NAMDRC

WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY, CRITICAL CARE AND SLEEP MEDICINE

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NAMDRC Annual Meeting, Evaluating the e-ICU

The 43rd Annual Meeting and Educational Conference of the National Association for Medical Direction of Respiratory Care will be held March 12 to 14 at The Scottsdale Resort at McCormick Ranch. NAMDRC's annual meetings are developed around the organization's core principles of improving the quality of patient care, reducing barriers to that care and anticipating changes in our practice environment. One of the highlights of this meeting is the opportunity to have a personal interaction with respected educators and meet with industry leadership to discuss clinical challenges in an informal setting. Of particular interest this year will be a talk by Claibe Yarbrough, MD, Chief of Pulmonary and Critical Care of the North Texas Health Care System Veterans Administration, on the application of tele-technology to aid in the care of critically ill patients.

An Historical Perspective

In 2000 there was a collision of several centers of interest and needs that led to a focus on the care of the critically ill. This included a report from the Institute of Medicine published by the National Academy of Sciences, a study by the Committee on Manpower for Pulmonary and Critical Care Societies (COMPACCS) published in the Journal of the American Medical Association and a study published in Critical Care Medicine by physician thought leaders practicing in intensive care units.

The report from the Institute of Medicine Committee on Quality of Health Care in America, *To Err is Human: Building a Safer Health System,* generated shock waves through the medical community and drew intense media scrutiny. The report presented startling statistics of death and injury from medical error attributed not to healthcare personnel but to bad systems of care.
Coincident with the release of the IOM report, a study by the Committee on Manpower for Pulmonary and Critical Care Societies found that The United States was facing an unprecedented, and largely unrecognized, shortage of physicians trained to provide critical care services; *Angus DC, Kelley MA, Schmitz RJ, et al. Current and project workforce requirements for care of the critically ill and*

The ***WASHINGTON WATCHLINE*** *is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.*

NAMDRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

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NAMDRC 43rd Annual Meeting and Educational Conference will be held:
March 12– 14, 2020
The Scottsdale Resort
at McCormick Ranch
Scottsdale, AZ

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"NAMDRC will directly affect your practice more than any other organization to which you belong."

patients with pulmonary disease: can we meet the requirements of an aging population? JAMA 2000; 284:2762–2770. In December of 2000 Brian Rosenfeld and colleagues published *Intensive care unit telemedicine: alternate paradigm for providing continuous intensivist care* in the journal of the Society of Critical Care Medicine.

The Institute of Medicine report "breaks the silence that has surrounded medical errors and their consequence." It was estimated that as many as 98,000 people die in any given year from medical errors that occur in hospitals. While policymakers and the media were occupied with a response to this report, Derick Angus and his colleagues revealed a national shortage as well as a maldistribution of clinical critical care personnel. They pointed out that there were more than 7,000 intensive care units in the country with approximately 5,500 intensivists in active practice. At the time, only 15% of ICUs had dedicated intensivist care and only 35% of hospital ICU patients had an intensivist involved in their care. Furthermore, approximately 40% of US hospitals were located in rural communities where there were few physicians with advanced training in critical care. Importantly, this group pointed out that there was no expectation of an increase in availability of physicians trained in the field of critical care medicine. They noted that the number of intensivists who would be entering the workforce over the ensuing 5-10 years would be approximately equal to the number retiring from practice. Well aware of the existing physician staffing challenges and the issue of medical errors Rosenfeld and his colleagues published a description of their experience with evolving telemedicine technology to improve the care of critically ill patients. Their novel project used continuous intensivist oversight of a surgical ICU using video conferencing and computer-based data transmission at a remote site. This study demonstrated significant reductions in ICU and hospital mortality, ICU complications, and ICU and hospital length of stay and costs compared to control periods.

The Leapfrog Group

The Institute of Medicine report caught the attention of large employers and other major purchasers of healthcare. Concerned about the safety of their employees and the high cost of medical errors they banded together to form The Leapfrog Group. Taking a business approach to the problem, the goal of the group was to develop metrics to evaluate hospital errors, injuries, accidents, and infections and to develop a hospital scorecard that would empower purchasers of healthcare to find the highest-value care. The group believed the time had come for purchasers to use marketplace leverage to encourage hospitals to focus on the processes of medical care. Data acquired during their initial studies suggested that over 54,855 deaths that occurred in the ICU could be avoided with improved staffing models and they developed an ICU physician staffing standard:

Hospitals fulfilling the IPS Standard will operate adult or pediatric general medical and/or surgical ICUs and neuro ICUs that are managed or co-managed by intensivists who:
1. Are present during daytime hours and provide clinical care exclusively in the ICU and,
2. When not present on site or via telemedicine, returns pages at least 95% of the time, (i) within five minutes and (ii) arranges for a physician, physician assistant, nurse practitioner, or a FCCS-certified nurse to reach ICU patients within five minutes. Hospitals in rural areas earn partial credit for teleintensivist coverage that meets explicit requirements.

