



TOOLKIT FOR RESPIRATORY THERAPISTS

Marketing Yourself to the Physician Practice

2016

Toolkit for Respiratory Therapists: Marketing Yourself to the Physician Practice

Overview

Have you ever thought about working outside the acute care setting? Would you like to pick up some extra money working part-time? Would you consider working under a contractual arrangement? Would you like to gain some new experiences that can benefit you as a health care professional as well as your patients? Are you retired and looking to get back in the profession in a meaningful way? If any of the answers are “yes”, you may want to consider working in a physician practice setting.

Respiratory therapists (RT) play an important role in caring for patients with chronic lung disease. With Chronic Obstructive Pulmonary Disease (COPD) now added to the list of conditions subject to penalties under Medicare’s Hospital Readmissions Reduction program, a greater emphasis has been placed on discharge planning and coordinating care for the patient post-discharge. Since much emphasis has been placed on transition from “hospital to home,” opportunities are greater now than ever before for the RT to be involved outside the inpatient hospital setting.

This toolkit is designed to help you hone your marketing skills to work in a physician practice, even if it is part-time or under contract. It provides information about the health care system today, the challenges facing physician practices, and why there are increased opportunities for RTs to work in the physician practice setting. So take some time to get educated and see if this is a right fit for you.



The New Paradigm in Health Care Delivery

The entire landscape of health care delivery is undergoing a seismic shift that affects all types of health insurance programs and payers. For example, Medicare, the nation's largest health care payer, has begun an ambitious program to link care and payment to quality measures instead of the number of services rendered. It has embarked on new alternative payment models that are designed to encourage physicians, hospitals and other providers to improve care and reduce costs by working together through formal arrangements that “follow the patient.” Additional emphasis has been placed on the importance of care coordination among primary care physicians, specialists, suppliers and other community-based services in order to reduce excessive hospital readmissions.

Many private payers, such as Blue Cross/Blue Shield, Aetna, and others, tend to follow in Medicare's footsteps since it wields a considerable influence in how health care is delivered and paid for today. Nevertheless, private and public payers can vary with respect to coverage and payment, so there is no “one size fits all”. Therefore, it is not possible to cover all types of coverage and/or payment scenarios that RTs may face if they seek employment outside the acute care setting.

While RTs may often treat and care for patients with chronic lung disease who are elderly or may be disabled and are on Medicare, you are also just as likely to treat non-Medicare patients of varying ages with lung disease who have private health insurance through their employers, self-pay plans, Medicare Advantage plans that provide services through a designated network of providers, or even Medicaid.

Regardless of how health insurance pays for care, this new paradigm in health care delivery opens up greater opportunities for RTs. With emphasis on value and quality care, the new system improves opportunities for RTs in the physician office setting that showcase their expertise and improve the health outcomes of patients who suffer from chronic lung disease.

New Medicare Covered Services Increase Opportunities for RTs

We have often talked about the need to increase the RT presence in physician practices since so much emphasis today is placed on post-acute care and transition from “hospital to home”. The discussion below helps you understand the Medicare benefit category that allows RTs to work in the physician office setting and describes some of the new care coordination incentives and innovative payment models that are being tested by the Centers for Medicare and Medicare Services (CMS) that incentivize physicians to change the way they provide care.

Medicare’s “Incident to” Benefit

In the Medicare program, the primary benefit category that permits RTs to work in the physician’s office is under the “incident to” benefit. “Incident to” also applies to the services of other practitioners such as nurse practitioners, physician assistants, certified nurse specialists and others who can bill Medicare directly for their services. It’s an employment opportunity currently available to RTs but one that is rarely utilized. So what does that really mean and how is the RT impacted by it?

“Incident to” services are those that are:

- Furnished in a physician’s office or clinic;
- Commonly rendered without charge or included in the physician’s bill;
- Integral, though incidental, to the physician’s services in the course of diagnosis or treatment of an injury or illness; and,
- Furnished under the *direct supervision of the physician**

*The *direct supervision* requirement does not mean that the physician or other health care practitioner has to be in the room where the service is being furnished; it requires only that they be somewhere in the office suite.

Services that are integral or “incidental” to the physician’s service furnished by a RT would have to be related to the patient’s diagnosis and/or condition and the purpose of the office visit and be services the physician or another qualified practitioner (i.e., nurse practitioner or physician assistant) would otherwise perform personally. In other words, you could not demonstrate use of a nebulizer or MDI inhaler if the primary purpose of the office visit was to remove a cast due to a broken arm.

