A Path to Success to Improve COPD Outcomes

by Charlene Raley, RRT

As the two Political Advocacy Contact Team (PACT) representatives from South Dakota, Charlene Raley, RRT, and Carleen Waltner, RRT, participated in the 2015 Respiratory Therapy Capitol Hill Advocacy Day and scheduled meetings with their senators and representative. Their mission was to educate these members of Congress on the importance of how South Dakota RTs could help improve their state's pulmonary health through the emerging telehealth technologies. Moreover, there was legislation that would do just that — the Medicare Telehealth Parity Act. They had an interesting meeting with staff from Sen. John Thune's office, who listened attentively to their presentation on the telehealth issue but then asked if they could be more specific. In other words, they wanted to know just how RTs are impacting patient care through the use of telehealth services and especially if they could show how an emerging way to provide care was working or could work better in South Dakota.

Following is their response to that inquiry, which they hope will be informative not only to Sen. Thune's staff but to all respiratory therapists. ■

— Cheryl A. West, MHA
AARC's Director of Government Affairs

As a health care organization and as health care providers, we are all challenged with the new imperative to deliver the highest level of care while simultaneously becoming more cost effective. The COPD patient population represents a huge opportunity in this regard. As respiratory therapists, our direct involvement in developing better approaches to patient education and actively participating in multidisciplinary rounding for all COPD patients has quickly become an important focus. While this vital imperative is quite achievable in major metropolitan institutions, the paucity of respiratory therapists in rural hospitals and outlying clinics can present significant challenges, as is the case within our system. For us, the issue is that many of our patients are admitted to our institution but, following discharge, return to homes located in distant rural areas. As such, continuing follow-up care is problematic. Many believe, us included, that passage of the Medicare Telehealth Parity Act would go a long way in resolving this perplexing problem.

about the author...

Charlene Raley, RRT, is a patient educator at Avera McKennan Hospital in Sioux Falls, SD.

Step 1

Our journey to improve COPD outcomes began In November 2012 when the respiratory care team at Avera McKennan Hospital and University Health Center in Sioux Falls, SD, was tasked with defining and creating a multidisciplinary approach to reducing the COPD readmission rate. Our initial step was to see if we could identify common denominators that contributed to the current 20% readmission rate. However, we soon learned that our patients' needs went far beyond just treating their symptoms when they presented with an exacerbation, only to later send them home with a handful of prescriptions. This led us to ask the question, "what if we could identify the high-risk COPD patient at the time of admission (or readmission) instead of waiting until after discharge?" Would this help us better reach our goal by identifying characteristics or recurrent episodes unique for each individual patient?

While we did have the information technology (IT) infrastructure to collect post-discharge data, we realized that we needed to create a report that would begin tracking the patients on the day they actually were admitted/readmitted. In collaboration with our IT department, we were soon able to generate a true time report. Reviewing and analyzing these reports over time gave us valuable insight into the various elements that characterize and impact this high-risk patient population, both individually and collectively.

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Step 2

Another important step along our journey was to have one of our respiratory therapists trained and designated as a COPD coordinator. We envisioned this individual as someone who would work to develop and coordinate the care, education, and follow-up of our COPD patient populations. This meant not only working directly with COPD patients and family but also ensuring that all RTs in our department were equally versed in the current Global Initiative for Chronic Lung Disease (GOLD) guidelines. We felt it extremely important that all messaging to our patients be consistent, irrespective of who or when any patient encounter occurred. The COPD coordinator was also responsible to reach out to other providers and solicit their involvement, especially for the management of comorbidities.

We were fortunate that within our entire Avera Health Network, we were able to bring together the various other care providers we felt we needed. This included nurses, physicians, social workers, and pharmacists. Our goal was to identify what educational material should be developed and then to standardize it system wide. We believe that the use of standardized education materials in all primary care clinics, hospitals, and critical access hospitals became one of the fundamental building blocks in making our program successful. For one of our clinical sites where an RT isn't available, having the ability to use telehealth is a vital tool. In those situations, our RTs can educate caregivers and patients across the system.

Interestingly, at Avera McKennan Hospital and University Health Center, the work of the COPD coordinator not only started to improve outcomes in a noticeable way but also heightened the clinical awareness and professional appreciation for RTs throughout the entire system. Most importantly, this program created a smooth transition to providing consistent and standardized education to all care providers in our system, thereby helping to eliminate gaps that can occur with inconsistent communication.

Not surprisingly, as a result of our new appreciation for population-based health, we now recognize that patients have one or more unique situations in their daily lives that need to be addressed. Identifying these unique needs allow us to set specific learning goals to help mitigate the negative impact on recovery and successful disease control. To that end, we embraced the "teach-back" approach to patient education. We feel that if the same method is not used all the time and important content reinforced each time, simple things such as smoking relapse, proper medication management, and failure to keep follow-up appointments can easily contribute to preventable readmissions.