Three years after the publication of the COMPACCS study representatives of the critical care societies published; *Framing Options for Critical Care in the United States: A Report from the Critical Care Professional Societies*. In that report they recognized that meeting Leapfrog guidelines would require an additional, actively practicing, 35,000 to 40,000 intensivists. They concluded that to prevent a national crisis, the organization of critical care delivery would require a fundamental redesign that included the incorporation of innovative technology. It was suggested in that report

that the application of telemedicine could contribute to ameliorating the problem. While there was pushback on the role of telemedicine oversight of ICU care by many academic institutions other domains, including the military, the Veterans Administration and community hospitals began to explore the use of the technology.

The Appeal of ICU Telemedicine

Successful clinical decision making when caring for critically ill patients depends on integration of multiple pieces of data on multiple levels. Few health care environments require as much technology as the ICU. Critical care practice incorporates diagnostic devices, physiologic monitoring and clinical information systems. For an already stressed health care work force, technological advances provide a double-edged sword. Health care workers must manage more and more clinical data, which requires additional time and personnel to generate, document, store, integrate, and act upon this information. On the other hand, technological advances, particularly in information technology, offered new opportunities for increased clinical efficiency as well as improved patient outcomes. Novel approaches that leverage
technology have the potential improve utilization of scarce resources such as intensivists time. The display of clinical trends, particularly with thresholds or alarms for pre-determined trends or abnormal results, emphasizes early, proactive rather than delayed, reactive patient management.

The barriers to acquisition and application of the tele-ICU were substantial and included high up-front investment costs, the challenges of personnel training, physician acceptance of the new approach to patient care and limited evidence of efficacy. As in other areas of critical care medicine when quality data was lacking or clinical routine is threatened, an emotional debate over the effectiveness of ICU tele-monitoring and intervention ensued. This debate was fueled by published studies both, favorable and unfavorable, that were poorly designed and the results poorly analyzed.

Building the Evidence Base

In March 2010, recognizing the importance of addressing the quality gaps in critical care medicine and the potential benefit of remote monitoring and intervention under the guidance of an experienced intensivists, the four major critical care societies convened a conference, funded by the Agency for Healthcare Quality and Research, at the offices of The American College of Chest Physicians (ACCP). In addition to ACCP leadership, representatives from The American Thoracic Society, The American College of Critical Care Nurses and The Society for Critical Care Medicine attended. The resulting document was submitted to The National Institutes of Health and published in CHEST in 2011. *The Research Agenda in ICU Telemedicine. A Statement From the Critical Care Societies Collaborative.* Jeremy M. Kahn, MD; Nicholas S. Hill, MD, FCCP; Craig M. Lilly, MD, FCCP; Derek C. Angus, MD, MPH, FCCP; Judith Jacobi, PharmD; Gordon D. Rubenfeld, MD; Jeffrey M. Rothschild, MD, MPH; Anne E. Sales, RN, PhD; Damon C. Scales, MD, PhD; and James A. L. Mathers, MD, FCCP. CHEST 2011; 140(1):230–238

This group recommended that future research should be organized around a framework that enabled consistent descriptions of both the study setting and the telemedicine intervention. The framework should include standardized methods for assessing the pre-implementation ICU environment and describing the telemedicine program in order to facilitate comparisons across studies and improve generalizability by permitting context-specific interpretation. Specifically, future research should focus on causation instead of simply associations and elucidate the mechanism of action in order to determine exactly how ICU telemedicine achieves its effects.

Since 2011 there have been numerous articles published on the use of telemedicine in the ICU.

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Several well structured studies make the case for the benefit of telemedicine for care of the critically ill. The UMass Memorial Critical Care Operations Group, University of Massachusetts Medical School, have published several studies that help us understand both the application of the technology and the impact of changes in processes of care:

A Multicenter Study of ICU Telemedicine Reengineering of Adult Critical Care Craig M. Lilly , MD , FCCP; John M. McLaughlin , PhD , MSPH; Huifang Zhao , PhD ; Stephen P. Baker , MScPH ; Shawn Cody , RN , MSN , MBA; and Richard S. Irwin , MD, Master FCCP; for the UMass Memorial Critical Care Operations Group; CHEST. 2014 Mar; 145(3): 500-7.

