

A TURN KEY PROGRAM AT YOUR FINGERTIPS

Chronic Obstructive Pulmonary Disease (COPD) is a chronic and debilitating illness for which home care can be beneficial. Disease management in this illness makes sense. The goal is to address a patient's illness or condition with maximum effectiveness and cost efficiency by developing a systematic approach and patient ownership to the problem. Historically, disease management has been shown to improve patient outcomes and quality of life while potentially reducing overall costs. It is an important approach to integrated care for the COPD patient.

This "turn-key" Pathway was developed with the following intent:

- Identification of patients: either new or previous patients already receiving home care services with the diagnosis of COPD. The earlier a patient is identified the better.
- Implementation of the disease management program with physician order and patient consent.
- Impact of program on patient disease progression (effectiveness and cost efficiency)

The pathway will introduce the program to the patient after obtaining a physician order, and then provide a thorough follow thru for each patient using personal and

telephone "visits". Outcome assessment is completed through the entire program with the intent to demonstrate the effectiveness of the program in the patient's disease process.

The materials for the entire pathway

are designed as three modules: Provider, Physician, and Patient. Each module can be developed into an individual notebook for reference by each party. The Modules include the following:

Modules	1) Provider Manual	2) Physician Manual	3) Patient Manual
Components	i) GOLD Programs (a) What is it (b) Spirometry ii) Know Your Numbers Concept iii) Flow Chart iv) Assessment Form (a) Borg Scale v) Survey Form vi) Visit Schedules (a) Clinician (b) Patient vii) COPD Education viii) Smoking Cessation Materials	i) PowerPoint Marketing Presentation (a) Managing Your COPD Patient with the Homecare Pathway ii) Welcome Letter iii) Order Form iv) COPD Pathway Flow Charts v) Survey Form vi) Assessment Form (a) Borg Scale vii) Patient Education Material (a) PEP sheets from MED GROUP (b) COPD Education (c) Smoking Cessation viii) GOLD Program (a) Slide Presentation (b) Pocket Guide (c) Spirometry (d) Support Articles ix) Know Your Numbers (NHLEP)	i) Client Visit Schedule ii) Client Flowchart iii) COPD Education Materials (a) MED Group PEP Sheets iv) Smoking Cessation Materials

The COPD Homecare Pathway is based on the premise that certain intervention techniques founded upon education and therapeutic principles can assist an individual suffering from COPD. However, those techniques also do not comprise the whole program. It is the thoughtfulness, respect, passion and competence with which those techniques are conveyed that is at the core of the Program. Therefore, as directed by the physician, the respiratory therapist in the role of teacher, the efforts of the client and the techniques found here must equally interact to ensure the program's success. The ultimate goal is to "enhance the quality of life through communication and education". ✨

[RESPIRATORY REVIEW]

A QUARTERLY RESPIRATORY NEWSLETTER

spring 2006

OXYGEN THEN AND NOW

Will we ever forget the words of Dorothy in the movie "The Wizard of Oz" as she clicks her heels together and repeats, "There's no place like home. There's no place like home." until she magically returns to the safe haven of her bedroom in Kansas. Like Dorothy many patients feel there's no place like home. Some studies have shown that people heal more quickly at home than in an institution and that home health care often is the less expensive alternative.



Alvan Barach was the first to systematically employ oxygen for the treatment of bacterial pneumonia. Barach modified an oxygen tent, originally invented by Leonard Hill. Barach was also interested in the role of oxygen and relief of dyspnea, shortness of breath, during exercise. In 1958 he developed a small transfillable oxygen cylinder suitable for use during exercise. Cotes and Gilson also gave oxygen to ambulatory patients from small portable high-pressure cylinders in the United Kingdom. Cotes reported on

increased walking time and improved arterial oxygen saturation, oxygen in the blood. By 1955 approximately 30% of all "chemists" in Wales and Monmouthshire (population 2.6 million) were supplying oxygen by prescription to an astonishing 860 patients. Oxygen cylinders were the only modality of therapy in that era.

The patients of the past who went home needing medical equipment, were either going home to die or for very short recuperative periods. The first patients needing oxygen were home bound needing support for their oxygen needs. Home medical equipment suppliers provided patients a concentrator and an E tank weighing about 29 pounds in the 1970's. Patients weren't expected to leave their homes for anything. Doctors in those days still made house calls. Patients were always home so there was no need to schedule your visits. You could just knock on the door and check your equipment. People lived in their homes for years and then passed them on to their children. Equipment wasn't lost or stolen like it is today by the transitory patients.

