Michigan Society
For Respiratory Care

MSRC Spring Conference

April 13-15 , 2016 ◆ Dearborn ◆ MI

Impact of Government Change on Respiratory Care Practice

Patrick J. Dunne, MEd, RRT, FAARC
Fullerton, CA

pjdunne@sbcglobal.net

Disclosure

Professional relationship with

- Monaghan Medical Corporation
- Mylan Pharmaceutical

Career-long member/supporter of

- AARC
- State affiliates – MSRC

Objectives

- Review the government changes in health care replacing the traditional fee-for-service payment model;
- List those instances where government change will directly influence the delivery of respiratory care;
- Describe the key features of the emerging chronic care model and how RTs can become actively involved, and
- Identify ***high-value*** services that RTs can make to demonstrate our value contribution.

Situational Analysis

Spring 2016

- **Health care reform's operative *buzz words***
  - ***Disruptive change, Transformational change, Game changer, Disruptive innovation, Radical redesign, Fundamental shift, etc.***
- **Bottom line - - *It's system wide***
  - **All providers eventually affected**
- **PPACA of 2010**
  - **6 years & getting more engrained**
    - **In spite of set-backs with exchanges, subsidies, etc.**
    - **Millions of Americans realizing positive benefits**
  - **1 more year of continued implementation**
    - **2016 Election – Some campaigning on *complete repeal***
    - **Given evidence – Complete repeal no longer a realistic option**

Repealing Obamacare

Politically Contentious Elements

- **Universal mandate**
  - **Individual tax**
  - **Employer (≥ 50 employees) fine**
- **Medicaid expansion**
- **Minimum coverage policies**
- **Cadillac tax**
  - **High cost health plans ($10,200 individual; $27,500 family)**
- **Medical device tax**
- **Insurance Exchanges**
  - **Federal subsidies**

Government Changes in Health Care

Moving Away from Fee-for-Service

- **Value-based Purchasing**
  - **FY 2016: Up to 1.5% bonus (or) penalty**
    - **30% of all payment by 2016; 50% by 2018**
- **Hospital Readmission Reduction Program (up to 3% penalty)**
  - **FY 2016: $420 million from 2,592 hospitals**
- **Hospital-acquired Conditions Reduction Program (1% penalty)**
  - **FY 2016: $364 million from 758 hospitals**
  - **Post-op pulmonary conditions (PPCs) a *major* patient safety concern**

The Bigger Picture

For healthcare providers . .

It's not so much about

Health Care Reform

As it is about

Payment Reform!

Government Changes in Health Care Payment

Sleepless in the C Suites

MAJOR ONGOING ORGANIZATIONAL CHALLENGES

- **Revenue Stream/Cash Flow**
- **Transition to ICD-10 coding**
- **Physician alignment**
- **The 2 “Rs” - - - EHR & HR**
- **Newer Joint Commission expectations**
  - **Patient Safety, Discharge Planning**
- ***Reducing costs of care; Minimizing governmental penalties***

Government Changes in Health Care

The New Environment of Care

TRADITIONAL EMPHASIS	NEWER EMPHASIS
Acute care	Chronic care
In-patient	Out-patient
Treat symptoms	Manage disease
Individual patient	At-risk populations
Billable procedures	Outcomes of care
Fee-for-service	Pay-for-performance

Fee-for-service = volume incentive

Pay-for-performance = value incentive

The AARC Response to ACA

Strategic Plan 2015-2020

AARC Strategic Plan

AARC Strategic Plan — 2015–2020

AARC Mission Statement

The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care.

AARC Vision Statement

The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.

20 AARC Times February 2015

- **Linked to *2015 and Beyond* initiative**
- **Formally approved October 2014**
- **Eight (8) major objectives**

The AARC Response

Summary

- Traditional *scope of practice* is expanding
  - Requires advanced knowledge, skills & attributes
    - Continued growth in new technology, clinical innovation
  - Concept of patient-centric care
  - Multi-disciplinary care-teams
- Newer educational & licensing requirements
  - Entry level education/licensing being elevated
  - Existing workforce expected to adapt

Government Changes in Health Care

The New Environment of Care

TRADITIONAL EMPHASIS	NEWER EMPHASIS
Acute care	Chronic care
In-patient	Out-patient
Treat symptoms	Manage disease
Individual patient	At-risk populations
Billable procedures	Outcomes of care
Fee-for-service	Pay-for-performance

