

**Acute Care Hospitals:
Facing *The Perfect Storm***

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

Disclosure/Acknowledgement

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Hospital Challenges - - Spring 2011

- ❖ **Facing *The Perfect Storm***
 - ❖ Decreasing Medicare margins
 - ❖ Changing inpatient reimbursement process
 - ❖ Transparency and public reporting
 - ❖ Recovery Audit Contractor (RAC) program
 - ❖ Continuing financial uncertainty



Hospital Sound Bites - - April 2011

- ◇ Under the current payment system, hospitals are the hub of the health care experience

- ◇ They do the most expensive procedures but accountability for the patient ends at discharge

- ◇ Multiple studies have estimated that \$.30 to \$.40 of every \$1.00 spent on health care (≥ \$500 billion/yr) is for unnecessary, inefficient and even unsafe care



Sound Bites - - April 2011

- ◇ New efforts (incentives) will be directed at keeping patients out of the most expensive site of care

- ◇ The challenge is to now transform an idea that makes *common sense* (less volume) into one that makes *good business sense* (greater value)

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Nine US Financial Regions
Annual Medicare Cost Report



Medicare Inpatient Margin Percentage
By Geographic Region

FISCAL YEAR	2001	2003	2005	2007	2008
East N Central	7.1%	0.7%	-2.4%	-4.9%	-6.5%
East S Central	9.5%	2.9%	3.8%	2.3%	3.9%
Middle Atlantic	20.7%	17.0%	7.6%	7.1%	6.0%
Mountain	6.7%	-0.7%	-3.4%	-7.4%	-10.4%
New England	14.5%	6.4%	3.5%	-0.3%	-11.0%
Pacific	14.2%	5.2%	-4.0%	-7.9%	-9.4%
South Atlantic	7.3%	0.1%	-2.6%	-5.4%	-5.1%
West N Central	6.0%	-1.9%	-3.6%	-7.8%	-9.7%
West S Central	10.3%	3.2%	2.1%	1.0%	-3.4%
TOTAL ALL	11.0%	4.4%	0.2%	-2.3%	-3.6%

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Value-Based Purchasing Program

aka PAY-FOR-PERFORMANCE (P4P)

- ❖ **Centers for Medicare & Medicaid Services**
 - ❖ Goal: To transform CMS from a *passive payer* of claims into an *active purchaser* of high quality, affordable care
 - ❖ Shift focus from from *volume-based* to *value-based* health care
 - ❖ Rewarding improved outcomes and innovations
 - ❖ Effective October 1, 2012
 - ❖ NOT a zero sum program!

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Transparency and Public Reporting

- ❖ **Hospital Inpatient Quality Reporting Program**
 - ❖ www.hospitalcompare.hhs.gov
 - ❖ 45 quality of care measures for 2011
 - ❖ Patient *experience of care* survey
 - ❖ Basis for establishing payment performance standards under P4P
 - ❖ Goal: To make all health care providers more *accountable* for the care they render

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RAC Demonstration Project

March 2005 - 2008

- ❖ Section 306 of MMA 2003
 - ❖ Authorizes CMS to evaluate Medicare payments
 - ❖ Goal: To reduce improper Medicare payments by detecting/collecting overpayments, and identifying/ repaying underpayments
 - ❖ Four independent contractors
 - Contingency-based payment format
 - ❖ Six states (AZ, CA, FL, MA, NY, SC)
 - ❖ ≥ 525,000 overpayment determinations

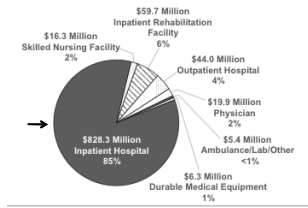
RAC Demonstration Scorecard

Overpayments recovered	\$992.7 million
Repayments upon appeal	<\$60.0> million
NET RETURNED TO TRUST FUND	\$693.6 million

Primary reasons for disallowing payment:

- Services/care provided did not satisfy CMS's medical necessity criteria
- Services provided incorrectly coded
- Inadequate documentation to support the claim

Recovery by Site of Care



Key message: For all inpatient care, apply evidence-based medicine and thoroughly document all care/service provided!

