TASC 90 Webinar: Overview of the Chronic Obstructive Pulmonary Disease (COPD) Manual and Pulmonary Rehabilitation Assessment

August 15, 2019
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The overall purpose of this manual is to provide information about COPD and clarity around best practices of care management for those with COPD in rural communities.

The objective is to help rural hospital leadership develop a thorough understanding of COPD services in rural areas, clinical diagnosis and treatment including treatment options available and new developments in technology that are useful to rural populations.

Rural hospitals should use this manual to identify areas for improvement in diagnosis, treatment, and long-term care of COPD patients in their communities.

State Offices of Rural Health (SORH) partners may also benefit from this guide when meeting with hospital leadership, to assist them in thoughtful discussion related to improving the community’s health.
Intended Audience

- This manual is intended for:
  - State Flex personnel and programs
  - Rural hospitals, including Critical Access Hospitals (CAHs)
  - Provider-based Rural Health Clinics (RHCs)
- Goals of the manual are to increase awareness on the benefits of COPD services, including disease burden and clinical aspects, and to support the development of pulmonary rehabilitation services, including:
  - Expanding existing services or developing services
  - Financial viability of services
  - Conditions of participation
  - Billing/coding
  - Workforce development
  - Operational efficiencies
What Topics are Covered in the Manual?

- **Introduction to Chronic Obstructive Pulmonary Disease in America**
  - Urban Versus Rural
  - Importance of COPD Services
  - Current State of COPD Services in Rural America, Including Barriers
- **Clinical Diagnosis and Treatment of COPD**
  - Risk Factors for COPD
  - Signs and Symptoms
  - Assessment and Diagnosis
  - Clinical Treatment Options
  - Treatment Compliance
  - Performance Measurement
  - Research-Based Clinical Practices
- **Models of Treatment Services**
  - Oxygen Therapy and Ventilator Support
  - Smoking Cessation
  - Pulmonary Rehabilitation Services
- **Care Management**
- **Community Support Services**
  - Community Health Workers
  - Community Paramedics
  - Home Health
- **Technology to Deliver Healthcare for Effective Rural COPD Services**
TASC COPD Work Group Force

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<tr>
<th>Neyal Ammary-Risch</th>
<th>Suzan Michele Collins</th>
<th>Grace Anne Dorney Koppel</th>
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<tr>
<td>Dr. Dan Doyle</td>
<td>Lannette Johnston</td>
<td>Dr. Mark Lindsay</td>
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<td>Ira Moscovice</td>
<td>Dr. Antonello Punturieri</td>
<td>Pat Schou</td>
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<td>Karla Weng</td>
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- Work group provided the oversight from various perspectives including:
  - Clinical
  - Research
  - Patient
  - Advocacy
  - Quality
  - State partner
COPD in America

• **Chronic obstructive pulmonary disease (COPD):** a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation

• COPD was the third leading cause of death in the United States in 2015, and the fourth leading cause in 2016

• In 2015, **15.5 million adults** were diagnosed with COPD in the U.S.
  • That is over 6% of the U.S. adult population in 2015 diagnosed with COPD in the span of one year!

• While 15.5M adults were diagnosed, **350K Medicare patients were hospitalized**, and approximately **150K deaths occurred** as a result of this preventable and treatable disease

• **More than $32B was spent on COPD-related patient** care in 2010, and this is projected to **increase to $49B by 2020**

COPD in Rural America

• Prevalence rate for COPD is about **12% for individuals living in rural communities** compared to 7% across the U.S.

• **Age-adjusted prevalence of COPD for adult populations in rural areas is 8.2%,** almost twice the prevalence rate for adults in metropolitan areas of 4.7%

• Why such a divide?
  • Rural populations have a greater exposure to the risk factors associated with COPD
    ✓ Tobacco exposure
    ✓ Respiratory infections
    ✓ Occupational and environmental exposures
    ✓ Genetics
  • Higher proportions of lower socio-economic residents

COPD in Rural America, Continued

- Why such a divide? (continued)
  - Limited access to appropriate healthcare services for COPD
    ✓ Smoking cessation programs
    ✓ Specialty care
  - Barriers to access healthcare services
    ✓ Transportation
    ✓ Geographic accessibility
    ✓ Uninsured/under-insured
    ✓ Cultural perception

Pulmonary Rehab in Rural

• 1,366 US counties or county equivalents have at least one hospital outpatient pulmonary rehab program, while 1,776 counties do not have a pulmonary rehab program, including 697 counties that do not have a hospital

• 36.3% of CAHs and 46.7% of rural PPS hospitals have an outpatient PR program, along with 53.2% of urban PPS hospitals

Percent of Hospitals With Outpatient Pulmonary Rehab by State 2018

Value Proposition

- Overall improvement health and education
- Decreased admission/readmissions – profitability, quality
- Decreased ED visits
- Outmigration
- Additional service offering to support patient needs
- Value-based healthcare
  - Provide high-quality, low cost patient care
Pulmonary Rehab Assessment

• Stroudwater in partnership with TASC, developed an assessment for Critical Access Hospitals (CAHs) to gain insight on current services currently being offered related to pulmonary rehabilitation.