Fee-for-service = volume incentive

Pay-for-performance = value incentive

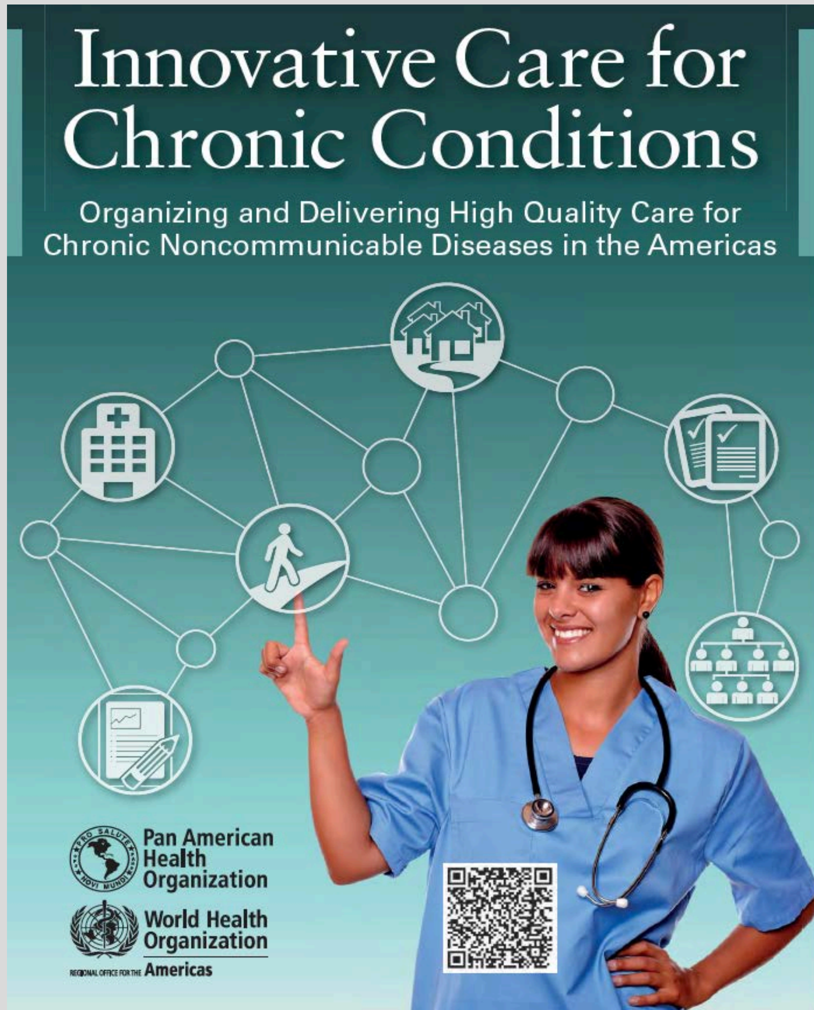
Impact of of Chronic Conditions

- Life-long condition
  - Account for 70% of all deaths in the US (1.7mm/yr.)
  - Not curable BUT controllable
  - Many patients have multiple conditions
- Chronic conditions overly expensive
  - ≥ ⅔ of $3.1 trillion annual expenditures
  - Many suffer frequent exacerbations
- Baby-Boomer generation
  - 2011- 2023 ≈ 2.5 million/year turn 65
  - High prevalence of chronic disease

Sick Care vs. Chronic Care

Chronic Disease Conditions

A Global Problem; (www.paho.org)



- **Care for chronic diseases (cardiovascular conditions, diabetes, cancer and COPD) a global problem**
- **Majority of patients *not* receiving appropriate care; Only ½ diagnosed; Only ½ of those treated**
- **Existing system of *sick care* not conducive to improving chronic care outcomes**