Hospitals - - Spring 2011

- ❖ **Financial uncertainty to continue**
 - ❖ Medicare net margin in 2011 **-\$7.1%** (*1/1/11 = 7K/24 hrs*)
 - ❖ RAC Audits now permanent
 - ❖ Fragility & volatility of worldwide financial markets
 - Cost of transitioning to EMR ?
 - ❖ *Door to Discharge* analysis now in play
- ❖ **≥ 60% hospital budget - - *personnel***
 - ❖ *Are you a "renter" or an "owner" ?*
 - ❖ As an "owner", what can I/we do?
 - Reduce inefficiency, waste
 - Improve outcomes of care
 - Lessen financial impact of chronic conditions
 - Become part of the solution, not the problem

Evolving Role of the RT

- ❖ **RTs are best qualified by training and experience to assume a role as chronic disease manager**
- ❖ **2015 and Beyond**
 - ❖ AARC's strategic initiative to prepare the profession for the new health care delivery system
 - ❖ Aligning RT practice with the new delivery system
 - ❖ Emphasis on improving outcomes of care for patients with chronic respiratory diseases
 - ❖ Embraces the concept of *value-based care*
 - Empowering patients to assume a proactive self-care approach for sustained symptom control

The Changing Health Care Environment

Today

- Acute treatment
- Cost unaware
- Professional prerogative →
- In-patient
- Individual profession
- Traditional practice
- Patient passivity
- Volume-based

Tomorrow

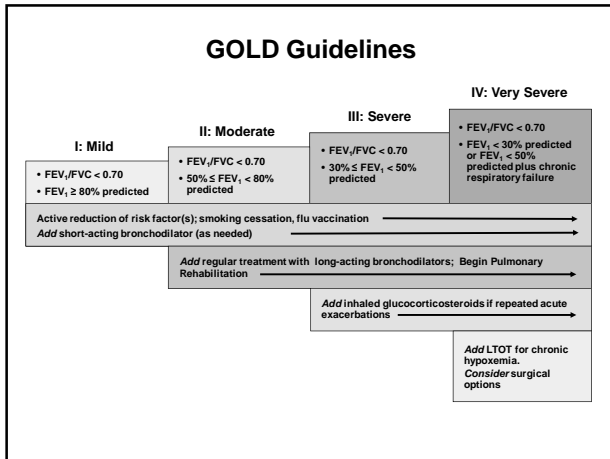
- Chronic disease mgmt
- Cost-of-care the focus
- Consumer responsive
- Out-patient
- Team
- Evidence based practice
- Activated patients
- Value-based

COPD - - Opportunities for RTs!

- ◇ Not curable, but treatable and controllable!
- ◇ Incidence is increasing
- ◇ High degree of recidivism
 - ◇ *re.cid.i.vism (n) - - relapsing into crime*
 - ◇ In health care, aka
 - *Frequent flyer*
 - *Revolving door*
 - *Bounce-back*
- ◇ Unplanned re-admissions are costly
 - ◇ Medicare especially concerned
 - No longer paying for in-hospital mistakes (*never events*)
 - 30-day re-admissions a growing concern

Unplanned Rehospitalizations

- ◇ NEJM April 2009: Jencks, SF et al
 - ◇ October 1, 2003 through December 31, 2004
 - ◇ 19.6% Medicare hospitalizations due to re-admission for same condition within 30 days of discharge
 - 2.3 million of 11.8 million total
 - ◇ Diseases with highest recidivism:
 - CHF (27%)
 - Psychosis (25%)
 - Vascular surgery (24%)
 - COPD (23%)
 - Pneumonia (20%)
 - ◇ Cost impact ⇒ \$17.4 billion



The Quality of Obstructive Lung Disease Care for Adults in the US as Measured by Adherence to Recommended Processes*

- ◇ 260 asthma patients with 2,394 care events
- ◇ 169 COPD patients with 1,664 care events
- ◇ **Findings:**

“Americans with obstructive lung disease receive only 55% of recommended care.

The deficits and variability in the quality of care present ample opportunities for quality improvement”

* Mularski RA, Asch SM, et al. Chest: December 2006

Discrepancy in the Use of Confirmatory Tests in Patients Hospitalized with the Diagnosis of COPD or CHF *

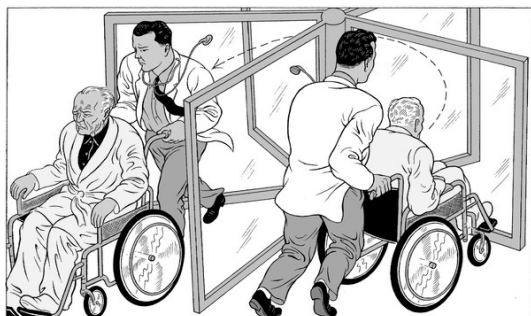
- ◇ **Confirmatory tests**
 - ◇ For COPD ⇒ spirometry
 - ◇ For CHF ⇒ 2-D echocardiography
- ◇ 553 pts discharged with Dx of COPD
 - ◇ 173 (31%) had spirometry
- ◇ 789 pts discharged with Dx of CHF
 - ◇ 619 (78%) had 2-D echo