• Assessment topics included: COPD disease prevalence, program certifications, workforce, operational performance, program operations, and quality.

THANK YOU! To the State Partners for sharing the assessment with your CAHs!
## Assessment Respondents

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Non Duplicate Hospital Count = 345

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<td><strong>Grand Total</strong></td>
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Does your organization currently offer PR?

- 50% of the respondents do currently offer PR service, while 49.1% do not

- Top barriers attributed to not supporting a PR program:
  1. Staffing (72.8%)
  2. Capital (60.9%)
  3. Space (55%)
  4. Medical Oversight (42.6%)

- Other reasons include:
  - Low patient volume
  - Reimbursement
  - Unfamiliar with program
Organizations who are in planning phase

• 59.8% of the organization who are currently not offering a PR program, plan on doing so in over a years time

• Top reasons for wanting to implement a PR program include:
  1. High rate of COPD patients within the community (45.5%)
  2. Limited access to local treatment options (38.5%)

• Other responses include:
  • Not planning on implementing
  • Improving case management / chronic disease management will support the need
Program Characteristics

• 80.2% of PR programs are located in the hospital

• Last year (2018), respondents had approximately 4,050 enrolled patients in their PR programs

• On average hospitals offer PR program 3 days per week, each session is 2 hours and the duration of the program on average is 16 weeks

• Top healthcare professionals who refer to PR program include: Pulmonologist (92.5%) and Primary Care Practitioner (91.7%)
Patient Characteristics, Continued

- Top medical diagnosis of patients participating in PR program: COPD, Pulmonary Fibrosis, Emphysema, Asthma
  - 83% patients have a co-morbidity (i.e., diabetes, cardiovascular disease, hypertension, osteoporosis, physiological disorder) in addition to their primary diagnosis

- 51.9% of enrolled patients met the GOLD Stage III (Severe)
  - Must meet GOLD Stage II to qualify for PR services

- Majority of the enrolled patients had a recent exacerbation (42.2%)

- Enrollee demographics: 70.1% (61-70 years old), even distribution between male and female, 74.6% have Medicare coverage
PR Program Components

- Only **11.7% of organizations with PR programs are certified** by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

- 78.4% of organizations conduct individual PR sessions, while 67.6% offer in a group setting

- Top exercise components within program:
  1. Aerobic Exercise (treadmill)
  2. Breathing Exercises
  3. Aerobic Exercise (cycling)
  4. Resistance Training (upper extremity)
• 51.4% of organizations offer Tobacco Cessation programs

• Top education subjects offered within the PR program:
  1. COPD Disease
  2. Energy Conservation Technique
  3. Effect of Exercise and Physical Activity
  4. Nutrition
  5. Oxygen Therapy

• 76.8% of families are allowed to participate in the educational sessions, typically led by a respiratory therapist (71.8%) or a nurse (52.7%)
PR Program Outcomes

• 50.4% of organizations follow-up with patients after they have completed their PR program, utilizing the following activities:
  • Telephone Support (71.2%)
  • Supervised Exercise (50.8%)
  • Reassessment (47.5%)

• Majority (56.9%) of the follow-up activity is done within 1-month post PR program completion

• 70.4% of patient complete the PR program in full, barriers for non-completion include:
  1. Transportation (64.5%)
  2. Lack of Motivation (51.4%)
  3. Exacerbation (hospitalization) (43.9%)
  4. Lack of Insurance Coverage (43.9%)
Healthcare Professionals

- Top members of the PR program team include:
  1. Respiratory Therapist (84.4%)
  2. General Practitioner (60.6%)
  3. Dietician (63.3%)
  4. Nurse (56.9%)

- Family Practice Physician (32.4%) or a Pulmonologist (23.8%) provides medical directorship
Additional Highlights

- 75% of the organization utilize Home Health to support PR program

- **95.3% of organizations do not utilize telehealth** for PR program

- Readmissions of patients who participated in PR program are not being tracked (59.4%) and there is **no readmission risk assessment** for new PR program patients (67.4%)

- Of the organizations currently offering PR, **49.7% are also offering Cardiac Rehab**
Next Steps

• Distribution of COPD Manual

• Hold education sessions regarding the manual, if necessary for State Partners / Hospitals

• Present on Manual and Assessment Findings @ NRHA CAH Conference in September
Questions?

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