COPD Post Discharge Disease Management
RT as a COPD Case Manager

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Hospital Readmission Reduction Program
Section 3025 Affordable Care Act
Effective FY 2013 (10/1/12 - 9/30/13)
Financial penalties for excessive 30-day readmissions to acute MI, CHF, Pneumonia
Effective FY 2015 (10/1/15)
Target condition COPD

Value-based Purchasing program (VBP)
Bonus payment or penalty linked to performance reporting for acute MI, CHF, Pneumonia
COPD (as of 10/1/15)

Key: Demonstrate your value, help your hospital achieve VBP bonus payments by ensuring proper documented evidence in medical records.

Re-hospitalizations among patients in the Medicare Fee-for-service Program
New England Journal of Medicine
Stephen F. Jencks, MD, MPH, Mark Williams, MD and Eric A Coleman, MD MPH

Abstract
1 in 5 Medicare beneficiaries are readmitted within 30 days, which equates to 2.3 million patients.
National cost of over $17 Billion
Half of patients readmitted had no physician contact.
70% of surgical readmits were for chronic medical conditions.

Potentially 40% of all Readmissions are preventable
What does the future hold

COPD was predicted to be #3 cause of death by 2020
It reached this milestone in April 2011 according to CDC

Population >65 will increase 73% by 2025
Baby Boomers are over 80 million strong.

PCP shortages of 20-27% by 2025.
Allergists, PCP, anesthesiologists.

There are over 100 Million patients in the US classified as having chronic conditions

Kallstrom, T. "The Long Term Implications of the Affordable Care Act". AARC Times, Oct 2012. pg 20-21

Rationale

Ongoing data collection is required to assess the nation's progress toward Healthy People

2020 COPD objectives includes:

(1) Reduce activity limitations among adults with COPD;
(2) Reduce death from COPD among adults;
(3) Reduce hospitalizations for COPD;
(4) Increase the proportion of adults with abnormal lung function whose underlying obstructive disease has been diagnosed.

Facts About Re-Admission

AARC webinar August 28-12 "Hospital to Home-efforts at Reducing Hospital Readmissions". Greg Spreit BS, RRT; Kimberly Wise BS, RRT; Becky Anderson RRT.

69% were non compliant with meds
51% lacked knowledge: How to use Therapy Devices
45% inadequate knowledge of medications
42% unable to self manage care
37% had no follow up visit with Physician
31% develop infection post discharge
Gone are the days of performing breathing treatments, doing vent checks, attending code blue, then clocking out.

RT’s are professional, licensed, highly skilled clinicians who specialize in Pulmonary disease as well as Cardiac conditions. RT leaders, MUST support ongoing development in clinical skills, intervention delivery, documentation, adopting the credential of RRT as the minimum standard for new-hires, immersing RT staff in patient advocacy, the patient care team/care continuum, while barring complacency. Strive to keep moving forward with improved patient outcomes, data collection to support your claims, separation with staff who do not perform on a DAILY BASIS, because they represent YOU. They represent all of us!

The Truth
Wake Up Call

Re-hospitalizations are costly, frequent, and many avoidable.

These numbers can be reduced

Requires action beyond the level of the individual providers

Provider, association, community and State levels are essential

Future of Healthcare is Beyond a single site

Patient centered vs task centered

Reconnect Physicians into the continuum of care

Outpatient services linked to home care data.

It Takes A Village To Make A Positive Impact
Current research shows that COPD is a fast growing disease with lasting effects on healthcare.

COPD stands on similar platforms with Cancer, Diabetes, CHF, and Stroke.

"Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading causes of mortality in the world, representing 63% of all deaths." – World Health Organization

COPD is a comorbid disease with multisystem impacts similar to sepsis.

It affects primarily the respiratory tract including the lungs and upper airways, the gastrointestinal system, and eventually the cardiac system.

COPD implies a disease with long duration and slow progression.

What is Case Management?

"Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client’s health and human services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."

<table>
<thead>
<tr>
<th>QUALIFY WITH ONE OF THE EDUCATION CATEGORIES</th>
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<tbody>
<tr>
<td>LICENCING</td>
</tr>
<tr>
<td>* Passed a licensing examination in the health or human services field.</td>
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<tr>
<td>Full-Time</td>
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<tr>
<td>* 24 Months of full-time case management experience.</td>
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<th>QUALIFY WITH ONE OF THE CERTIFICATION CATEGORIES</th>
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<tbody>
<tr>
<td>FULL-TIME</td>
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<tr>
<td>* Certified in case management.</td>
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Case Management Process

High-Level

1. Screening
2. Assessment
3. Planning
4. Implementing care interventions
5. Relating to patient
6. Transferring responsibilities
7. Discharge
Case Manager

Coordination: The role of the case manager in managing the COPD patient involves coordinating the care needed for the patient who likely has other comorbid diseases such as Diabetes and CHF.

