Emerging Changes in the Care of the COPD patient

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Learning Objectives

Upon the conclusion of this session the participant will be able to:

1. Explain the expanded roles of respiratory therapists in COPD management.
2. Identify strategies that can be implemented to reduce re-admissions for COPD.
3. Describe the role of a COPD Transition Coach.
4. Summarize successful outcomes of effective transition programs.

Overview

- Can you, as respiratory therapists, make a difference in the care of patients with COPD?
  - Hospital
  - Home
- What has Lee Memorial Health System done to improve the care of patients with COPD?

COPD: Can RT's Make a Difference?

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Disclosures

I have nothing to disclose.

Overview

1. Current care
2. Affordable Care Act
3. Optimal care for management
4. Strategic roles for respiratory therapists

"Anyone who thinks they are too small to make a difference -
has never spent the night in a bedroom with a mosquito!"

Can RTs make a difference?

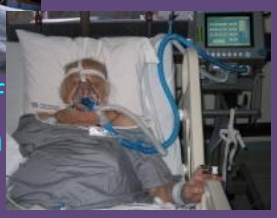
Absolutely

How many of you….

…….are hospital based RTs?
…….are home care RTs?
…….are pulmonary rehab RTs?
…….are pulmonary function testing RTs?
…….are case managers?
…….are RNs?
…….are care transition coaches?

RTs On the Front Lines

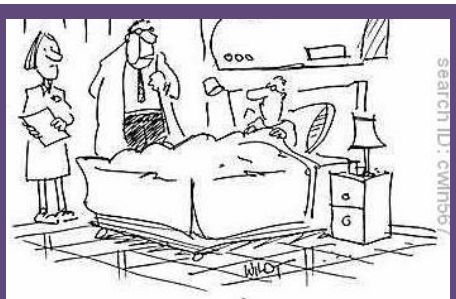
RT's are intimately involved…



in the care of patients with COPD

Where do we see them?

In-Patient	Out-Patient
• EDs	• PFT Labs
• Floors	• Pulmonary Rehab
• ICUs	• Home



What do we do for them?

- Assess current status
- Oxygen therapy
- Aerosol drug therapy
- Airway clearance therapy
- Noninvasive ventilation
- Invasive ventilation.

Patient Improvement

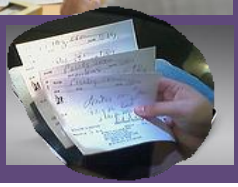
- Aerosol drug therapy every 4 hours or longer
- Clinical and ABG stability for at least 12 to 24 hours
- Acceptable ability to eat, sleep, and ambulate

Ready for discharge

What happens after they leave?

Discharged with best intentions






The Truth is…….

- Prescriptions
  - Not filled
    - "Don't need"
    - "Don't' want to take meds"
    - "Can not afford the meds",
  - Filled
    - "Don't understand how to take meds"
    - "Someone showed me, but I can't do it properly"
    - Patient taking meds, but not properly.

The Truth is…….

- Physician follow-up
  - Patient not an active participant in care
  - Don't ask questions
  - Financial barriers
- Knowledge of actions to take
  - Don't know red flags
  - Don't know how to respond.

Readmission

Revolving Door

Affordable Care Act

- Hospital Readmissions Reduction Program
  - Withholds reimbursement for excessive readmissions:
    - AMI
    - CHF
    - Pneumonia
  - 2015
    - Hips & Knees
    - COPD

Why add COPD to the Short List?

- COPD ranks 3rd most frequent cause for readmission to hospitals within 30 days[1]
- COPD preventable readmissions = 27%[2]
- Each readmission cost averages $25,000 – $32,000

[1] Physician's Weekly, Oct. 13, 2013
[2] Joynt, K.E., Jha A.K. "Thirty-Day Readmissions – Truth and Consequences." NEJM, Apr. 12, 2014.