The patient of today is indeed nothing like the patient of those times. Now our patients hold jobs and are very transitory. The patient of today must have portable oxygen systems that can be easily transported to facilitate their busy lifestyle.

Today's patients take trips with family and friends across country and sometimes even to other countries. The needs of the patient have indeed changed from those days. In many ways they are far more demanding and costly for the provider, however the amount paid for these services is considerably less and continues to decrease. The staff that offer support and education to the patient are a costly but necessary



expense. The patient of today is a very smart consumer wanting more information about their disease and the options they might have to treat that disease. Taking care of today's patient requires more than just a desire to help those in need. It requires the business sense to stay profitable in an ever changing world or meet the demise of the companies in the past, who could not survive the ever decreasing reimbursement levels and increased cost of equipment and service. ✿

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brought to you by

Demand Nothing Less - Best Practices for Selecting Oxygen Systems

Physicians write prescriptions for home oxygen with the intention of meeting their patients' clinical needs and improving the quality and length of life.

Active patients desire the freedom to perform activities of daily living without dependency on oxygen deliveries (cylinder or liquid). Patients want the freedom to take their oxygen and leave on a moment's notice to see a neighbor, visit a local shopping mall, go out to eat, or enjoy a movie at a local theater.

Home Care Providers need a cost-effective home oxygen system that is adequately reimbursed and clinically effective for their patients. Of equal importance is the peace of mind of knowing that the patient will not run out of oxygen while enjoying these activities. Our patients depend on the skills and expertise of their physician and the HME provider to give them the proper equipment to meet their lifestyle requirements. Payor sources, however, have demonstrated that they are not as concerned with the beneficiary's quality of life as they are with reducing their monthly expenditures. Often, the cost efficiencies of new technology are unused and misunderstood while short-term cost reductions remain in place.

Current technology allows three distinct methods for delivering oxygen:

- Two or more deliveries per month usually involves liquid oxygen but could include a concentrator with cylinders in some situations. If cylinders are being delivered twice

per month, consider other methods of oxygen administration.

- One or more deliveries per month is typically for users of combination systems (oxygen concentrator and liquid oxygen stationary and portable system) or a concentrator with M6 or M9 cylinders for example.
- No monthly deliveries result from home-filling cylinder devices from a concentrator. One brand uses pulse technology at all times, (this reduces the consumption of oxygen from continuous to on-inspiration-only) and can be used as both a stationary and portable device as long as the patient can clinically tolerate an oxygen conserving device (OCD), during all activities of daily living, including sleep. Proof of sleep or adequate oxygenation during sleep can be demonstrated through an overnight oximetry study that proves the patient does not desaturate at night.

The number of deliveries per month is important because of the recurring cost to the HME provider over the entire life cycle of the patient. These costs of doing business—trucks, fuel, insurance, oxygen contents, and driver salaries—are real and escalate year after year while reimbursement drops or at best stays neutral.

The challenge for physicians and providers alike is to balance and satisfy the various market forces that affect oxygen delivery so to impact positive outcomes for our patients. Health care outcomes encompass three areas: cost, clinical practice, and patient satisfaction. Using The MED Groups' Best Business Practice approach, we begin to address the first two areas. Further work is required to demonstrate the essential value of the HME provider. We must define key metrics and measure results.

A strong bias exists by this author that the product decision should be under the trained guidance of the HME provider's credentialed respiratory therapist as directed by the physician's order. It is our belief that


the physician should write the prescription for oxygen aimed at ensuring a target clinical goal (Spo2) at rest, during exercise, and during sleep, and defer the process of product selection to the HME provider using a best-practice oxygen process.

Generally speaking, the HME provider is in the best position to select the most appropriate method of oxygen delivery for each patient. The task of matching patients with the best system to meet their needs has always been an art. We believe it can become a science, thus supporting the previously stated bias.

The MED membership of HME providers have developed an empirical model that takes into account the clinical, physical, mental, and home environment of the patient along with the operational considerations of the HME provider. The skilled HME provider is in a unique position to look at all of these variables and make the most appropriate recommendation for the patient. The recommended model has become a valuable part of our best practices for oxygen delivery.