www.paho.org

Chronic Disease Management

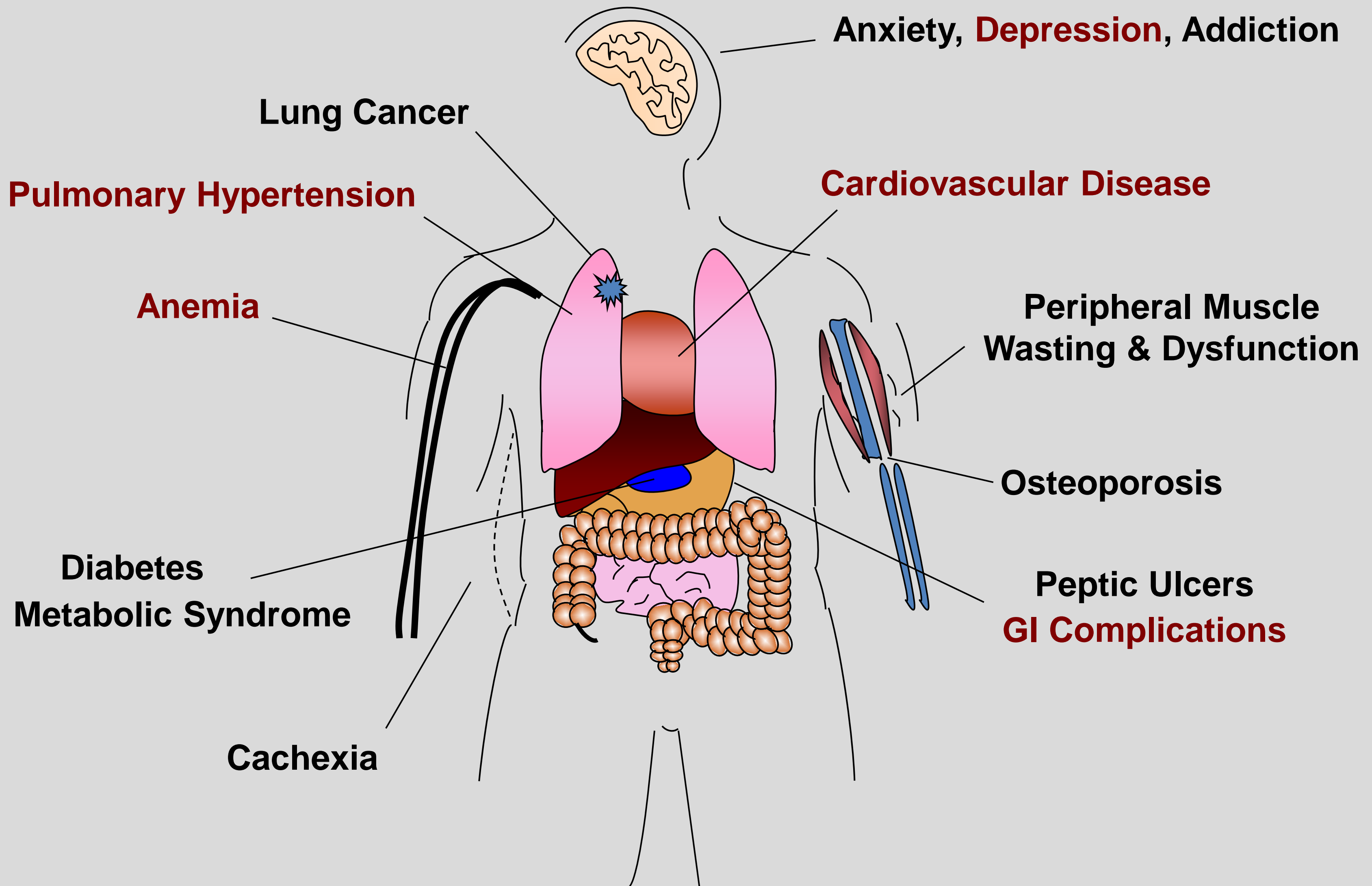
- **Coordinated approach to chronic medical care**
  - **Slow disease progression, minimize complications**
  - **Improve health outcomes, quality of life**
  - **Manage health care utilization**

- **Best chronic care:**
  - ***Patient-centric***
  - ***Evidence-based***
  - ***Multi-disciplinary***
  - ***Utilizes "care-teams"***
  - ***Follows the patient regardless of care setting***

Now, About COPD . . . .

- **Definition:**
  - ***A progressive, inflammatory chronic disease characterized by:***
    - ***Increasing airflow obstruction,***
    - ***Destruction of pulmonary gas exchange areas, and***
    - ***Clinically relevant extra-pulmonary effects secondary to systemic inflammation***
- **Prevalence is increasing**
  - **3rd Leading cause of death (120,000/year)**
    - **Since 2000, mortality greater in women**
  - **4th Leading cause of recidivism (EXPENSIVE $$$$)**
  - **Cost of hospital stay greater than reimbursement**
- **A largely preventable disease**

COPD is a Multisystem Disease



Adapted from Kao C, Hanania NA. Atlas of COPD. 2008.