Focus

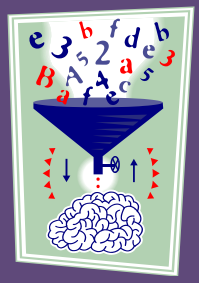
↓Costs and ↑ Revenue

↑ Quality and ↑ Outcomes

Effective COPD Management

- **Patients**
  - Well-informed
  - Well-educated
- **Practitioners**
  - Knowledgeable
  - Partners in care

We must expand our knowledge of COPD!



How?

- COPD educator course -AARC/COPD Foundation
- Alpha-1 Antitrypsin Deficiency- AARC/A1F
- COPD Foundation web site
  - Guidelines
  - Educational videos
- Attending conferences.

Optimal Care for Management of COPD

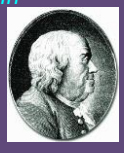
- Quality patient education
- Smoking Cessation
- Annual well visit (spirometry reassessment)
- Medication Management
- Testing for Alpha-1 Antitrypsin Deficiency
- Patient-Centered Long Term O_2 Therapy
- Pulmonary Rehabilitation
- COPD Support Groups/Community Workshops.

Key to successful COPD care

- Proactive, **Not** Reactive, approach
- Be familiar with every aspect of COPD
- RTs are in a unique position to enhance quality and improve outcomes.

Why a Proactive Approach?

- "An ounce of prevention is worth….."
  Ben Franklin



- Exacerbations of COPD
  - Contribute to lung function decline
  - Reduce the quality of life

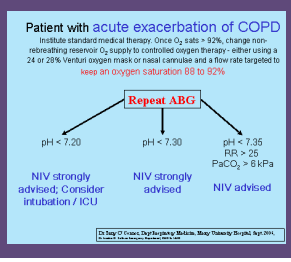
STRATEGIC ROLES FOR RTS IN COPD MANAGEMENT

✔Patient Education & Disease Mgmt.

- Emergency department & hospital clinics
  - Major access points
  - Address simple cognitive and psychomotor goals
    - 5 minute videos
    - Pamphlets (cartoon pamphlets)
    - Demonstrations
    - Teach-backs
    - Discussions

✔Inpatient Protocols and Guidelines

- Ensure patients receive:
  - State of the art care
  - Consistent care
  - Consistent education



✔ Discharge Readiness

- Use protocols to evaluate discharge readiness
- Provide COPD education
- Provide COPD action plan

✓Follow up

- Post discharge follow up
- Ensure following care plan
- Answer questions

✓ Refer Patients to . . . . . .

- Pulmonary Rehabilitation
- COPD Management (outpatient clinic)
- COPD Care Transition

Best chance for
avoiding exacerbations
gaining ground on COPD
reduce risk for readmission

What Can Staff RTs Do?

- Teach or review aerosol delivery techniques
- Assess patient readiness for smoking cessation
- Teach use of compressors, cleaning, storage
- Identify potential barriers to successful discharge
- Remind and encourage patients to keep appointments.

Develop a COPD Transition Plan

Seamless Transition

Decrease readmissions

COPD Care Transitions: Reducing the Risk of Readmission



Bob Sobkowiak, RRT
Care Transitions Coach
Lee Memorial Health System

Overview

From Hospital-to-Home: The Care Transitions Story

A Statistical Analysis of the Data

The Role of the COPD Care Transitions Coach

Developing a Care Transitions COPD Management Program

PART I

From Hospital-to-Home: The Care Transitions Story

Acute Care Hospitals

LMHS Care Transitions

- CTI is a 4-week program to help patients transition from hospital to home while learning how to manage their chronic condition
- Focuses on CHF, AMI, pneumonia, and COPD
- It combines components from several different research-based CTI programs, including Coleman Model, Project RED and BOOST

The Five Basic Areas of Coaching

- Patient Self-Management Assessment
- Medication Management
- Personal Health Record
- Diagnosis / Red Flags / Actions
- Communicating with Health Care Professionals

Outcomes

- Improving discharge processes
- Teach-back patient education throughout continuum
- Reduce readmission rates
- Increased patient satisfaction
- COPD Management Program initiated Aug 2013

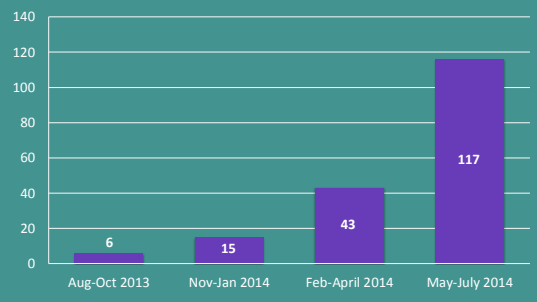
"I don't let COPD get the best of me anymore. Care Transitions helped me take back my life."

