Continuing Care & Rehabilitation Bulletin

March/April '99

Notes from the Chair & Editor

by Trina Limberg, BS, RRT, RCP

By the time you receive this issue, spring will have sprung and many of us will be in the midst of budget preparations. Hopefully, you are getting your capital equipment and program needs approved. Personally, I am hoping – okay, so it could be *wishing* – for a new treadmill and an oximeter.

As previously reported, the primary purpose of the *Bulletin* is to keep you informed about pulmonary rehabilitation activities. In the last issue you were provided with a dyspnea outcome tool. This issue features an update by Julien Roy on the AARC's pursuit of a national pulmonary rehabilitation policy with the Health Care Financing Administration (HCFA). Our next issue will focus on providing maintenance exercise sessions to rehab graduates. If you have a subject you would like information on – or one that you would like to submit information on – please contact either Julien Roy or myself at the numbers listed on page two.

We have been busy submitting topics for the next AARC International Congress, scheduled for December 13-16 in Las Vegas. The Program Committee met in February to begin planning this important meeting. Thanks to all of you who took the time to submit ideas.

Our section is currently in need of a volunteer to serve as an Internet listserve monitor. The main responsibility of this job is to visit the site regularly and keep the leadership informed about topics being posted. If you are interested in assuming this position, or providing any other service to the section, please write or call. There are many great ways to get involved without becoming overwhelmed.

By now, all programs that participated in the AACVPR certification process should have received notification of approval or denial. If you are not familiar with the process or application requirements, you can contact the AACVPR office at (608) 831-5122, or visit their web site at http://www.aacvpr.org. There is also a hot link between the AACVPR and AARC. Program certification is only available to active members of the AACVPR. The next opportunity for application submission has not been scheduled but may occur sometime this summer.

Lastly, I want to urge you once again to please consider submitting an article for publication in a future issue of the *Bulletin*. We know you are doing things that are of interest to your peers, so take the leap and put finger to keypad and share those ideas with the rest of us! At the very least, if you have questions or topics that you would like to see covered, submit them and we'll do our best to get information to you through the *Bulletin.* ■

Update on Reimbursement

by Julien M. Roy, BA, RRT, FAACVPR

Having difficulties with reimbursement for pulmonary rehabilitation services in your state? Join the club!

Other than managed care, reimbursement is the number one problem facing pulmonary rehabilitation programs. We, at the AARC, have been diligently working to assure fair reimbursement for our patients throughout the continuum of care. Over the past few years, much progress has been made. Evidence-based guidelines, a joint effort of the

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American Association for Respiratory Care

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American College of Chest Physicians and the American Association for Cardiovascular and Pulmonary Rehabilitation (AACVPR); the acceptance of pulmonary rehabilitation as a standard of care for the National Emphysema Treatment Trial (NETT); and the soon-to-be-released American Thoracic Society (ATS) statement on pulmonary rehabilitation have all prompted the Health Care Financing Administration (HCFA) to reopen the topic of pulmonary rehabilitation reimbursement coverage for the nation. As of this writing in mid-February, industry leaders are scheduled to meet with HCFA officials on March 3 to discuss inpatient pulmonary rehab coverage. I will represent the AARC at that meeting and will keep you posted on any new developments that arise.

As some of you are aware, Florida, Pennsylvania, California, and Ohio are truly the only states where intermediaries have issued clear guidelines specific to the delivery of pulmonary rehabilitation. Other states are working to develop policies similar to those in use in these states, and many others are using components of respiratory care for reimbursement (i.e., pulse oximetry codes). Our role has been to help you make some sense of the political language involved in these negotiations. Presently, Alabama has a policy pending at their Medicare intermediary, and Arizona and Louisiana have both met with their intermediaries for policy development. Thanks to the dedication of many therapists and nurses in those states, the barriers are being broken down.

One might ask why each state has to develop an individual policy. The answer is that HCFA never committed to nationally-recognized pulmonary rehabilitation guidelines, instead leaving the task of reimbursement for such services to each individual state. The power to say "yes" or "no" to pulmonary rehabilitation in this country will remain the sole responsibility of each intermediary unless professionals in our field take a proactive role in such matters.