Resource Allocation: The case manager would help identify resources, locally, that the patient could use in improving their health and wellness as they journey through the pulmonary rehabilitation program or other disease programs.

Support Team: The case manager would also provide support for the patient through recommendations on what support groups may exist to aid their disease management process.

The Patient

Seek Help: A patient that would succeed in managing his/her COPD condition will be one willing to seek help.

Self-Motivated: This patient must be self-motivated, wanting to take that extra step to improving their conditions.

Follow Instructions: A COPD patient that will excel in managing the disease would follow the instructions of their caregivers.

Independent Research: The patient should be eager in doing independent research on what ways he/she could improve their health and wellness and consult the care team regarding findings.

Registered Respiratory Therapist (RRT/RCP)

Respiratory Assessment: The RT should perform an assessment on a new COPD patient as well as on existing patients with every visit. The client’s problems, needs, and desires, as determined from the findings of the client’s assessment must be addressed.

Patient Education: The education of the patient on managing their disease with the action plan developed in conjunction with the physician is an important role of the RT. This includes identifying symptoms, smoking cessation, breathing exercises and medication administration in the right way.

Progress Notes/Documentation: The role of the RT includes documenting the progress of the COPD patient through the disease management. A patient undergoing a pulmonary rehabilitation program will have a chart for their sessions where the RT will document all activities pertaining to the rehab process.

Tests: The respiratory therapist would also be involved in diagnosis of a new patient as well as the evaluation of the patient’s progress through testing. A Pulmonary Function Test is needed to identify the patient’s FEV1 and FEV1/FVC ratio. In patients who are unable to undergo the PFT, the RT could utilize a peak flow meter for a quick assessment of the patient’s peak inspiratory flow.
RT's Role

RT as a Physician Extender
Work in POC office assessing patients, prescribing medications.

RT as Case Managers
Most of these therapists hold the RRT credential, and earn the Certified Case Manager (CCM) credential.

- Teach self management
- Modify patients behavior at home
- Coach, encourage and give advice
- Regular communication between patient and RT
- Identify unmet health needs
- Keeps patients:
  - Out of Hospital
  - Out of ED
  - Out of Physician office

HARP (Hospital admissions risk program)
Melbourne, Australia study
Patient focused and self management of care through acute and community health sectors

<table>
<thead>
<tr>
<th>Case Managed COPD</th>
<th>Control Group</th>
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<tr>
<td>ED Visits</td>
<td>10%</td>
</tr>
<tr>
<td>Hosp Admits</td>
<td>25%</td>
</tr>
<tr>
<td>Hosp LOS</td>
<td>18%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>45%</td>
</tr>
<tr>
<td>Hosp Admits</td>
<td>41%</td>
</tr>
<tr>
<td>Hosp LOS</td>
<td>51%</td>
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Reactive VS Proactive

Reactive Behavior
- No intervention until a problem occurs
- Reactively, meaning high risk pts.
- Not proactively doing lung expansion and/or airway clearance on high risk patients
- Suffering only time of defense for MV pts.

- Could result in:
  - Requiring of invasive (or other invasive) therapy
  - Increased morbidity/mortality

Proactive Behavior
- Respiratory Protocols for all MV pts.
- Medical assessment
- Early intervention with lung expansion and/or airway clearance
- Discharge planning involvement

- Could result in:
  - Prevention of respiratory complications
  - Faster weaning
  - Decreased ICU/hospital LOS
  - Increased QOL
  - Improved morbidity/mortality
  - Reduced costs/savings

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Preventing Readmissions

Improve Quality Of Inpatient Care

1. **Education**
   - Choose a champion
   - Customize patient education
   - Use teach back regularly
     - Especially with regard to understanding discharge instructions
   - Teach patient self-managed care
   - Involve different disciplines to teach
     - RT required to teach therapy devices
   - Currently an average of 8 minutes is spent on education of our patients in the hospital!

