"Food for Thought" continued from page 3

- Unclear $O_2$ prescription
- Inability to effectively mobilize secretions
- At risk for smoking relapse
- Inability to perform light to moderate ADLs
- Lacks self-assessment skills
- Poor understanding of $O_2$ use and purpose

**Establishing plan objectives**

The first step in establishing plan objectives is to identify the areas in which the patient may improve. These may include:

- Activity/exercise/ADL performance
- Symptom management
- Coping/QOL — the ability to make life adjustments
- Improve knowledge/understanding of disease

The therapist will also want to:

- Identify specific areas within each larger objective (such as, "patient will bathe without assistance" in the ADL performance objective) for improvement.
- Communicate plan objectives to patient/family
- Make patient teaching purpose-based
- Get input from other disciplines, such as exercise, mental health, nutritionists, MD, RN

**Stating plan objectives**

In order to ensure proper documentation of the treatment plan, the therapist must clearly state plan objectives. In terms of activity, these would include:

- Improve ability to perform ADLs
- Recommend tests to establish exercise tolerance and limitations
- Develop an exercise prescription
- **Tx Goal:** Improve exercise tolerance, endurance, and strength
- **Plan:** Supervise exercise U/L, extremity, knowledge/skills

In the area of patient knowledge and skills, the therapist will work on:

- Self-assessment, symptom management
- Administer medications correctly
- Understand and use $O_2$ as prescribed
- Mastery of breathing techniques
- Knowledge of disease process and treatment
- Knows/Does: An independent home exercise program

Symptom management goals include:

- Identify signs/symptoms of infection
- Articulate/contact physician within 2 days
- Master breathing techniques
- Uses judgment to adjust medication; MDI use and activities based on need
- Learns/uses panic control/relaxation techniques

Quality of life objectives include:

- Decrease fear with information and skill
- Improve perception of abilities with positive exercise experiences
- Involve social support members
- Help patients to feel better by understanding what's happened to their bodies; help them to regain self-confidence

**Monitoring progress**

Lastly, the plan must include a means by which the therapist can modify the patient treatment plan and goals as the treatment progresses. The major areas of concern include the patient's:

- Activity
- Understanding
- Symptom management
- Psychosocial needs and development ■

# Resource Panel Update: *We Need You!*

We will be mailing an updated version of our Resource Panel Directory with our January-February issue and would like to include as many new names as possible. If you are interested in volunteering to serve as a resource for your peers in the section — or if you need to update your contact information from a previous listing — please fill out the following form and send it to: Kelli Hagen, AARC, 11030 Ables Lane, Dallas, TX 75229. All information received by December 20 will be included in the new directory.

*Name* _____

*Address* _____

*Phone* _____ *FAX* _____

*e-mail* _____

Areas of Expertise: (Check all that apply)

__*Pediatric Cardiopulmonary Rehab*
__*Patient Education/Compliance*
__*Documentation/Reimbursement*
__*Discharge Planning*
__*Pre- and Post-Lung Reduction Surgery*
__*Smoking Cessation*
__*Pulmonary Development/Organization*
__*Home Care/Home Ventilation*
__*Travel Consultants*

*Other Area(s) of Expertise* _____

_____

Continuing Care & Rehabilitation Bulletin

Nov./Dec. '99



American Association for Respiratory Care

# Notes from the Chair

*by Trina M. Limberg, BS, RRT, FAACV*

It hardly seems possible, but as I write this column in mid-October, most of the year is already behind us and the AARC International Respiratory Congress is just around the corner. I hope to see all of you at the section business meeting, but if you're not able to attend this year because you lack the budget to do so, rest assured you're not alone. All of the professional organization meetings that I have attended this past year have experienced a reduction in meeting attendance, and their organizations have reported a problem with decreased membership. As you might expect, this can create budget shortfalls, as most organizations generate revenue from membership and hosting educational meetings and seminars. So when you get your AARC renewal notice this year (trust me, it will appear in your mailbox very soon), please remember the value of being an active member of your professional association.

This year, we have been asked by Program Committee Chair Mari Jones to submit topics for the AARC's millennium conference by mid-December. I need your ideas! Please e-mail or phone me with any topics that you would like to see presented during next year's conference.

As a point of interest, the AARC is in the process of transitioning to a different structure for its Board of Directors (BOD) that was approved by Bylaws changes earlier this year. For the past several months, a special task force has been working on the transition. The BOD will, in the near future, include the chairs of those specialty sections with 1,000 members or more. Unfortunately, the Continuing Care and Rehabilitation Section does not currently meet that requirement. If we can grow our membership to the 1,000-member level, however, we will be able to take advantage of this representation in the future.