But what is involved when it says the service must be *commonly rendered without charge or included in the physician’s bill*?

- Services that are “commonly rendered without charge” could include services furnished by nurses that are routinely part of the physician’s practice for which a charge is not submitted.
- Other services may be bundled, i.e., multiple services identified by a single code for which only one payment is made to the physician. For example, if a RT furnished self-management education and training which may include a discussion with the patient about his or her disease and how to recognize its symptoms and triggers that may lead to an acute exacerbation, it may be bundled into the payment the physician would receive as part of his or her evaluation and management of the patient or it might be included in the transitional care or chronic care management services which are discussed in detail below. Currently, self-management education cannot be billed separately; it can only be billed if it is bundled with another covered service(s).
- The physician could, however, receive a separate payment for a number of services a RT could furnish to pulmonary patients. Examples include pulmonary function testing, office-based spirometry, CPAP initiation/management or bronchodilation evaluation.



Generally it is up to those on the physician's staff who are coding experts to determine the appropriate code that the physician can use to be reimbursed for the RT's service. However, you may want to review AARC's coding guidelines on those respiratory care services we are asked about most frequently for additional information.

http://www.aarc.org//app/uploads/2014/10/coding_guidelines.pdf

Before proceeding, it is important to remember that under the "incident to" benefit, RTs cannot bill directly for their services. The physician must bill Medicare and receive the payment directly. It is up to the physician to determine the amount of payment that will be provided to the RT or whether the RT will receive a base salary for his/her services or be paid on an hourly or per diem basis.

New Incentives Exist for RTs

In the past, there was not a huge incentive for physicians to hire RTs to work in the office setting due to concerns about payment for the RTs' services. But that is not the case today. Covered services that offer physicians' separate payment and incentives to improve the care of their patients have increased over the past few years and innovative payment models are adding to the mix. In fact, new transitional care and chronic care management services discussed below now permit clinical staff such as RTs to work under the *general supervision of the physician* (for these two new benefits noted below, this is a significant change from the "direct physician supervision" which is still mandated under the "incident to" benefit) . That means the physician does not have to be present or in the office during the performance of the service. Further, you do not need to be an employee of the physician to take advantage of these programs. The physician can contract with you to work certain hours or days if that is better suited to your schedule.

Transitional Care Management (TCM) Services

In 2013 Medicare began paying physicians separately for transitional care management (TCM) services. The TCM services are designed to prevent hospital readmissions by providing seamless care when a patient is discharged from an institution to community-based care. This means the patient can be discharged from not only the hospital setting, but from a long-term care hospital, a skilled nursing facility, or even an inpatient rehabilitation hospital which increases the ability of RTs to render their expertise in caring for patients with chronic lung disease.

While the physician is required to have a face-to-face evaluation with the patient within 7 to 14 days depending on the complexity of care required, there are several non-face-to-face services that are covered when furnished by the physician's clinical staff, which could include RTs. These include the following:

- Communication with the patient and/or caregiver within two business days of discharge and with other home health agencies or community services as applicable;
- Assistance with referrals the patient may need, such as durable medical equipment;
- Provision of self-management education to the patient and/or family/caretaker; and,
- Assessment and support of adherence to the treatment regimen and medication management, which could involve among other things oxygen utilization.

Chronic Care Management (CCM) Services

Medicare began coverage of Chronic Care Management (CCM) Services January 1, 2015. To qualify, a patient must have 2 or more chronic conditions that are expected to last through their lifetime or that put the patient at significant risk of death, an acute exacerbation/ decompensation or functional decline. One of the unique things about this benefit is that it offers beneficiaries 24/7 access to their health care needs. Like TCM services, coverage is based on non-face-to-face services that include, among other things, the following:

- Assessment of the patient's medical, functional and psychosocial needs;
- Medication reconciliation with review of adherence (e.g., oxygen) and potential interactions;
- Management of care transitions between and among health care providers, which could include home equipment suppliers
- Follow-up after an emergency department visit and after discharges from hospitals, skilled nursing facilities and other health care facilities.

Physician Quality Reporting System (PQRS)

The PQRS is a program designed to provide incentives to physicians and other eligible professionals such as nurse practitioners, physician assistants, clinical nurse specialists, etc., to improve care, reduce the number of unnecessary services and reduce excessive hospital readmissions by reporting certain quality measures which they voluntarily choose to report.