The other question frequently asked is, why don't we have a national policy to take care of all patients in the US? Indeed, a national policy would handle all reimbursement issues throughout the continuum and would also eliminate much of the fraud and abuse that arises from trying to bill for such services using other non-appropriate codes. But you must first understand HCFA's position: by committing to a national policy, the federal government would have to disburse a great deal of money for pulmonary rehabilitation services to areas where such funds are not presently available. However, as evidence of the positive outcomes of pulmonary rehabilitation mounts, the government is becoming more willing to move in this direction.

Last year, HCFA asked our colleagues at the AACVPR to develop a task force to write a national policy for pulmonary rehabilitation. I have been very fortunate to be a member of this team, which includes distinguished professionals such as John Hodgkin, MD, Neil MacIntyre, MD, Lana Hilling, RCP, and Kevin Ryan, RCP. We were charged with researching all existing policies and programs to create a fair document that, hopefully, will benefit all programs in the US, and most importantly, all patients suffering from COPD and other respiratory ailments treatable with pulmonary rehabilitation.

The good news is that we completed this task in mid-January. The policy is now at HCFA, and we are awaiting its outcome. I will keep you posted on its progress. In the meantime, please feel free to contact either myself or our section chair, Trina Limberg, if you are in need of help with pulmonary rehabilitation reimbursement. We can be reached at the addresses/numbers listed on this page. ■

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AARC Provides Travel Resource for Oxygen Dependent Patients

The American Association for Respiratory Care (AARC) is proud to announce the Breathin' Easy Travel Guide. The Guide has been in publication for the past two years, and now, the updated 1999 edition is available. Breathin' Easy founder Jerry Gorby, oxygen dependent himself, developed the Guide to make traveling easier for oxygen dependent patients.

The Breathin' Easy Travel Guide has served as an excellent resource for traveling oxygen users and also for the home care providers and therapists who work with them. Updated

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annually, this Travel Guide is a "must have" reference book for every oxygen dependent patient. It lists information on oxygen refill sites throughout the United States and also provides helpful travel tips for oxygen patients.

One oxygen dependent patient, John S., recently told us about his 4,172 mile cross-country driving trip. "I had my liquid oxygen tank filled by five different providers, four of which came to my attention in the Guide. The Guide made planning the trip quite easy, and I'm grateful to you for producing it."

Also, be sure to visit the new Breathin' Easy website, http://www.breathineasy.com (or oxygen4travel.com). Already visitors like Cheryl V. are singing its praises. "Kudos to the AARC for developing the new website for traveling with oxygen . . . I will be passing it on to all O2 patients as a way of encouraging them to get moving," she says.

Be the first one in your area to take advantage of promotional opportunities available with the Breathin' Easy website and printed Travel Guide. For more information about getting listed in the Breathin' Easy Travel Guide, contact Jerry Gorby at 707/252-9333, or to purchase a printed guide ($19.95 + $4.65 s&h), call 972/406-4663. For more information about promotional opportunities on the Breathin' Easy website, http://www.breathineasy.com (or oxygen4travel.com), contact Tim Goldsbury by e-mail (goldsbury@aarc.org) or by telephone at 561/745-6793. ■

Pulmonary Rehab Tip: Catching Your Breath with Bubbles

by Lynn Wattles, RRT, pulmonary rehabilitation therapist, Jupiter Medical Center, Jupiter, FL

Editor's Note: In the spirit of learning new strategies in pulmonary rehabilitation, this next short article offers something you can use during your next session in pulmonary rehabilitation to help your patient better deal with shortness of breath. I know it works, because I tried it with my patients this week. If you have any new techniques that you have found helpful in your program, please share them with the rest of the membership through an article in the Bulletin.

One thing that we consistently have to remind our patients to do is "breathe." But no matter how many times we remind them to purse-lip breathe, it's not always easy for them to remember when they're exercising. Before they know it, they're short of breath. It is very important for them to learn to be in control of their breathing. Anything we can do to remind them will make a big difference in their functional capacity and ventilatory requirements.

As we all know, the amount of air you breathe in and out during exercise must satisfy your body's need for oxygen. Patients with COPD, emphysema, or asthma have impaired gas exchange due to the amount of scar tissue in their lungs. Therefore, proper exhalation during exercise is important to maintain an adequate O2 saturation.

When my patients are on the treadmill or bike and I notice them getting short of breath, I have them blow bubbles. Yes, BUBBLES! If they can't blow bubbles then they are not exhaling properly. By blowing out too hard and not long enough they are creating more of a resistance to flow and will become more short of breath.