There are also plans in the works to change the way section chairs are selected. Currently, chairs are appointed by the president, but soon they will be elected by the section membership. That means all of you will be involved in the process. How? By submitting nominations for the chair position and voting for your candidate of choice. I hope some of you will consider the opportunity to serve as a way of enhancing your professional development.

I will continue to serve as your section chair throughout the year 2000. As most of you know, the *Bulletin* comes out six times a year. I would like to start the year off strong with submissions from you. If you have information to share or a success story to report, please write to me. I would be more than happy to discuss any possible ideas you might have. I look forward to hearing from and getting to know more of you in the coming year. ■

# The Importance of Being Involved

***by Debbie Koehl, BA, RRT, manager, pulmonary rehabilitation program, Clarian Health-Methodist***

Since being asked to contribute to the *Bulletin*, I've spent hours wondering what to write about. I don't necessarily feel like I am an "expert" in our field of pulmonary rehabilitation, and I wasn't sure if there was really anything that I do on a daily basis that would be interesting to my fellow members of the section. As a manager of a rehab program, I sometimes feel like all I do is check paperwork, work the budget, write letters, and fight for reimbursement. I am also constantly looking for avenues in which to market our program. When I am not busy with those tasks, I am exercising and educating our patients to help them improve and smile.

Our program began in March of

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1997, but I was actually hired to put the program together in November of 1996. It was a huge challenge, and as I look back at the process of getting all the components together, I often wonder how I survived. What really helped was to be involved in our professional organizations.

I enjoy challenges, but I also realize that success is influenced by who you can recruit to help with the process. When I was stumped for an answer to something, I contacted peers from the AARC and other organizations. Being involved with your professional organization at the local, state, and national levels helps you to grow as a professional and is a way of increasing your knowledge in the field.

As we try to find our way through the maze of CPT coding, collecting outcomes, and remaining fiscally solvent while at the same time justifying our existence to administration, having other professionals to network with is important. We all need to be able to pick up the phone and call a colleague. Being involved also means being informed. Don't you hate being the last one to know the latest scoop? If you stay involved, you'll stay informed! With so many changes in health care, it is essential to stay informed.

Okay, so how does all of this relate to pulmonary rehabilitation? I have been in the field of respiratory care since graduating in 1981. I've been a member of the AARC since then as well. I've joined various specialty sections for the information, but when I started managing a pulmonary rehab program, I really became aware of how important our section is. I began reading the section *Bulletin* and attending the section meetings. I volunteered to do anything I could to help — and that's when I was asked to write this article for the *Bulletin*!

What can all of this involvement do for you, the pulmonary rehab therapist? It allows you to meet your colleagues and exchange e-mail addresses and phone numbers. It helps you to feel comfortable about contacting peers who have experience and knowledge that may generate ideas for your program. These individuals can often provide sound advice that might just make your job a little easier and more satisfying as well.

We all owe it to our pulmonary patients to provide them with a good quality program. We can do that by keeping ourselves and our program current, fresh, and challenging. We need to make sure our programs survive so that quality pulmonary rehabilitation services will remain available to the patients who need them. So, get involved and stay involved!

I love what I am doing today. I enjoy the challenge of managing and developing our program. I love watching our patients get better and enjoy life. And I get some of my best ideas by listening to other professionals who present information and discuss their programs.

You don't need to be a superstar to get involved. Just volunteer to do something small. Keep your eyes and ears open. Check out your resources — like the section Bulletin, the section web site and, of course, the section meetings. If you can't attend the national meeting, call or e-mail the section chair and volunteer to get involved. Link up with the AACVPR's state affiliates. They work with the section collaboratively on issues such as reimbursement and policies. Remember the saying, "little things mean a lot." Start with something little and you'll be surprised where it leads! ■

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# Pulmonary Rehabilitation Update

***by Trina M. Limberg, BS, RRT, FAACV***

**AACVPR and Program Certification**

Applications are being accepted for the second round of reviews scheduled to take place October through December. The Oversight Committee and the Board of Directors decided to offer application submission on an annual basis. Although the organization would prefer to offer additional opportunities, the process is very labor-intensive. I also learned that the organization must accept applications from non-members. Please note that this is new information from the last issue. You don't have to be a member to submit an application, although you should maintain membership to be abreast of clinical and health care policy developments.

The application fee was increased to $300. Application certification is good for three years. Submissions will be returned if they are not organized and placed in a three-ring binder. It is time-consuming for state and oversight reviewers to review submissions, but it is even more time-consuming when the submissions are not well-organized. Program certification is based on the second edition of *The Guidelines of Pulmonary Rehabilitation* which is published by Human Kinetics.

