



CLINICAL ASSESSMENT OF HOME CARE PATIENTS: WHY IT'S NECESSARY

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The new year has brought the specter of a continuing downturn in our economy, rising unemployment and, for the home care industry, enactment of the Medicare Improvements for Patients and Providers Act (MIPPA). This measure brings a 9.5 percent across-the-board reduction in reimbursement for home care equipment and start of the 36-month capped rental on home oxygen systems.

What are home care providers to do in the face of this adversity? Some options that have been considered and already implemented by some DME companies include the elimination of some services, employing more economical ways of delivering oxygen

or even limiting cylinder deliveries and reducing the involvement of respiratory therapists in providing home care to their patients. While some of these alternatives may help keep home care companies afloat, they do little for advancing the quality of patient care in the home setting.

DME companies can elect to be strictly equipment (DME) oriented and not follow a clinical path. These organizations are simply involved in having a service technician deliver oxygen to a patient, and then, based on state law, have an RT follow up by either phone or personal contact to ensure safe setup and use of the oxygen system. In this particular case, there is no clinical assessment, and any follow-up is provided by the service or delivery technicians when they perform routine preventive maintenance on the stationary oxygen unit, bring supplies or replace portable oxygen cylinders.

Some companies go even further and drop-ship CPAP equipment and rely on patients viewing the accompanying video and calling if they have any questions. This course of action does not sound like very good patient care and certainly does not result in patient compliance or favorable patient outcomes. The same is true for the setup of compressor and nebulizers in the home for the delivery of medicated aerosol treatments.

In all of the above scenarios, patients are basically on their own to take their treatments, maintain the equipment and comply with the prescribed home care regimen.

The overall result appears to be, at least for some patients, the "frequent flyer" syndrome. For example, these are patients with chronic lung disease that are hospitalized three to four times a

year. Based on Centers for Medicare & Medicaid Services data, the average length of stay in 2006 for a Medicare beneficiary with COPD was 5.2 days, and the average cost of hospitalization was \$4,600 per day. This totals about \$24,000 per hospitalization. Multiply this by four hospitalizations per year and we are looking at almost \$100,000 per year per patient.

Wouldn't it be more prudent for CMS and other healthcare payors to try to keep their beneficiaries at home? What about encouraging RTs to do patient follow-up visits in the home and reimbursing them for their services? Reimbursement of RTs is not a panacea, but it certainly would not hurt the situation.

There is currently an initiative in Congress to consider reimbursement of RTs providing home care services. However, this payment would only be for those patients who have no other health care professionals such as nurses or physical therapists providing home visits. And yet, there are DME companies that are presently expanding their scope of services and providing RTs for clinical assessment and education without CMS reimbursement. Most of this is part of disease management programs that home care companies offer.

These organizations are providing excellent patient care within the home and will probably reap more referrals from both healthcare facilities and physician offices. In the long run, they will benefit and survive because of their commitment to the well-being of the patient.

Having an RT conduct clinical assessment and follow-up is not overly expensive and is usually not too labor intensive. An RT well-trained in home care can do a thorough patient assessment, including pulse oximetry at rest and with activity, in about 30 minutes or so. This assessment should also include monitoring respiratory rate, heart rate,

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Shouldn't CMS and other health care payors try to keep their beneficiaries at home?



blood pressure and breath sounds, plus a review of signs and symptoms, a cursory physical examination and review of the patient's medication profile.

Assessments can be done pre- and post-treatment and usually include peak expiratory flow rate determinations. In some instances, basic spirometry (FVC, FEV1 and FEV1/FVC) may also be performed, adding to the value of the RT visit.

This is probably a lot more than what is done in many hospitals or other healthcare facilities at the patient's bedside. Patient census, department staffing and time naturally affect the involvement that many facility-based RTs have with many of their patients. In addition, nurses, physicians and other health care providers also conduct documented patient evaluation.

But in the home, it's actually fulfilling to perform patient assessments and use many of the skills that RTs have acquired. Some education can also be mixed in such as breathing exercises and a discussion of respiratory medications or activities of daily living, adding significant value to the visit. However, the time now spent with the patient may approach or exceed one hour.

This type of activity in the home, along with routine visits to the patient's health care provider, results in better patient care, increased therapeutic compliance on the part of the patient, fewer problems, fewer visits to the emergency room and reduced number of hospitalizations for cardiopulmonary reasons. If carried out in a timely fashion, patients will become more knowledgeable about their condition and become more aware of what warning signs to look out for along with the proper response to each.

Patients will also be more likely to take their treatments or therapy as prescribed. These measures alone can help reduce frequent flyers and result in decreased health care expenditures. However, there is one thing that needs to be considered, and that is the commitment of home care providers to invest in better patient care through RT involvement.

The expertise that the RT brings to the home setting is invaluable and is definitely priceless. Not only are an RT's assessment skills excellent, the knowledge these professionals can impart to patients, family members and other caregivers is also very valuable. RTs can become the eyes and ears of the physician and other health care providers, but only if patient assessment is conducted in the home. This assessment has little or no value if it is rushed.

Some would even argue that it should not be done at all if the RT only spends five to 10 minutes with the patient. Sufficient time must be set aside for each patient visit that results in a comprehensive review of patient condition, equipment use and benefits, or problems associated with their respiratory therapy. Few other health care professionals possess the knowledge base, clinical skills, and intuition regarding cardiopulmonary conditions and patient evaluation that RTs have.

The public is well aware of the current status of health care today. When it comes to COPD and other chronic lung diseases, RTs have a handle on the situation, and it simply comes down to their overall dedication and involvement in home care. Patient assessment and follow-up must be done and kudos to the DME companies that are committed to RTs. RT dedication and involvement enables their patients to achieve therapeutic goals and, in the long run, home care companies attain their mission statements.

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