- Active in Pulmonary Rehab
- Swims 2-3 times a week
- SHARE Club Member
- Recently Completed Diabetes Education Program

PART II

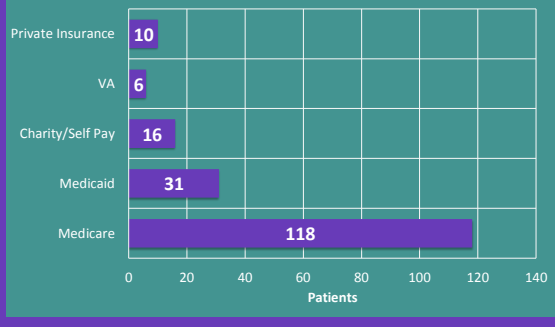
A Statistical Analysis of the Data

COPD CTI New Enrollment

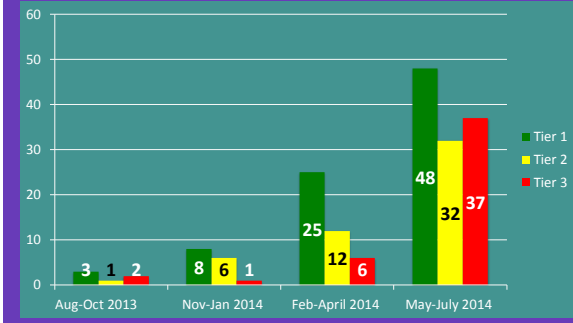


Total Number of Patients Participating in COPD Care Transitions - 181

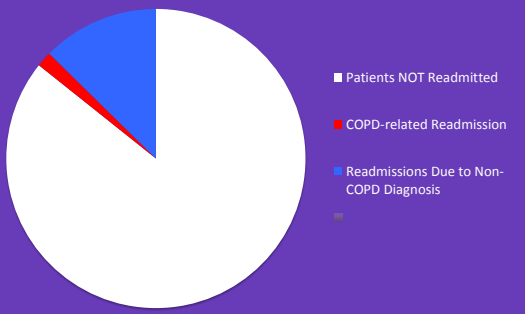
Patient Breakdown: Insurance Coverage



Patient Breakdown: Risk of Readmission



At Look Into 30-day Readmissions

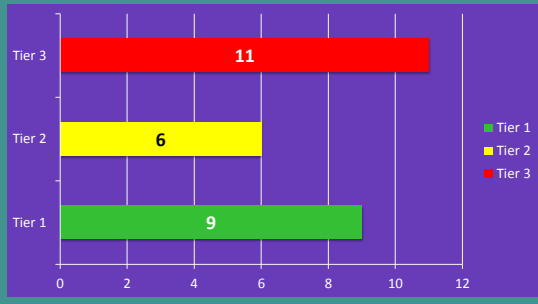


Rate of 30-day Readmissions: Insurance Coverage*

Medicare	Medicaid	Charity/Self Pay	VA	Private Insurance
17	5	0	3	1
9%	2.8%	--	2%	.6%

** Based on total number of COPD CTI participants – 181 patients*

Rate of 30-day Readmissions: Risk of Readmission



LMHS COPD Care Transitions 30-day Readmission Rate of Medicare Patients:

14%

National 30-day Readmission Rate of Medicare Patients:

23%

Cost-Savings to LMHS…

$406,750+

in Medicare expenses annually

Plus, an additional savings of

$375,000+

in uninsured patient expenses

COPD Care Transitions: Indirectly Increasing LMHS Revenue

28	Pulmonary Function Tests Completed
7	Polysomnography Completed
7	Patients Actively Participate in Pulmonary Rehab
2	Patients Attended LMHS Diabetes Education