Essential components of the model include lists of "factors" that elicit goal oriented responses. For example, under the physical section of the model are questions about patients' activity level, where they go, how often, body weight, ambulation abnormalities, or if they are bed-bound. Responses to these questions, and those in the other sections, allow the respiratory therapist to complete an "objective patient evaluation." This evaluation provides (at a glance) the potential technology that is appropriate for that patient.

Often, there is more than one method of oxygen delivery that is appropriate for that particular patient. Once this analysis has been completed, the HME provider is then ready to review the economics of one delivery system versus another.

Site reference: Thomas J. Williams, MBA, RRT, Jacquelyn McClure, BS, RRT; *Best Practices Make Profit*, Dealer/Provider, September, 2005. 

Respiratory Review is Published
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CHANGING REIMBURSEMENT AND THE HOME RESPIRATORY CARE PATIENT

In December 2005 the United States House of Representatives introduced, debated and passed the Deficit Reduction Act. A similar version of this bill narrowly passed the Senate with Vice President Cheney casting the deciding vote in late December 2005. When the House of Representatives reconvened on February 1, 2006 after the holiday break, the Senate version of the bill was voted on and narrowly passed by two votes.

The home care provider also provides services twenty four hours per day, seven days per week for rental equipment failures; equipment that is owned by the patient is not the responsibility of the home care provider to service on an emergency basis.

The Deficit Reduction Act is designed to save the United States government approximately forty billion dollars with approximately 11 billion dollars of savings coming from Medicare and Medicaid reimbursement changes. Durable medical equipment reductions and changes in Medicare reimbursement would save an estimated seven hundred million dollars over the next four years.

The Medicare savings would occur in the following ways. First, capped rental equipment which includes aerosol and continuous positive airway pressure therapies would be reduced from fifteen months to thirteen months. The two month reduction of capped rental payment is equivalent to a thirteen % reduction in payment for the equipment and services. Additionally under the Act, the patient would own their equipment at the end of the capped rental period as opposed to the option of owning. Secondly, oxygen equipment would begin to participate in

the capped rental program with a cap after thirty six months.

Oxygen historically was reimbursed by Medicare indefinitely as long as there was medical necessity for the services. With oxygen moving into a capped rental program, patients will own their oxygen equipment after thirty six months of continuous usage. The average number of months of oxygen utilization in the home is currently between twenty four and thirty months depending on which statistics are used to calculate the average. While the average is below the thirty six month cap there are many patients who use oxygen therapy services beyond the thirty six month cap.

When the rental cap is met, the title of the equipment will transfer to the patient and the patient is responsible for all maintenance and repairs of the equipment. Currently oxygen therapy equipment is maintained by the home care provider per the manufacturer's guidelines. The home care provider also provides services twenty four hours per day, seven days per week for rental equipment failures; equipment that is owned by the patient is not the responsibility of the home care provider to service on an emergency basis. In addition, the provider is responsible for back up equipment, replacement equipment and supplies associated with the normal use of the equipment.

Unclear at this time, is how the ambulatory oxygen needs of the patient will be met and reimbursed under the new guidelines. Under the perpetual rental system ambulatory oxygen needs were met with one of the following:

- Compressed gas cylinders with or without a conservation device
- Liquid oxygen with or without a conservation device
- Portable battery operated oxygen concentrator
- Oxygen concentrator system which self fill compressed gas cylinders.

Some examples of questions are, how will a patient get the cylinders they own refilled,

or who would pay to have the cylinders filled. Another concern is the maintenance of the cylinders as they have to be inspected and tested at specific intervals per the federal government regulations.

A capped rental program for oxygen therapy to date also has not addressed the progressive nature of Chronic Obstructive Lung Disease. The bill does not address what will take place if a patient owns one type of oxygen system and based upon changes in their lung disease would benefit from a different system. A patient's choice of providers may become limited once a patient becomes established with a provider because a new provider may be reluctant to work with a patient that is nearing the capped rental period with another provider. This could be a major issue for a patient if they move out of a service area and must change providers.

The Deficit Reduction Act is designed to save the United States government approximately forty billion dollars with approximately 11 billion dollars of savings coming from Medicare and Medicaid reimbursement changes.

Your MED Group provider feels that it is important as these major changes in oxygen reimbursement are implemented that all health care professionals are informed and involved regarding home oxygen therapy and how these changes may affect their patients.

Your MED Group provider is committed to working with you to provide home oxygen services based upon clinical best practice standards and to work with the health care industry and Congress to insure that the clinical needs of the patient will not be forgotten during this transition. 🌸