There are a number of pulmonary measures involving COPD, asthma, tobacco cessation and sleep apnea that physicians, especially pulmonologists, can choose to report. (A sample list of the measures is attached). Each year the measures are revised through the formal rulemaking process, but typically once a measure is on the list it is carried over from year-to-year. The physician would be more likely to choose to report these measures if there was a RT working in the practice because the value and expertise the RT provides to pulmonary patients can go a long way to improve the quality of care for his or her patients.

Beginning in 2019, physicians and other eligible practitioners, such as nurse practitioners, physician assistants, and certified nurse specialists who treat Medicare patients will be faced with a new payment system that builds and improves on the quality measures and other incentive payment programs physicians must meet currently. In addition, physicians who perform well under the new system have the opportunity to earn a bonus payment if they participate in alternative payment models or meet certain performance measures. High-performing physicians can earn substantial bonuses and that's why there is an incentive to add RTs to their team, especially those who specialize in treating chronic lung disease.

Alternative Payment Models

The Medicare program is testing a variety of payment models aimed at providing better health, improving outcomes, and reducing costs. Quality, care coordination and value are the buzz words used to describe these new programs. Many of these programs' goals include improving care for patients with chronic conditions, including COPD and asthma.

The descriptions listed below are taken from CMS website at:

<http://innovation.cms.gov/initiatives/index.html#views=models>

Just remember – you don't need to know the ins and outs of these programs. You just need to know that they exist and offer additional opportunities for RTs outside the hospital setting than were available in the past.

- **Accountable Care Organizations** - ACOs are groups of doctors, hospitals, and other health care providers, such as skilled nursing facilities and durable medical equipment suppliers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. A new type of ACO called “Next Generation” offers a limited expansion of telehealth services.
- **The Bundled Payments for Care Improvement Model** - This initiative is comprised of defined models of care that link payments for multiple services beneficiaries receive during an episode of care. Providers can choose from numerous episodes of care which include COPD and bronchitis/asthma. The models include acute care stays only, a combination of acute and post-acute care, and post-acute care only which can expand opportunities for RTs to help their patients while they are in the hospital as well as post-discharge.
- **Independence at Home Demonstration** - CMS works with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so whether such services improve care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration rewards health care providers that provide high quality care while reducing costs.
- **Medicare Coordinated Care Demonstration** – This pilot project tests whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs. The selected projects represent a wide range of programs, using both case and disease management approaches, and operate in both urban and rural settings.
- **Community-based Care Transitions Program (CCTP)** – This initiative tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

These programs and demonstration projects vary in size and the areas of the country where providers are participating, so there are limitations as to their availability. Accountable Care Organizations and those working together as part of the bundled payment initiative have the most visibility and comprise the largest network of providers. If you are interested in pursuing other employment opportunities, we encourage you to check out the CMS website noted above which describes the models in more detail and lets you know the hospitals and providers that are participating in your state.

While we tend to focus on Medicare, especially in recognition of the fact that the number of beneficiaries will increase substantially over the next decade as baby boomers continue to age into the program, it is important to emphasize that the pulmonary patients you may treat in the physician office setting could be infants, young adults, middle age adults as well as the elderly.



This means that a variety of insurers will be involved in paying for the services you can offer to pulmonary patients, so it's not just about what Medicare covers. Keep that in mind as you discuss your skills and the attributes you can bring to the physician practice.

Choosing a Physician Practice

Where to Start

- The first decision you need to make is to decide if you want to work in the physician office setting. There is no restriction on whether you are a CRT, a RRT, or hold a specialty credential. It is up to the physician to determine if your qualifications meet the needs of the practice and the pulmonary patients it serves.
- While technically every physician office could benefit from RTs in their practice, especially primary care practices (family/general practice or internal medicine), realistically those practices that see a high number of patients with lung conditions would most likely be ones most open to hiring the RT, e.g., specialists such as pulmonologists. Thus, their patient-base would benefit the greatest from the expertise of the RT.

The majority of physician offices that would consider hiring a RT would most likely use the RT on a part-time basis. This is especially true since, in addition to patient volume, primary care practices may not be able to offer the types of benefits (e.g., health insurance, paid leave, etc.) that RTs are afforded in the hospital setting. Most important, working in a physician practice may be most appealing to those RTs who have retired from day-to-day full-time employment. Their expertise and years of experience can be most helpful in this venue.

Regardless of your current status, this toolkit offers strategies for you to consider if you want to embark on a new pathway in your career.