“We must raise awareness of the need to confirm the diagnosis of COPD and its severity with spirometry”

* Darmla W, Celli BR, et al. Respir Care: October 2006

***How can respiratory therapists
make a difference?***

***By developing and implementing
a hospital-wide COPD Transition Protocol***



COPD Transition Protocol

- ◇ **First step: ask the right questions**
 - ◇ How many admissions in past year?
 - ◇ Does the patient still smoke?
 - ◇ Is spirometric data current?
 - ◇ What is frequency of patient's SABA use?
 - ◇ Is patient prescribed long-acting bronchodilator(s)?
 - ◇ Is patient capable of using MDI, DPI?
 - ◇ Is patient hypoxemic breathing room air?

COPD Transition Protocol

- ❖ **How many admissions in past year?**
 - ❖ First time (*this is good*)
 - ❖ 2 or more (*not so good*)
 - A hospitalization for exacerbation of COPD is, in and of itself, a risk factor for subsequent re-admissions
 - Share with every COPD patient importance of keeping symptoms under control to avoid rehospitalization
 - Help patients/family identify "early warning signs" and when to contact their physician (*within one week of discharge*)
 - ❖ Pulmonary Rehab referral

COPD Transition Protocol

- ❖ **Does the patient still smoke?**
 - ❖ If no, reinforce importance of continued abstinence
 - ❖ If yes, tobacco cessation counseling is imperative
 - Smoking will undermine all self-care efforts
 - Take advantage of smoke-free environment
 - Tobacco cessation counseling an RT responsibility!
 - Resources galore at www.aarc.org
 - Suggest pharma aides to support efforts



COPD Transition Protocol

- ❖ **How current is spirometric data?**
 - ❖ Ideally, within past 24 months
 - ❖ Chart review & patient interview
 - When did you have your last breathing test?
 - Do you remember where you had your test?
 - Get existing results into chart
 - ❖ If needed, advocate for replacement tests
 - This data required to effectively stage disease severity to properly align appropriate therapy

COPD Transition Protocol

- ❖ **Frequency of SABA use?**
 - ❖ Ideally, $\leq 2-3$ times per week; (Never ≥ 1 inhaler/month)
- ❖ **Is patient prescribed long-acting bronchodilator(s)?**
 - ❖ LABA (salmeterol * arformoterol† formoterol*)
 - ❖ LAMA (tiotropium *)
 - ❖ Combination (LABA & ICS)
 - (salmeterol & fluticasone **)
 - (formoterol & budesonide **)


Key: * DPI **pMDI † Neb solution

COPD Transition Protocol

- ❖ **Can patient effectively use an inhaler?**
 - ❖ For pMDI - - an anti-static, valved holding chamber
 - ❖ For DPI - - peak *inspiratory* flow rate ≥ 30 L/min
 - Unlikely when $FEV_1 \leq 40\%$
 - ❖ SVN may be necessary for optimum effect
 - Consider high efficiency jet nebulizer (BAN)
 - ❖ Primary objective is to make it easy for patient to remain adherent on a daily basis

Anti-Static Holding Chamber
Not all Spacers/Holding Chambers Are Created Equal!

New Look. Same Superior Drug Delivery.
 More Time to Breathe Easy.



Flow-Vu®
 Indicator is easier to see
 provides confidence in proper
 inhalation technique allowing
 compliance:

- Count patient breaths
- Confirms a correct seal
- Coordinates activation with inhalation

25% Smaller Chamber
 for people on the go. Same great
 benefits in smaller design

Anti-Static Chamber
 provides consistent aerosol delivery
 right out of the package

Consumer Friendly

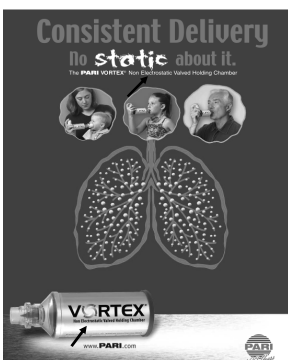
- Easy to read user instructions
- Handy opening design

Combining over 25 years experience in aerosol delivery and chamber design

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AeroChamber
Flow-Vu

Consistent Delivery
 No static about it.
 The PARI VORTEX™ Non-Electrostatic Vortex Holding Chamber

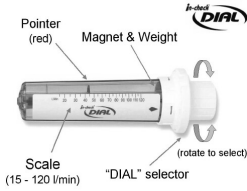


VORTEX
www.PARI.com

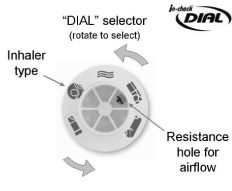
**PIFR Requirements per Manufacturer's
 Package Insert for DPIs**