** This figure does not include PFTs performed at the COPD Management Outpatient Clinics. An approx. 30 additional COPD CTI patients completed their PFTs and attended at least one session with a COPD Educator at one of the outpatient locations.*

PART III

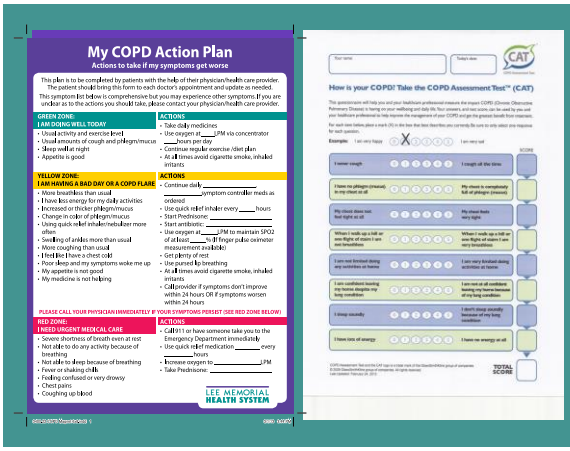
The Role of the COPD Care Transitions Coach

Meet the First Patient to Complete the COPD Care Transitions Program…

"The COPD Care Transitions program taught me how to work with my doctors. My coaches are special people who care about me. They gave me the confidences I needed to take care of ME. I just love them to death."

COPD Care Transitions Coach Tools

- Personal Health Record
- Medication Management Systems
- Inhalers Devices Training
- Scales & Spacers
- COPD Educational Resources



My COPD Action Plan

Actions to take if my symptoms get worse

This plan is to be completed by patients with the help of their physician/health care provider. The patient should bring this form to each doctor's appointment and update as needed.

This symptom list below is comprehensive but you may experience other symptoms. If you are unclear as to the actions you should take, please contact your physician/health care provider.

GREEN ZONE:
I AM DOING WELL TODAY

- Usual activity and exercise level
- Usual amounts of cough and phlegm/mucus
- Sleep well at night
- Appetite is good

ACTIONS

- Take daily medicines
- Use oxygen at ____LPM via concentrator ____hours per day
- Continue regular exercise /diet plan
- At all times avoid cigarette smoke, inhaled irritants

YELLOW ZONE:
I AM HAVING A BAD DAY OR A COPD FLARE

- More breathless than usual
- I have less energy for my daily activities
- Increased or thicker phlegm/mucus
- Change in color of phlegm/mucus
- Using quick relief inhaler/nebulizer more often
- Swelling of ankles more than usual
- More coughing than usual
- I feel like I have a chest cold
- Poor sleep and my symptoms woke me up
- My appetite is not good
- My medicine is not helping

ACTIONS

- Continue daily _____
- _____symptom controller meds as ordered
- Use quick relief inhaler every _____ hours
- Start Prednisone: _____
- Start antibiotic: _____
- Use oxygen at ____LPM to maintain SPO2 of at least ____% (If finger pulse oximeter measurement available)
- Get plenty of rest
- Use pursed lip breathing
- At all times avoid cigarette smoke, inhaled irritants
- Call provider if symptoms don't improve within 24 hours OR if symptoms worsen within 24 hours

PLEASE CALL YOUR PHYSICIAN IMMEDIATELY IF YOUR SYMPTOMS PERSIST (SEE RED ZONE BELOW)

RED ZONE:
I NEED URGENT MEDICAL CARE

- Severe shortness of breath even at rest
- Not able to do any activity because of breathing
- Not able to sleep because of breathing
- Fever or shaking chills
- Feeling confused or very drowsy
- Chest pains
- Coughing up blood

