost effective. Overall, maintenance exercise programs provide an important way for pulmonary rehabilitation graduates to maintain improvement in strength and function. ■

FYI . . .

Rehabilitation plus surgery improves quality of life

Combining pulmonary rehabilitation with bilateral lung volume reduction surgery (LVRS) can lead to improved quality of life for patients with severe emphysema, say researchers from Brigham and Women's Hospital in Boston who administered a health-related quality of life medical outcomes questionnaire at three points during a study to 19 patients with severe

emphysema who were scheduled for pulmonary rehabilitation prior to LVRS.

Patients were surveyed three months prior to the rehabilitation phase to establish baseline data, following rehab and prior to surgery on one lung; and then six months after surgery on the second lung. The measurements focused on quality of life areas such as physical functioning, role limitations, body pain, general health, vitality, social functioning, emotional role, and

mental health.

Researchers found that a combination of pulmonary rehabilitation and LVRS resulted in statistically significant progress in four of the eight areas measured, including physical functioning, role limitations due to physical problems, social functioning, and vitality. But while both pulmonary rehabilitation and LVRS contributed to the overall advances, each did so in a distinct

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manner. For example, pulmonary rehabilitation accounted for more than 90% of the improvement in role limitation due to physical problems while LVRS accounted for virtually all of the progress in physical functioning and vitality and for most of the gains in social functioning. (CHEST, 2/99)

Asthma education pays off

Asthma education results in fewer hospitalizations, reduced urgent care visits, lower oral steroid use, enhanced self-management skills, and improved quality of life, say investigators from Wilford Hall USAF Medical Center.

In their study, asthmatic patients presenting to an emergency department or outpatient clinic received individualized education in an allergy clinic in accordance with the NIH National Asthma Education and Prevention Program Guidelines. Prior to initial and follow-up sessions, a questionnaire was administered and metered dose inhaler technique observed.

According to the findings:

- Hospitalizations decreased by 55%
- Oral steroid courses decreased by 62%
- Emergency department visits decreased by 60%
- Urgent care visits decreased by 54%

The study was presented at a recent meeting of the American Academy of Allergy, Asthma and Immunology. (American Academy of Allergy, Asthma and Immunology)

Combination MDI better for COPDers

University of Arizona researchers have found that a metered dose inhaler combining ipratropium bromide and albuterol sulfate is more effective in the treatment of COPD patients than an MDI containing albuterol alone.

They compared the two techniques in a group of 357 patients enrolled at 17 centers, half of which received the combination therapy and half of which received albuterol alone. Those using the combination MDI exhibited a mean improvement in FEV1 over a six-hour period on day one and on day 29 of the 29-day trial of at least 15% over baseline, and the overall response to the combined therapy was considered superior to albuterol alone, particularly in the first four hours of treatment.

In addition, more than twice as many patients in the albuterol alone group developed exacerbations requiring further treatment than those in the combination group. Those in the combination group had fewer hospital admissions and emergency room visits than those in the albuterol alone group.

About a quarter of the patients on the combined therapy reported adverse side effects or worsening of the preexisting condition, compared with about a third of those in the albuterol alone group. The most commonly reported side effects were lower respiratory tract disorders. (Arch Intern Med 1999;159:156-160)

New OSA guidelines issued

Noting that about 40% of obstructive sleep apnea patients have difficulty using CPAP for long periods of time and that BiPAP is often better tolerated, researchers have published new guidelines on the various forms of positive airway pressure (PAP) available for the treatment of OSA. The guidelines, which appeared in the March issue of *Chest*, offer advice on:

- Which patients should undergo diagnostic techniques such as polysomnography
- What criteria should be met to appropriately define apnea and hypoxia
- What conditions warrant treatment with which PAP therapy
- What efforts should be undertaken to help patients adhere to their treatment

The guidelines were based on peer-reviewed studies and widely accepted clinical practice and should serve as an interim guide until results from research such as the Sleep Heart Health Study and various other evidence outcome studies can provide the data upon which to develop more formal consensus recommendations.

Gum disease linked to chronic lung disease

Chronic lung disease is associated with bacteria from infected gums, say researchers from the University at Buffalo School of Dental Medicine.

In a study involving 13,792 subjects from the Third National Health and Nutrition Examination Survey, researchers found that persons with chronic lung condition had more gum detachment than those with no lung disease. There also was a direct correlation between the amount of detachment and lung-disease risk. Subject with gum detachment that exceeded 2 mm had a 40 percent greater risk of developing lung disease than those with attachment loss of less than 2 mm.

The study was presented during a meeting of the American Association of Dental Research and the International Association of Dental Research.

1999 Summer Forum

The AARC will hold its annual Summer Forum July 16-18 in Phoenix, AZ. This outstanding meeting promises to provide a wealth of information for practitioners holding positions in management and education and should be of interest to anyone wanting up-to-the-minute information about the profession and where it is headed as we prepare to enter the new millennium.

For more information about the Forum and how you can attend this important meeting, see your April issue of *AARC Times* or visit the AARC's web site at www.aarc.org. ■

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