2. **Multidisciplinary rounds**
   1. Scheduled communication times to discuss patient as a team
   2. Set up a discharge plan that is looked at and signed off on by all disciplines
     - RT should always be involved with chronic lung patients discharge plan

3. **Use Pulmonary Rehabilitation Facilities**
   1. Within 3 days of discharge
   2. Teach and explain medications and lifestyle changes, exercises, smoking cessation, etc...

4. **Establish follow up plan before discharge**
   1. Provide patient meds at discharge
   2. Have a dedicated advocate/coach for patient at discharge and beyond

5. **Early post discharge follow up**
   - Remote monitoring/televised health information
   - It was shown that an RN or RRT giving patient education over the phone reduced hospital re-admissions by 40% and ER visits by 41% for COPD patients.

6. **Reconciliation of Medication**
   - Prevent medication errors

7. **Need Proactive Thinking rather than Reactive**
   - There is a lack of preventative healthcare
   - Symptoms treated, not the root cause
Better Breathers Clubs

offer the opportunity to learn ways to better cope with COPD while getting the support of others who share in your struggles. These support groups give you the tools you need to live the best quality of life you can.

Better Breathers Clubs meet regularly and feature educational presentations on a wide range of relevant topics, including:

- How COPD affects the lungs
- Breathing techniques
- Exercise
- Talking with your physician
- Breathing Control
- Medications and other treatment options
- Medical tests
- Nutrition
- Oxygen therapy
- Home health care
- Living arrangements
- Air pollution

If you feel alone and isolated, these support groups can help. It feels good to talk with others who understand, which has a positive impact on your health.

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Modified British Medical Research Council (mMRC) Dyspnea Questionnaire

<table>
<thead>
<tr>
<th>Severity</th>
<th>Score</th>
<th>Level of Breathlessness</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>Not troubled with breathlessness except with strenuous exercise</td>
</tr>
<tr>
<td>Mild</td>
<td>1</td>
<td>Touched by shortness of breath when hurrying or walking up a hill</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>Walks slower than people of the same age due to breathlessness or has to stop for breath when walking at own pace on the level</td>
</tr>
<tr>
<td>Severe</td>
<td>3</td>
<td>Stops for breath after walking approximately 100 meters or after a few minutes on the level</td>
</tr>
<tr>
<td>Very Severe</td>
<td>4</td>
<td>Too breathless to leave the house or breathless when dressing or undressing</td>
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Measures Health Status improvement in COPD

COPD Teach-back Questions

What should you do first if you are having more trouble with your breathing?

What is the name of your fast-acting/rescue inhaler?

How often do you use it?

If your shortness of breath continues without getting better, what should you do?

What are the warning signs for you that would indicate that you should call your doctor?

What should you do to prevent from having a flare-up (getting worse) with your breathing and lungs?
Teach-back with Discharge Instructions:
Can you show me on these instructions:
how you find your doctors' office appointment?
What other tests you have scheduled? and when?
Is there anything on these instructions that could be difficult for you to do?
Have we missed anything?
Use statements such as:
“I want to make sure I explained everything clearly to you. Can you please explain it back to me in your own words?”
“I want to make sure I did a good job explaining this to you because it can be very confusing. Can you tell me what changes we decided to make and how you will take your medicine now?”
If needed, educator will clarify and reinforce the explanation to improve patient understanding.

Take Home Message

Staying Involved

Reaching Beyond your Comfort Zone Partner with Nursing, Finance, Materials Management to learn what is needed to be a contributor in your Hospital’s Business Model vs. a drain on the Budget.
Shun Complacency

Take on More: What projects can you Champion? What Committee Meetings Do you Need to be Represented at? EX: Infection Prevention – do you Chair Hand Hygiene? Delegate attendance to multi-disciplinary meetings to trusted and respected front line staff. Respiratory Care is involved in EVERY patient care area; we need to be present to be seen and heard.

Our Role as a Care Provider has EXPANDED and the demands from our Department will continue to grow...

COPD Educator Course (Certificate)

www.naecb.org

CERTIFIED ASTHMA EDUCATOR (AE-C®)
Who is eligible to take the exam?
Currently licensed or credentialed health care professionals are eligible.
If an individual is not a licensed or credential health care professional, they are eligible to take the exam by providing direct patient asthma education, counseling, or coordination services with a minimum of 1,400 hours experience in these activities. This is verified through a letter from a supervisor.
Exams Fee $250
www.naecb.org
National Asthma Educator Certification Board (NAECB)
References


Thank You!

Questions?