

WANTED! QUALITY OF LIFE AND ECONOMIC MEASURES FOR HOMECARE & HME PROVIDERS

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I recall conversations with some of my former colleagues about a year ago regarding the future of the home care/HME industry and where it would be in the next 5-10 years. Many felt as though the products delivered by providers to patients in their homes would end up as commodities which patients simply purchase as over the counter items similar to humidifiers, crutches and canes in the local pharmacy. Others commented that products will be prescribed and provided by the same local pharmacies to the patient or their caregiver who'll present a prescription, pay their co-payment, pick up the product, take it home and hopefully, use it correctly. The fact remains that both scenarios are not that far fetched in the uncertain future of the home care/HME industry. However, the future can be *shaped* by home care provider's if they begin engaging in practices currently in place in other areas of the continuum of care.

Last year when I presented a session on outcomes at the HME Business Summit in Chicago, the eyes of some of the participants began glazing over. As I proceeded with the presentation I came to realize that I was discussing a topic that many did not understand or were not very interested in learning about. As I proceeded with presenting facts and figures from the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), I was rescued by a former Durable Medical Equipment Regional Carrier (DMERC) Medical Director who had recently joined the rank and file of the HME industry. He grabbed the microphone and exclaimed succinctly: "You all had better listen up here because you will soon

realize how important it will be not only to *understand* quality indicators and outcomes data but the *value* of the data when arguing your case with CMS or the DMERC Medical Directors". Now, either this gentleman was a visionary or he knew that competitive bidding, in addition to the 36-month cap on rental for oxygen concentrators, was on the horizon. Some of you are thinking: Everyone knew that was coming! Well, the question then is why didn't we prepare better? Or better yet, why didn't we prevent it from happening in the first place? The answers are different based on who you ask and of course their opinion of the correct focus for the industry. I bet if I presented the same topic today the eyes of "all" of the participants would be fixed on the data.

The industry suffers from lethargy and poor timing and the focus is still on preserving reimbursement instead of addressing the root cause that forces policy makers to consider cuts and changes in reimbursement in the first place - no data and more importantly, no valid measurement tools for the industry to establish quantifiable data. Now, don't take it personally. After all I endured the snoring of key industry leaders during my presentation so you all should endure the facts, which are: (1) Data speaks for itself (2) We don't have much of it quantified in evidence-based peer reviewed publications, and (3) Developing one-hit wonders with reports developed by firms commissioned to make arguments on behalf of the industry has not been successful - At all! Data is needed now more than ever and more importantly we need to invest more into programs that allows us to establish enduring data versus conducting surveys when we are threatened by impending legislation or - more cuts.

The solution to all that ails the industry is the development of data measurement tools by commissioning credible organizations such as the National Institutes of Health (NIH), Agency for Healthcare Research & Quality (AHRQ) and their contracted Evidence-Based Practice Centers (EPC) to develop instruments for measurements of quality of life and economic indicators for the home care and HME industry. The solution is not with investing 100's of thousands of dollars on lobbying firms that are only as effective as their relationships with the politicians (or their staffers) currently in office. Evidence-based medicine withstands the test of time and party affiliation. Case in point; we are still referring to the NOTT study when discussing oxygen qualification; and CMS still uses this as the basis for oxygen qualification. Now, we as an industry must go the extra mile by overlooking our comfort zones, step out of the boat and invest more into "true" and "enduring" solutions. This in the minds of many is a stretch but quite frankly is a definite must for our survival as an industry. It will, however, take a thought leader to boldly proclaim: "Stop the insanity!" So, the next step is to research the resources available to get a general idea on where to begin.

In addition to the AHRQ, organizations such as the Blue Cross, Blue Shield Technology Evaluation Center (BCBSA-TEC) can be contracted to develop the measurement instruments as well as guidelines on their use. Also, Plymouth Meeting, PA based ECRI is the ideal choice to develop product specific

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Umbilical Cord Blood Gases... *Continued from page 28*

Reproductive Care Program published Obstetric Guideline 6B on fetal monitoring. The guideline states that blood in a double clamped segment of the umbilical cord is stable for up to an hour at room temperature but once the sample is drawn into a syringe it must be analyzed within 30 to 60 and kept at room temperature. They report the following normal values (Mean \pm SD) for umbilical artery blood from term infants: pH = 7.27 \pm 0.069, PCO₂ = 50.3 \pm 11.1 mm Hg, HCO₃ = 22.0 \pm 3.6 mEq/L and for umbilical venous blood: pH = 7.34 \pm 0.063, PCO₂ = 40.7 \pm 7.9 mm Hg, HCO₃ = 21.4 \pm 2.5 mEq/L.

Clinical Outcomes

Although the previously mentioned guideline uses a critical cutoff value for umbilical artery pH of 7.10 more recent studies give a value of 7.20. A study in 2004 by Victory et al. evaluated the correlation between adverse outcomes and umbilical artery pH using logistic regression analysis with odds ratio calculations using a critical cutoff pH value of 7.20. This study found an umbilical artery pH of 7.24 \pm 0.07 in their population of 20,456 singleton, term, live born infants. Their analysis determined a significant inverse relationship between Apgar score < 7 and 5 minutes, NICU admission, and need for assisted mechanical ventilation and umbilical artery pH by logistic regression. Using a critical cutoff value of 7.20 they determined the odds ratio for each of these outcomes. The values for the odds ratio are given as OR with 95% confidence intervals in parentheses. For having an Apgar < 7 at 5 minutes if pH < 7.20 the odds ratio was 4.7 (3.4-6.5), for NICU admission the odds ratio was 2.3 (2.1-2.6) and for need of assisted mechanical ventilation the odds ratio was 6.4 (4.0-10.4).

Conclusions

The most recent studies indicate that umbilical artery blood should be sampled since this reflects the state of the infant and not how well the placenta is functioning. However, if you suspect that placental malfunction might be a problem for an infant then both should be sampled. The accepted critical value is an umbilical artery pH less than 7.20. The studies reported above indicate that when the umbilical artery pH is less than 7.20 the odds of having an Apgar score < 7 at 5 minutes is 4.7 times higher, the odds of requiring NICU admission is 2.3 times higher, and the odds of requiring NICU admission is 2.3 times higher than if the pH > 7.20.

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Quality of Life and Economic Measures... *Continued from previous page*

instruments for devices such as oxygen concentrators to assist providers with measuring and quantifying health and economic outcomes from the products as well as the services associated with the provision of these devices to help defend against cuts and changes in reimbursement methods.

Many providers lose sleep over the changes associated with home care and HME products and question if they should stay in business, purchase non-delivery oxygen technology or simply wait to be acquired; which is not happening very often these days. Despite the decision, quality and economic indicators must be developed for home care and HME providers if we are to prevent additional changes from occurring - or purchase a local Rite-Aid and sit back and wait for the commodity train to take off.

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