Hold up the bubble wand so that they can blow into it and tell them to purse-lip breathe and exhale completely. Before you know it, they are in control of their breathing again because they can actually see the results – bubbles! It's therapeutic, it's fun, but most of all, they'll remember the proper breathing technique the next time! ■

Patient Assessment Course: Back By Popular Demand

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- Function as a member of an interdisciplinary care team.
- Determine the patient's physical condition, assess the patient's needs, monitor and evaluate services and outcomes, and document services and activities.
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Philadelphia April 30-May 2
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For more information about this excellent continuing education opportunity, contact the AARC at 972/243-2272.

FYI . . .

tudy uncovers effective treatment or depression in the elderly

In the first study to compare different therapies for the treatment and revention of recurrent major depression in the elderly, researchers at the niversity of Pittsburgh Medical enter have found that a combination f medication and psychotherapy is gnificantly more effective than edication or psychotherapy alone. /hat's more, continued treatment an significantly reduce the risk of ecurrence.

The study examined the rate of ecurrence in a group of 124 epressed elderly participants aged 0 and older who had been split into our groups to compare the effectiveess of different treatments. One roup received both the antidepressnt drug nortriptyline, a tricyclic ntidepressant, and monthly interpersonal therapy (IPT). A second group eceived only the medication, while a ird group received only IPT. The ourth group received a placebo. All our groups were followed for three ears.

The results showed that the combiation of nortriptyline and IPT preented recurrence of depression in 0% of the patients, while medication one prevented recurrence in 57% of e patients and IPT in 36%. Only 0% of patients in the placebo group emained well. (Journal of the merican Medical Association)

utch population suffering from ng function decline

Dutch investigators who studied ,155 people age 25 to 70 found that ore than 52% (604 persons) showed mptoms of previously undiagnosed OPD or asthma during a health creening. Of those with symptoms, 34 agreed to participate in a twoear follow-up monitoring project. In is group, more than 20% showed ther a persistently reduced or a pid decline in lung function. More an 19% of the remaining particiants showed objective, mild signs of OPD or asthma.

According to the investigators, the wo-stage detection program evealed that a large proportion of the general undiagnosed population showed symptoms and objective signs of COPD and asthma." To support their initial screening criteria, a random sample of 200 additional persons who tested negative was followed for 3.6 years. None of those individuals were diagnosed with either COPD or asthma during that time period. (American Journal of Respiratory and Critical Care Medicine, 12/98)

It's in the genes

Why is it easier for some people to quit smoking than others? Researchers from Georgetown University and the National Cancer Institute (NCI) think it's all in your genes. In separate studies, they linked the ability to quit to a particular version of the dopamine transporter gene.

The Georgetown study, which involved 289 smokers and 233 nonsmokers, found that those with the SLC6A3-9 version of the gene were less likely to start smoking before the age of 16 and more likely to be able to quit smoking once they did start.

The NCI study, which examined 1,107 nonsmokers, current smokers, and former smokers, noted that the SLC6A3-9 gene was associated with certain personality characteristics that influenced a person's smoking behavior. Specifically, a person with the SLC6A3-9 genotype was found to have lower novelty seeking traits than a person without this genotype. Since novelty seeking has been associated with a desire to smoke, researchers believe those with low levels of novelty seeking have an easier time giving up cigarettes than those with higher levels. (Health Psychology, 1/99)

Combination therapy more effective

Combining a nicotine patch with nicotine nasal spray is more effective in helping smokers kick the habit than providing the patch alone, say researchers from Iceland and Sweden who conducted a study of nicotine replacement strategies over a six year period.

Smokers in the study ranged in age from 22 to 66 and received either the nicotine patch for five months and the nicotine nasal spray for one year or the patch plus a placebo spray.

Results showed that patients using the patch-spray combination abstained from smoking longer than those receiving the patch plus placebo spray. Researchers believe the combination therapy may be more effective because of the different speeds at which the two therapies work. While the patch releases nicotine slowly, the spray delivers nicotine quickly, thus providing immediate relief to a smoker's urge to light up. (British Medical Journal, 1/29/99)

Respiratory nurses set research priorities

A Task Force of the Nursing Assembly of the American Thoracic Society (ATS) has prepared an official statement on Research Priorities in Respiratory Nursing that has been endorsed by the ATS board of directors. The statement highlights research needs in three areas: "Health Promotion and Disease Prevention," "Therapeutic Strategies: Acute Care," and "Therapeutic Strategies: Chronic Care."