Do Some Homework

Your hospital may already be participating in one of the new Medicare alternative payment models, such as ACOs, where they coordinate with physician practices, suppliers and other community-based services. Check through your RC Department or others in the hospital to determine if your hospital is part of an ACO and if the physician practices that also participate are near your home or work location.

- If working in one of the new alternative payment models CMS is testing appeals to you, it would also be a good idea to go to the CMS website listed above and check out the various locations and providers that are participating so you know from the start what opportunities may be available and if they are located near you.

Over the past several years, the discharge planning process has changed significantly as a way to improve the process and reduce excessive, preventable hospital readmissions and further changes are being considered. The revisions include industry best practices which, among other things, call for a multi-disciplinary team approach that specifically includes RTs as the most effective way to position the patient for the care he/she will need post discharge.

- Talk with your patients and find out who they have as a primary care physician or specialist. You could leverage that information to contact the physician and offer to follow the patient to the physician practice once your patient is discharged. This is especially important if the physician is providing services that are part of the TCM benefit discussed above which is designed to reduce hospital readmissions.

Selling Your Expertise

It is important to remember that all of the services within your scope of practice and the services you provide in the acute care setting don't necessarily translate to the physician office setting. Obviously there are services for which your expertise could be instrumental in improving the care of your patients and those who visit their physician through regular office visits. Such outcomes are particularly appealing to physicians these days since they are encouraged to produce better results in order to receive incentive payments or, on the other hand, if they don't to be penalized with a negative payment.

You are the respiratory health expert when it comes to assessing and treating the needs of pulmonary patients, including providing disease management skills that can help improve their outcomes. You know best what you do and how well you do it. So, if you decide to move forward with a new experience in the physician practice setting, here's a list of things to help you.

Where to Start

- Begin with your education and training. Discuss the courses that you took as part of an accredited education program and the training and competency testing that was required in order for you to receive a credential from the National Board of Respiratory Care and attain the mandatory state license to practice in the respiratory therapy profession.
- Briefly give an overview of the respiratory therapist's scope of practice, recognizing that not all of the services you provide may be indicative of the physician office setting.
- Talk about the patients you have treated and their experiences and outcomes as a result of your expertise and what you think you can bring to the office practice. Highlight your skills and why they make you unique.
- Outline and describe briefly the services that you believe will be most helpful to pulmonary patients as well as the physician practice. This means going into some detail as to how your expertise and training provides an advantage to pulmonary patients. Services that are most likely to be provided in the physician practice include the following:
 - Pulmonary function testing
 - Spirometry
 - Evaluating bronchodilation responsiveness
 - CPAP initiation and/or management
 - Smoking cessation counseling
 - Inhalation treatments, especially if they patient comes into the office wheezing
 - Six-minute walk test (most likely required by pulmonologists)



- Educating patients about their disease and developing an action plan to assist patients in recognizing their symptoms and the triggers that can lead to an acute exacerbation
 - Demonstrating or evaluating the proper use of aerosol delivery systems, i.e., aerosol generator, nebulizer, MDI, IPPB device
 - Overseeing medication adherence with respect to use of respiratory devices and ensuring patients on oxygen get the right amount of oxygen saturation.
 - This is a critical area in which RTs can excel because of your expertise.
 - Advising on appropriate selection of oxygen delivery devices
 - Reviewing and advising on patient action plans
- Be sure to talk about your availability and whether it will be tied to your hospital schedule or whether you have flexibility to meet the practice's needs.
 - Don't be shy about asking how the physician practice pays its employees or independent contractors and, depending on the type of arrangement you are interested in whether there are any associated benefits.

Additional Ideas to Consider

- You may also want to point out that respiratory therapists are already making a difference in their hospitals by establishing best practices that reduce COPD readmissions. Improving access to your expertise in the physician's practice can go further to prevent returns to the hospital. In fact, there is a COPD Toolkit that may be of benefit to you that may give you additional ideas to get across to the physician. You can access it at the link below.