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The purpose of program certification is to:
- Improve clinical practice
- Advance multidisciplinary process
- Enhance quality of care
- Promote standard outcome measures
- Favorably impact reimbursement

It was interesting to note that, in Mississippi, a payer contacted the AACVPR office to ask for a list of certified programs in the area. In speaking with the medical director for the payer, an oversight committee member learned that they planned to use program certification as a qualifying requirement. But do not panic! This is not expected to happen for a year or so. But most experts think it will happen eventually. I would suggest that you contact the AACVPR office and request an application, even if you do not intend to submit this go-around. At least you will know what the process requires, and you can set goals and involve your staff in preparing for the future. The AACVPR office number is (608) 831-5122.

***National Policy on Pulmonary Rehabilitation***

While attending the annual AACVPR conference in Phoenix in September, I had the opportunity to hear a presentation by Phil Porte, a consultant from GRQ retained by the AACVPR to aid with this important issue. Unfortunately, little progress has occurred (in my opinion). As I understand it, a policy was submitted to the Health Care Financing Administration (HCFA), which is a sign that we at least have a toe in the door. The primary goal now seems to be getting the statute changed to include verbiage on cardiac and pulmonary rehabilitation. I am told this could happen as late as April 2000. Once the statute has been changed, the plan is to return to HCFA and revisit the national policy proposal. The AACVPR and the AARC remain committed to this important need. As long as we continue to practice without a policy, Medicare carriers will be allowed to interpret and set coverage as they see fit. This also means continued confusion about CPT code use and reimbursement. Hopefully, we will see some progress next year.

***Update on new Blue Cross of California policy on pulmonary rehabilitation***

The draft is in the final version, but designation of CPT codes is pending. We are all waiting for the word so we can change our charge masters and coding. Since many budgets are based on procedures and CPT codes, it will be interesting (okay, so I'm lying — it will be a nightmare!) to see how quickly we can implement changes within our already-burdened departments. I'll keep you posted in future issues of the *Bulletin*. ■

# Food for Thought When Writing an Individual Plan of Treatment

***by Trina M. Limberg, BS, RRT, FAACV***

When writing an individual plan of treatment, rehab therapists would do well to follow a step-by-step approach that ensures that all bases are covered. The following information, presented here in semi-outline format, is based on the process we use at the University of California San Diego Medical Center. It may be able to assist you and your program in developing treatment plans that not only cover all of your patients' needs, but also document your program's ability to provide high quality care.

**The evaluation**

The evaluation begins with a complete medical history and record review, followed by a comprehensive assessment of the patient that may include:
- Symptoms
- Activity tolerance
- Psychosocial needs
- Knowledge/understanding of disease and current treatment regimen
- Face-to-face screening interviews
- Use of screening questionnaires
- Recommendations for diagnostic tests
- Documentation of the findings
- Medical director involvement

During the patient assessment, the therapist will want to make the following observations:
- Is the patient well groomed? (Self-care deficit)
- Has $O_2$ been prescribed but the patient arrived without it? (Poor compliance, poor understanding, problems with using portable system?)
- Is the patient able to articulate medication uses/demonstrate correct use of MDIs?

The psychosocial areas of concern include:
- Perception of QOL/ability to adjust to disease
- Current fears and concerns
- Anxiety and/or panic episodes
- Feelings of depression (Beck Scale)
- Change in social roles
- Intimacy

**Identifying problems**

Once the evaluation is complete, the therapist will identify specific problems being experienced by the patient. These may include:
- Activity intolerance
- Symptoms such as cough, sputum, breathlessness with exertion, fatigue, weight changes
- Psychosocial concerns such as anxiety, fear, panic, coping impairment
- Education/skill deficits
- Medical-hypoxemia, severity of disease

The next step in the process of writing the treatment plan — establishing objectives — depends on the problems that have been identified. Consider the following case example of a 54-year-old male with a history of recurrent bronchial infections and a 50 pack-year smoking history. He quit smoking six months ago and has a current $FEV_1$ of .8 L. His symptoms include:
- Daily productive cough 2 tablespoons
- Exercise tolerance of 1-2 blocks
- Oxygen therapy "when needed"
- Unable to perform bathing tasks unassisted

What problems will the program want to target in the treatment plan? In this case, the therapist determines that the program will tackle the following issues:
- Productive cough
- Recently quit smoking
- Severe disease
- Dyspnea on exertion
- Recurrent infections

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