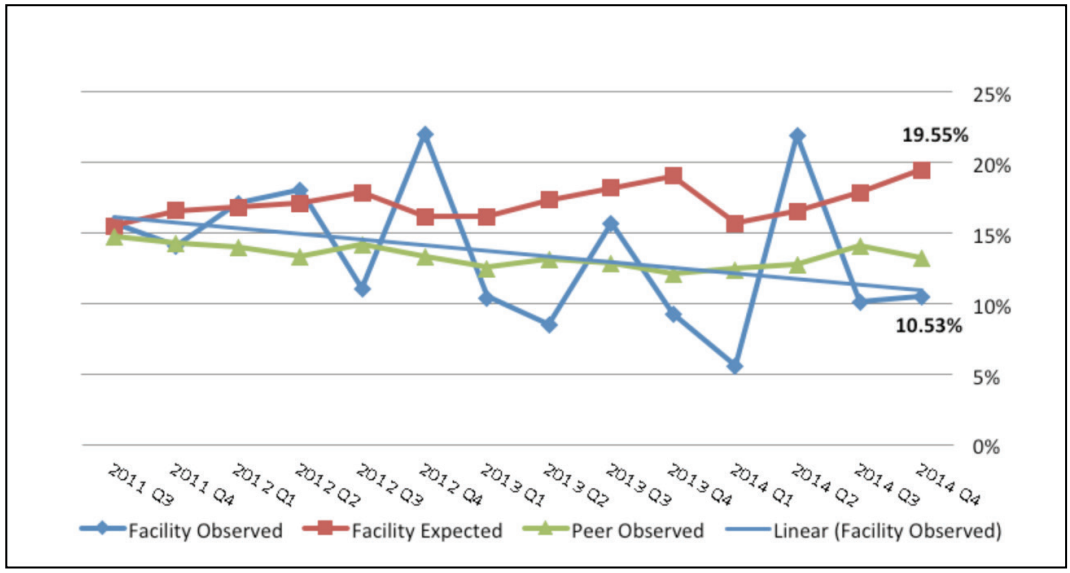

Figure 1. 30-day readmission rate from third quarter 2011 to fourth quarter 2014

Step 3

All of our educational tools are based on the current GOLD guidelines, and we are very serious about the importance of educating the primary care providers on the clinical significance of the guidelines. Tools used for patient education must be clear, concise, and easily understood. As we discovered, patient education efforts also need to include a pathway to help identify which patients may need financial assistance with medication as well as social resources.

During the patient's hospital stay, daily follow-up education by an RT assures that the patient is properly self-administering the correct inhaled medications. We also assess each patient's peak inspiratory flow rate to determine if they have sufficient inspiratory effort to adequately inhale their medication in a manner that proper lung deposition is achieved. For those patients who are unable to generate adequate peak inspiratory flow, the appropriate inhaled therapy medication is recommended to the prescribing physician. Pathophysiology of the disease is also discussed, including the consequences of non-adherence with the prescribed home care regimen. We also use the Epworth Sleepiness Scale to screen those patients who should be evaluated for sleep disorders.

At the time of discharge, a care transitions team is utilized to assure that a follow-up appointment has been scheduled with the patient's primary care provider and to again provide and reinforce relevant patient education. Patients are also evaluated for outpatient pulmonary rehabilitation. If the assessment deems that the patient would benefit from the program, an automatic referral is generated. The outpatient pulmonary rehab program at Avera McKennan and University Health Center includes more disease state education, strength and resistance training, nutritional counseling, both physical and occupational therapy assessments and, if needed, a speech therapy assessment and psychological counseling.

Selling teleheath

However, some patients live quite a distance from our facility, which precludes their participation in formal pulmonary rehab. For this reason, we eagerly await passage of the Medicare Telehealth Parity Act, which will then allow us to maintain sustained patient engagement when distance precludes participation in our onsite program.

Reducing COPD readmissions is not the sole responsibility of inpatient care providers. To be successful, it must involve all providers across the entire continuum of care — from the hospital to the home. Furthermore, efforts must be patient-centric; and sustained patient engagement is vital for continued success. For these reasons, follow-up care and continued education on the fundamentals of COPD and continued adherence with evidence-based maintenance therapy must be provided and encouraged by home care RTs, personnel in skilled nursing and residential care facilities, and all clinic staff. We have found that educating and helping these patients stay out of the hospital has been a much larger undertaking than we anticipated.

Although our initial efforts did prove successful, we realize that there is still more to be done. Eventually, telehealth will greatly reduce the burden for patients and their caretakers residing in rural areas by giving them access to RTs in their current living environment or community. ■