<http://www.aarc.org/resources/tools-software/copd-toolkit/>

- While most pulmonary rehabilitation programs are provided in the hospital outpatient setting, a number of physician practices, most likely pulmonologists, also provide pulmonary rehabilitation services. If this area appeals to you, you may want to review the Frequently Asked Questions about the program on the AARC website (See link below). It provides a wealth of information about the service components of pulmonary rehabilitation that can assist you in marketing your skills in this venue.

http://www.aarc.org/app/uploads/2013/07/PulmonaryRehab_FAQs_Final_rev2-12-14.pdf

- If you are an AARC member, you have probably received the AARC's Career Newsletters via e-mail. In addition, the AARC website has great career advice that includes such topics as interviewing, job search, professional development, resume writing and use of social media. If you feel you are at a point in your career that you want to make a change, and you feel the physician practice is a good place to start, check out <http://www.aarc.org/careers/> for helpful tips. You may also want to check with your State Respiratory Care Society for information relative to opportunities in your state.



Why Physicians Should Hire Respiratory Therapists Putting Things in Perspective

When respiratory therapists advocate for better access to their expertise in physician practices, especially when talking with Congressional leaders, they have a series of talking points to drive their message home and why it's important to have RTs in the mix.

Now that you've given the physician an overview of your expertise and explained your personal qualifications and the types of services you can provide to his or her pulmonary patients, it can be a real clincher to put it all in perspective.

- The purpose of the information below is to show that treating patients with chronic pulmonary disease is costly and prevalent and that with your expertise you can help the physician meet their challenges head on.
- It also shows that you are aware of what's going on with health care today in the broadest sense and not just what your personal experiences may bring to the table.

Talking Points to Help You

Below are some talking points that may be helpful when discussing why it's important for the physician to hire you and also to impress him/or her with your knowledge. You don't need to use all of them or any of them if you don't feel comfortable discussing the points. However, there are some that may be unique to your work experience and it's better to have the information available as opposed to not sharing it.

- Hospital readmissions are on everyone's radar screen with a lot of emphasis on improving transition from hospital to home.
 - With emphasis on improved care coordination, you can bring value to the practice in assessing the patient's needs, especially if the patient requires any type of respiratory equipment.
- Without proper self-management skills, pulmonary patients may end up in the ED or hospital because they don't know what do when acute exacerbation occurs.
 - You can help reduce costly acute care interventions by teaching patients how to recognize triggers and symptoms of their disease, slow its progression, and improve outcomes.
- The CDC lists COPD as the 3rd leading cause of death and the Medicare Payment Advisory Commission ranks COPD 4th among the most costly preventable readmissions.
- Due to the cost and prevalence of COPD readmissions, COPD was added to the list of conditions subject to hospital readmission penalties in October 2014. Pneumonia has been on the list since the inception of the Hospital Readmissions Reduction Program which was enacted as part of the Affordable Care Act (e.g., Obamacare).
- Treatment for patients with multiple chronic conditions that include COPD and asthma is costly.

- RTs have been involved in studies that show they can significantly reduce hospital readmissions with a simple disease management program and can significantly decrease inappropriate supplemental oxygen use managing home oxygen patients, which can result in cost-savings while providing improved health-care delivery. You can assist the physician in these areas. [NOTE: Details of the studies are provided at the end.]
- Most patients who use inhalers are not trained properly which leads to waste of the medication and the patient's inability to maximize its use.
 - You are the expert when it comes to demonstrating proper techniques and can minimize unnecessary, ineffective or wasteful interventions with your skills and expertise.
 - You can bridge the gap between the needs of pulmonary patients and the complex inhaler devices/new drug regimens/therapies that will assist in managing their disease and keep them out of the ED or hospital.
- Physician shortages are prevalent and expected to continue.
- Hiring you to be part of the physician's care team is more critical than ever and the value you can bring to the physician practice can be immeasurable.

Taking the Next Step

Now that you have some tools in your back pocket to make the transition, the rest is up to you to take the next step. It's never too late to consider new career paths.

In addition to the information in this Toolkit, there is an abundance of information on the AARC website at www.aarc.org. Search your favorite topics for additional information that may be of benefit to you as you consider employment in the physician practice setting.

Most of all, remember that you are the only allied health professional trained, educated and competency tested in all aspect of pulmonary medicine – so that gives you a leg up in the value you can bring not only to the physician practice but most of all to the patients you treat who have chronic lung disease.

Whatever you choose to do, your expertise and dedication to treating pulmonary patients makes you special.