ICU Telemedicine Comanagement Methods and Length of Stay; Helen A. Hawkins, PhD, Craig M. Lilly, MD, FCCP, David A. Kaster, BS, Robert H. Groves Jr., MD, FCCP, Hargobind Khurana, MD; CHEST 2016; 150(2):314-319.

At the same time concerns were being raised regarding the cost benefit of implementing this technology.

The Costs of Critical Care Telemedicine Programs A Systematic Review and Analysis Gaurav Kumar, MD ; Derik M. Falk, MD ; Robert S. Bonello, MD ; Jeremy M. Kahn, MD ; Eli Perencevich, MD ; and Peter Cram, MD, MBA; CHEST 2013; 143(1):19–29

A subsequent study from the University of Massachusetts helped answer this question:

ICU Telemedicine Program Financial Outcomes, Lilly CM, Motzkus C, Rincon T, Cody SE, Landry K, Irwin RS, for the UMass Memorial Critical Care Operations Group; CHEST 2017; 151(2):286-297

Promoting New Processes of Care

A decade ago CMS paid only for services that were reasonable, necessary and face-to-face. Members of the AMA House of Delegates recognized the benefit of telemedicine and over the last several years an increasing number of CPT codes have been approved for remote patient care in the outpatient setting. There has been a recent shift in CMS policy and the Agency has been taking steps to reimburse providers for implementation of telecommunications services. In January 2017 CMS adopted two G codes to compensate physicians rendering critical care consultation from a remote location. These services are limited to once per day, per patient; and are valued relative to existing evaluation and management services. Code G0508 is for the first hour of critical care consultation communicating with the patient and providers via telehealth and is valued at $263.69. G0509 is for a subsequent service and is valued at $254.27.

Successful healthcare advocacy requires a strong evidence base. While the evidence base for tele-medicine has been strengthened and both CMS and private payers have approved reimbursement there are still barriers to wide spread adoption. There is pending federal legislation to address these barriers in the 116th Congress that will expire January 2021. We look forward to hearing about Dr. Yarbrough's experience and thoughts on the future.

PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.

NAMDRC Membership Benefits AT *A GLANCE...*

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

https://www.namdrc.org/content/issue-advocacy

One of NAMDRC's primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC's key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

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MEMBERSHIP OPPORTUNITIES WITH NAMDRC

INSTITUTIONAL MEMBERSHIPS

NAMDRC has restructured its membership opportunities to more accurately reflect how physicians practice medicine, acknowledging that genuine "private practice" is nowhere near as prevalent today as it was even five years ago. Physicians are now employees of hospitals and medical systems.

To improve our communication with you and hospital based colleagues, we have revamped our dues structure, with individual/small practice remaining basically the same as it is today. We are renaming our group practice options into two specific categories:

Institutional Membership/Gold for institutions that identify at least seven physicians, but no more than 20 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive two half price registrations for our Annual Conference at the standard member rate.

Institutional Membership/Platinum for institutions that identify at least 21, but no more than 50 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive four half price registrations for our Annual Conference at the standard member rate.

Small Group Practice (1-6 physicians)	$295 for renewal
	$395 for new member (includes one-time $100 initiation fee.)
Gold Institutional Membership (7-20 physicians)	$1750
Platinum Institutional Membership (21 – 50 physicians)	$2500

If you are based at a particular institution, we believe this is an excellent way to bring NAMDRC and its benefits to the attention of many of your colleagues. And the aggregate cost, per membership, drops dramatically under these new membership categories.

RENEW NOW!

JOIN NOW!

Go to www.namdrc.org and join and/or renew your membership online.

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NAMDRC INSTITUTIONAL MEMBERSHIP APPLICATION

Please select the category you are applying for:

☐ Small Group Practice (1-6 physicians)	$295/year for renewal
☐ NEW Small Group Practice (1-6 Physicians) *(includes one-time $100 initiation fee)*	$395 for new member/year
☐ Gold Institutional Membership (7-20 physicians) *Includes two half price registrations for NAMDRC Annual Conference at the standard member rate.*	$1750/year
☐ Platinum Institutional Membership (21-50 physicians) *Includes two half price registrations for NAMDRC* Annual Conference at the standard member rate.	$2500/year

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person:_____

Email address: _____

Address: _____

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City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION *(Make check payable to "NAMDRC")*

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

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Billing Address (If Different From Above) _____

Printed Name_____ Signature _____

Email _____ Phone_____

USE THE ATTACHED MEMBERSHIP FORM TO LIST ALL MEMBERS OF YOUR GROUP

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