COPD

Opportunities for Improvement

- Current care outcomes less than optimal
- Growing concern over high recidivism rate
- Unplanned re-admissions are costly
  - 30 day re-admits *largely preventable*
  - Primary cause - poorly coordinated *transition of care*
- COPD evidence-based care guidelines exist
  - For both in-patient (exacerbation) and out-patient (Sx control)
  - Use of evidence-based care guidelines is low

Hospital Readmissions

Primary Contributing Factors

- Poorly coordinated transition of care
  - Unprepared for continuing self-care responsibilities
    - Gaps in disease knowledge, consequences of non-compliance
    - Incorrect medication regimens; access issues
    - Unaware of early warning symptoms of relapse
- Failure to make/keep follow-up MD appointment
  - 3 of 4 re-admitted patients – no follow-up visit
    - Ideally within 5-7 days of discharge
- Poor application of evidence-based medical practice
  - Especially maintenance therapy (GOLD Guidelines)

New Medicare Requirements

Discharge Planning

FEDERAL REGISTER

The Daily Journal of the United States Government

Proposed Rule

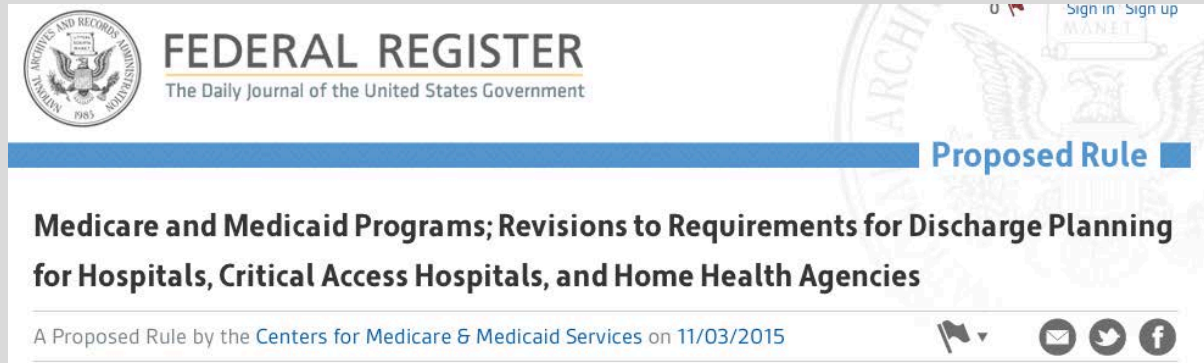
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

A Proposed Rule by the Centers for Medicare & Medicaid Services on 11/03/2015

- **Newest addition to hospital Conditions of Participation**
- **Embodied in new Joint Commission Standards**

New Medicare Requirements

Discharge Planning



- **Formalized discharge planning for ALL patients**
- **Ensure ALL continuing care needs met PAC**
  - ***Must include relevant care providers***
- **Must take into account patient's *goals/preferences***
  - ***Patient-centric care***
- **Process to begin within 24 hours of admission**
- **Must include complete *medication reconciliation***
- **Formal, post-discharge follow-up process required**

So, What's in a Name?

AARC 2015 Summer Forum and Others

- COPD Patient Educator
- COPD Care Coordinator
- COPD Clinical Specialist
- COPD Care Navigator
- COPD Transition Coordinator
- COPD Case Manager
- COPD Disease Manager
- Pulmonary Disease Educator
- Chronic Care Coordinator
- Cardio-Pulmonary Navigator

COPD Care Transition Plan

Coleman EA. www.caretransitions.org

- Coleman's *Four Pillars* for effective care transition:
  I. Medication management
  II. Red Flag warnings
  III. Follow-up MD appointment
  IV. Written care plan

COPD Care Transition Plan

Coleman EA. www.caretransitions.org

- **Coleman's *Four Pillars***
  I. **Medication management**
     - **Proper meds (LABA, LAMA, OPEP, LTOT)**
     - **Correct delivery devices (pMDI Spacer; Home nebulizer)**
     - **Continued access, Basic troubleshooting, Infection control**