Physician Quality Reporting Initiative – Quality Measures (Sample)

Category	Measure
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented
Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator
Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting	Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication
Medication Reconciliation	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months through 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Sleep Apnea: Assessment of Sleep Symptoms	Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of sleep symptoms, including presence or absence of snoring and daytime sleepiness
Sleep Apnea: Severity Assessment at Initial Diagnosis	Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis
Sleep Apnea: Positive Airway Pressure Therapy Prescribed	Percentage of patients aged 18 years and older with a diagnosis of moderate or severe obstructive sleep apnea who were prescribed positive airway pressure therapy
Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured
Optimal Asthma Control	Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age-appropriate patient reported outcome tools.
Tobacco Use and Help with Quitting Among Adolescents	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial

Kathryn L Rice, Naresh Dewan, MD, Hanna E. Bloomfield, MD, MPH, Joseph Grill, MS, Tamara M. Schult, MPH, David B. Nelson, PhD, et al. *Am J Respir Crit Care Med.* Feb 2010

Study Objective: To determine whether a simplified disease management program reduces hospital admissions and emergency department (ED) visits due to chronic obstructive pulmonary disease (COPD). This one-year study was conducted at five VA medical centers. Patients assigned to usual care received a one-page handout containing a summary of the principles of COPD care and the telephone number for the 24-hour VA nursing helpline, a service available to all VA patients. Patients assigned to the disease management arm attended a single 1 to 1-1/2 hour group education session conducted by a respiratory therapist case manager, an action plan for self-treatment of exacerbations, and monthly follow-up calls from a case manager.

Results: After one year, the primary outcome rate of hospitalization and emergency visits for COPD among the disease management patients was 48.4 per 100 patient-years compared to 82.2 per 100 patient-years among the usual care patients, a statistically significant 41% reduction.

Implementation of an Oxygen Therapy Clinic to Manage Users of Long-term Oxygen Therapy

John C. Chaney, MD; Kevin Jones, RCP; Kurt Grathwohl, MD; and Kenneth N. Olivier, MD, MPH
Chest 2002; 122:1661–1667

Study objective: To evaluate the initial benefits of establishing an oxygen therapy clinic (OTC) to manage users of long-term oxygen therapy (LTOT). The evaluations consisted of a focused medical interview and physical examination by a respiratory therapist of 283 patients. Demographic data, indications for supplemental oxygen, oxygen-related diagnoses, cardiopulmonary review of systems, pertinent physical examination findings, pulmonary function testing, and oximetry data were recorded.

- 97 patients with a new oxygen prescription during hospitalization were evaluated within 90 days. At follow-up, 50.5% no longer met CMS guidelines for LTOT and 27.9% required significant changes in their oxygen prescription.
- Of 95 outpatients with existing orders for oxygen who were contacted for recertification, 31.6% no longer met Medicare criteria for oxygen and 26% required significant change to their oxygen prescription.
- Of 91 home oxygen patients referred from other outpatient clinics, oxygen therapy was discontinued in 22% of the patients and the oxygen prescription was changed in another 29.7%.

Conclusions: Results of this initial evaluation suggest that the institution of a respiratory therapist-managed OTC to manage home oxygen patients can significantly decrease inappropriate supplemental oxygen use, which can result in significant cost savings while providing improved health-care delivery.



A randomized, controlled study to evaluate the role of an in-home asthma disease management program provided by respiratory therapists in improving outcomes and reducing the cost of care

Shelly DC, Legrand TS, Gardner DD, Peters JL. *J Asthma*. 2009 Mar;46(2):194-201. doi: 10.1080/02770900802610068.

Study Objective: To compare the effects of an in-home asthma disease management program (AMP) provided by respiratory therapists (RT) to a program provided by nurses (RN) and to usual care (UC) provided in physician offices or clinics. Subjects between the ages of 18-64 who had been admitted to the emergency department or hospital for acute asthma exacerbation were randomized into the three groups. Outcomes assessed included hospitalizations, in patient days, hospitalization cost, ED visits and cost, clinic visits, pulmonary

function, symptoms, health related quality of life, asthma episode self-management score, environmental assessment and patient satisfaction.

Results: At 6 months, the groups with nurses and respiratory therapists (AMP-RN n=54; AMP-RT n=46) had significantly fewer ($p < 0.05$) hospitalizations and in-patient days, lower hospitalization costs, and greater health-related quality of life physical component summary change scores when compared to the UC. However, respiratory therapists had greater pulmonary function and symptoms change scores when compared to the UC and significantly better asthma episode self-management and patient satisfaction scores as compared to nurses and UC.

Conclusions: An in-home asthma management program can be effectively delivered by respiratory therapists and may reduce hospitalizations, in-patient days, cost and improve measures of health-related quality of life and patient satisfaction in a population prone to asthma exacerbation.