In the "Health Promotion and Disease Prevention" section, the report stresses that tobacco use reduction is the single best way of lowering illness and death from emphysema, chronic bronchitis, and lung cancer. The report calls for research aimed at:

- Preventing tobacco use among children and adults.
- Designing and testing effective cessation programs.
- Developing cessation methods that adequately address the problems encountered by socioeconomically disadvantaged, under-served, and culturally diverse smokers.
- Determining the risk factors for pulmonary complications such as lung collapse, acute respiratory distress syndrome, and pneumonia.

In "Therapeutic Strategies: Acute Care," the Task Force focused on patients using ventilators for seven

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days or longer, saying that studies are needed to:

- Facilitate the weaning process for those on long-term ventilation, emphasizing high-risk patient needs, the appropriate ventilator mode, and clinical decision-making by the acute or subacute care team.
- Simplify end-of-life decision-making by identifying actions that will support families as they consider withdrawing or withholding treatment.
- Ensure that patients are comfortable and free from pain at the end of life through support efforts by special care teams and the appropriate use of narcotics and sedatives.

In "Therapeutic Strategies: Chronic Care," studies of asthma, COPD, lung transplantation, sleep apnea, TB and HIV infections, bronchopulmonary dysplasia, and cystic fibrosis are discussed. The report calls for studies on:

- Interventions connected with exercise therapy and the coaching of patients to control COPD through effective pulmonary rehabilitation, as well as those aimed at increasing COPD patients' appetites and intake of nutrients.
- Effective strategies to educate both patients and providers about the signs and symptoms of sleep disorders in adults and children.
- The risk factors associated with drug resistance to TB, including HIV infection, socio-demographi factors, treatment history, and th quality of the TB control program
- The physiologic, developmenta and psychological outcomes c infants with bronchopulmonar dysplasia (BPD).
- Effective disease managemer techniques for cystic fibrosi patients, along with coping strate gies for these patients as they awa further treatment breakthroughs.
- The efficacy of comprehensive pu monary rehabilitation and specifi interventions for children an adults with restrictive lung diseas and alpha-1 antitrypsin deficiency

(American Journal of Respirator and Critical Care Medicine, 12/98) ▌

AARC Releases New CPGs

The January 1999 issue of Respiratory Care contains four new AARC CPGs:

1. Removal of the Endotracheal Tube
2. Single-Breath Carbon Monoxide Diffusing Capacity, 1999 Update
3. Suctioning of the Patient in the Home
4. Selection of Device, Administration of Bronchodilator, and Evaluation of Response to Therapy in Mechanically Ventilated Patients.

An AARC Clinical Practice Guideline (CPG) is a systematically developed statement to help the practitioner deliver appropriate respiratory care in specific clinical circumstances. Practice guidelines are common in many disciplines and are developed for a variety of reasons. The AARC CPGs exist for the noblest of reasons-to improve the quality of respiratory care administered to patients.

The variability in clinical practice from one hospital to another is well known, and these variations hav come under increasing scrutiny ove the years. In response to this, th AARC published its first five CPG in 1991 and has continued to take leadership role in the development c clinical practice guidelines t improve the appropriateness of resp ratory care practice throughout th country. The Association currentl has 49 available CPGs. You can orde them from the AARC by callin 972/243-2272 or download ther from our website at www.aarc.org. ▌

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Live Videoconference: May 25, 11:30 AM - 1:00 PM CT

Coping with the Pediatric Respiratory Emergency
Live Videoconference: June 22, 11:30 AM - 1:00 PM CT

The Latest Word in the Treatment of COPD
Live Videoconference: August 24, 11:30 AM - 1:00 PM CT

PEEP: The State of the Art
Live Videoconference: September 28, 11:30 AM - 1:00 PM CT

New Developments in Respiratory Drugs, Medications, and Delivery Devices
Live Videoconference: October 19, 11:30 AM - 1:00 PM CT

For more information contact the AARC at 972/243-2272.

Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs).We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer-reviewed literature to support those suggestions.

Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at dhess@partners.org or fax them to 617/724-4495.

You will find copies of all the CPGs published by the AARC at:
http://www.rcjournal.com/online resources/cpgs/cpg index.htm

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