  II. **Red Flag warnings**
     - **Increasing dyspnea, cough, or mucus alteration**
     - **When/whom to call**

COPD Care Transition Plan

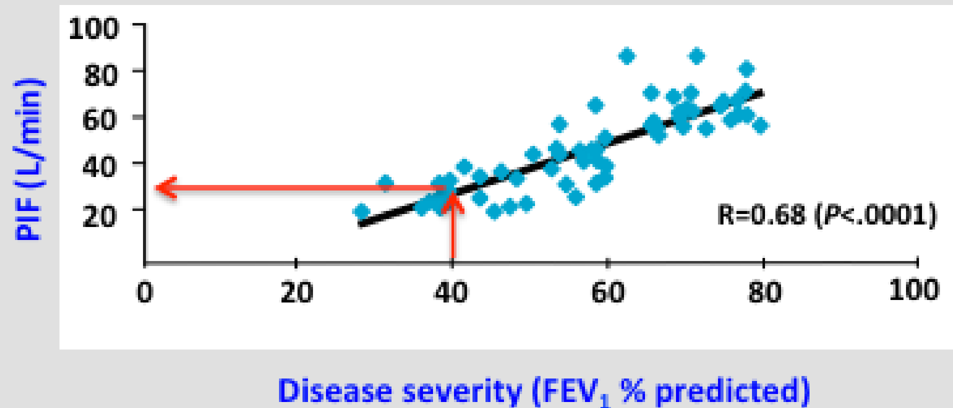
Coleman EA. www.caretransitions.org

- Coleman's *Four Pillars*
  - III. Follow-up appointments
    - Primary care/specialist; Pulmonary rehab; Spirometry; Immunizations
  - IV. Written care plan
    - Individualized; Comorbidities addressed; Daily medication regimen; Tobacco cessation; ADLs; Exercise regimen, etc.

Inhaler Misuse in COPD Patients

Important Considerations

- **Age-related physical/mental deterioration**
  - **Visual, hearing, tactile, memory**
- **Add disease-related limitations**
  - **Actuation/inhalation coordination issues**
  - **Inability to alter breathing pattern**
  - **Diminished PIFR capability due to low FEV_1**



Physical Ability to Use a DPI

Poor Use = Non-delivery of Medication

- **Value of assessing *peak inspiratory flow rate***
  - **Not demanding but insightful maneuver**
  - **Ability to generate PIFR ≥ 35-40 L/min**
  - **PIFR ≤ 35-40L/min candidate for nebulizer**

Role of Nebulized Therapy in COPD

Dhand R, et al. COPD; Feb 2012

Recommendation:

- **Many patients, especially elderly patients with COPD, are unable to use their pMDIs and DPIs in an optimal manner.** ***For such patients, nebulizers should be employed on a domiciliary basis*. . .**

- **Nebulizers are more forgiving to poor inhalation technique, especially poor coordination with pMDIs and the requirement to generate adequate peak inspiratory flows with DPIs.**

Nebulized Therapy at Home

Enabling Sustained Medication Adherence

- Ease of use; simple technique
- Effective, reliable drug delivery
- Use not limited by disease severity or mental acuity
- Inconvenience, IC issues addressed
- Device and unit dose meds covered under Medicare Part B

Home Cleaning/Sterilizing Options

AeroEclipse Reusable; Aerobika

- **Infection Control Options**
  - **Dishwasher safe**
  - **Immersable in boiling water**
  - **Microwave sterilizer**

Planning In The C-Suite

Ensuring Financial Viability

C-SUITE 2015 INDUSTRY SURVEY

Fueling Financial Growth Next 5 Years

- **63%: Expand outpatient services**
- **44%: Strategically grow existing market**
- **29%: Develop/join an ACO or PCMH**
- **18%: Develop health plan business unit**

Additional Trends

Continued CMS Payment Reform Initiatives - - CJR

FEDERAL REGISTER
The Daily Journal of the United States Government
Public Inspection: Proposed Rule
Medicare Program: Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services
An unpublished Proposed Rule by the Centers for Medicare & Medicaid Services on 07/14/2015

- **April 1, 2016: Single *bundled payment* in 67 metropolitan areas nationwide; 800 hospitals!**
- **90-day episode of care for ALL Part A & B services**
- ***Collaborative* care indispensible to control costs**

Summary

The Dawning of a New Era

- Re-design traditional role to compete in *new environment of care* realities:
  - Align practice with newer expectations
    - Embrace expanding scope of practice
    - Develop newer approaches to care delivery
  - Improving chronic care outcomes a new priority
    - Hospital's responsibility no longer ends at *discharge*
    - Poorly treated chronic patients - - huge financial liability
    - Patient-centric care promotes sustained engagement
  - Make evidence-based care the rule - not the exception
    - Protocol/algorithm directed practice inevitable
    - *Risk-sharing arrangements* demand reduced variation

Michigan Society
For Respiratory Care

MSRC Spring Conference

April 13-15 , 2016 ◆ Dearborn ◆ MI

Impact of Government Change on Respiratory Care Practice

Patrick J. Dunne, MEd, RRT, FAARC
Fullerton, CA

pjdunne@sbcglobal.net