DEVICE	PIFR
Discus	30 - 90
Flexhaler	60 - 90
Autohaler	30 - 60
Aerolizer	25 - 90
Twisthaler	30 - 60
Handihaler	20 - 90
pMDI	25 - 60

Peak Inspiratory Flow Rate Meter



Pointer (red)
 Magnet & Weight
 Scale (15 - 120 l/min)
 "DIAL" selector (rotate to select)



"DIAL" selector (rotate to select)
 Inhaler type
 Resistance hole for airflow

Provides an objective assessment of peak inspiratory air speed/velocity to determine patient's ability to effectively use a dry powder inhaler

Device - \$79 (KWM-510); 50 disposable mouthpieces - \$49 (KWM-2065)
www.kw-med.com

COPD Transition Protocol

- ❖ *Is patient hypoxemic breathing room air?*
- ❖ *Is resting SpO₂ ≤ 89%, and if so, what oxygen dose is needed to ≥ 90% ?*
- ❖ *During ambulation, does resting oxygen dose prevent desaturation, and if not, how much must oxygen dose be increased ?*

*"Only 32% of COPD patients with baseline hypoxia received home oxygen for routine management"**

* Mularski RA, et al. Chest; December 2006

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- ❖ **Is patient capable of using MDI, DPI?**
- ❖ **Is patient hypoxemic breathing room air?**

AARC Times, June 2010

Preventing Readmissions with a COPD Transition Protocol

by Patrick J. Dunne, MEd, RRT, FAARC

In spite of the new reality in Washington in terms of health care reform, one thing has not changed — namely, that the huge economic pressures that most hospitals have been dealing with for the past decade remain firmly in place and a quick fix is highly unlikely. In a sense, acute care hospitals are facing the perfect storm, with falling reimbursement rates, a growing incidence of uncompensated care, and, due to the economic crisis, restricted access to much-needed working capital. Yet at the same time, hospitals are continually being beseeched to improve the quality of care outcomes, improve patient safety, do a better job of caring for chronic medical conditions, and reduce the overall cost of care. To say that hospitals are caught between a rock and a hard place is an understatement of the highest order.

A recent report showing hospital inpatient margin percentages for treating Medicare beneficiaries aptly illustrates the growing financial pressures.¹ In 2003, the nation's hospitals averaged an 11% margin for all Medicare inpatients treated. By 2008, that number had plummeted to -3.6%, indicating that acute care hospitals are now losing money when treating Medicare patients. This is obviously not a good sign in and of itself, but it

What is an RT to do? As the nation's newly mandated health care system begins to take shape, the question is, "What can respiratory therapists do now to help their hospitals become more competitive?" One opportunity comes immediately to mind, and it is related to the significant adverse financial impact of unplanned readmissions for Medicare COPD patients within 30 days of discharge following an exacerbation.

about the author



Patrick J. Dunne, MEd, RRT, FAARC, is president of HealthCare Productions, Inc. in Yuleton, CA. He is also a trustee of the American Respiratory Care Foundation and an AARC representative to the International Council for Respiratory Care.

A study published in the April 2009 issue of the *New England Journal of Medicine* reported that, for a 14-month period during 2003-04, "13.6% of Medicare hospitalizations (2.3 million out of 11.8 million total) were due to readmission for the same condition within 30 days of discharge." The economic impact was estimated to be a staggering \$1.4 billion.² There is now a growing sense that many unplanned rehospitalizations might be preventable.

In listing the top five diseases contributing to the readmissions (congestive heart failure, psychosis, vascular surgery, COPD, and pneumonia), the authors concluded that "A large percentage of unplanned rehospitalizations appears to be directly related to poorly coordinated transition of care." In terms of the COPD patient population, this suggests to me that our patients did not



**Project RED
Re-Engineered Discharge Training
Program**

**Preparing to Redesign Your Hospital
Discharge Program**

www.ahrq.gov.qual/projectred

Improving COPD Care Outcomes

*Respiratory therapist can indeed make a difference
by:*

- *Helping COPD patients avoid exacerbations and rehospitalizations*
- *Providing for transition of care to ensure COPD patients are properly equipped for self-care responsibilities*
- *Advocating the application of evidence-based care guidelines for COPD*
- *Becoming a value-added member of your hospital care team*

**Six Habits of Great
Respiratory Therapists**

- ◇ **Displays professionalism**
- ◇ **Pursues continuing education**
- ◇ **Pays attention to clinical detail**
- ◇ **Communicates effectively**
- ◇ **Completely documents all care provided**
- ◇ **Owens-up when an "oops" occurs**

* DeWitt AL. AARC Times, March 2011

RC Practice - Changes in the Air