ACTIONS

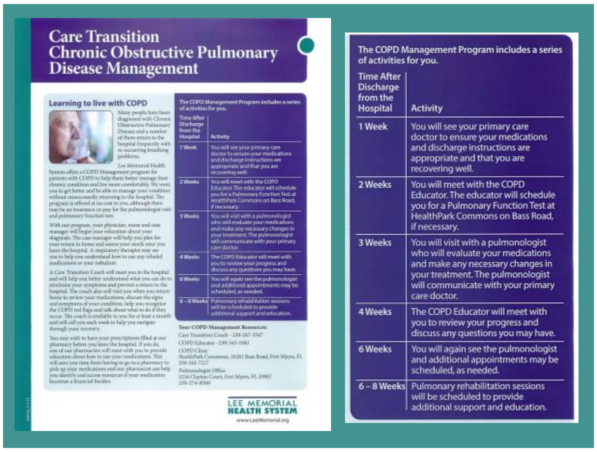
- Call 911 or have someone take you to the Emergency Department immediately
- Use quick relief medication _____ every _____hours
- Increase oxygen to _____LPM
- Take Prednisone: _____

LEE MEMORIAL HEALTH SYSTEM

CAT

How is your COPD? Take the COPD Assessment Test™ (CAT)

TOTAL SCORE



Care Transition Chronic Obstructive Pulmonary Disease Management

Learning to live with COPD

The COPD Management Program includes a series of activities for you.

Time After Discharge from the Hospital	Activity
1 Week	You will see your primary care doctor to ensure your medications and discharge instructions are appropriate and that you are recovering well.
2 Weeks	You will meet with the COPD Educator. The educator will schedule you for a Pulmonary Function Test at HealthPark Commons on Bass Road, if necessary.
3 Weeks	You will visit with a pulmonologist who will evaluate your medications and make any necessary changes in your treatment. The pulmonologist will communicate with your primary care doctor.
4 Weeks	The COPD Educator will meet with you to review your progress and discuss any questions you may have.
6 Weeks	You will again see the pulmonologist and additional appointments may be scheduled, as needed.
6 – 8 Weeks	Pulmonary rehabilitation sessions will be scheduled to provide additional support and education.

LEE MEMORIAL HEALTH SYSTEM

Identifying the Obstacles

- Psychosocial Needs
- Transportation
- Nutrition
- Utilities
- Financial
- Housing
- Medication Management
- Medical Follow-up

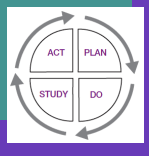
COPD Care Transitions Partners

- PATIENTS & CAREGIVERS
- Hospitalists
- Pulmonologist
- Case Managers/Social Workers
- Respiratory Therapists/Nurses
- Primary Care Physicians
- Pulmonary Function Lab
- COPD Educators
- Pulmonary Rehab
- Pharmacy
- Community Health Clinics
- Dept. of Human Services
- United Way 211
- Area Food Pantries/Churches
- Home Medical Equipment Companies
- Home Health Agencies
- Fresh Harvest/LeeSar
- Veterans Administration
- Skilled Nursing Facilities
- Palliative Care
- Hospice Services
- SHARE Club
- COPD Support Groups
- Sleep Centers

Part IV

Developing a Care Transitions COPD Management Program

- Form a Multidisciplinary Committee
- Evaluate readmission data and complete root cause analysis
- Establish goals and develop a charter
- Create a workflow process and revise as needed
- Plan-Do-Study-Act



Resources: Care Transitions Programs

The Coleman Model
www.caretransitions.org

Project RED
www.bu.edu/fammed/projectred/

BOOST
www.hospitalmedicine.org/projectBOOST

Resources: Patient Education

COPD Action Plan: www.action.lung.org

CAT Test: www.catestonline.org

ASK IT: www.healthcoach4me.com

Inhaler Education: www.use-inhalers.com

A Patient's Guide to Aerosol Drug Delivery:
www.AARC.org/education/aerosol_devices/

"Your proactive program should be used as a benchmark and model in every care facility in the country. I am positive it would change the lives of many others."

For more information, please contact:
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LMHS Care Transitions Coach
Robert.Sobkowiak@leememorial.org
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THANK YOU

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