RHIhub
Rural Health Information Hub

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Your *First* **STOP** for
Rural Health
INFORMATION

Introducing the Rural Chronic Obstructive Pulmonary Disease Toolkit

Housekeeping

- Q & A to follow – Submit questions using Q&A area
- Slides are available at https://www.ruralhealthinfo.org/webinars/copd-toolkit
- Technical difficulties please call 866-229-3239

Featured Speakers

Grace Anne Dorney Koppel, MA, JD, President, Dorney-Koppel Foundation

Tricia Stauffer, MPH, Principal Research Analyst, NORC Walsh Center for Rural Health Analysis

Stephanie Williams, BS, RRT, Director of Community Programs and Volunteer Management, COPD Foundation

Donna Dittman Hale, MHA, Executive Director, Bay Rivers Telehealth Alliance, the Area Health Education Center for the Rappahannock Region

Chronic Obstructive Pulmonary Disease (COPD) and Rural America

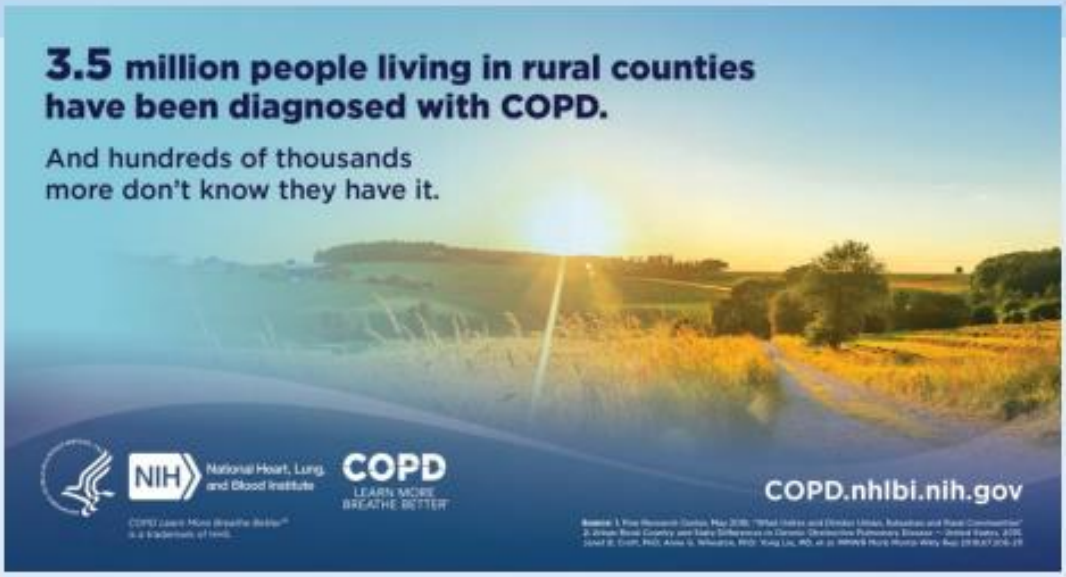
Grace Anne Dorney Koppel, MA, JD

President, Dorney-Koppel Foundation

RHIHub Webinar
Introducing the Rural Chronic Obstructive Pulmonary Disease Toolkit
November 20, 2019

"Hope has two beautiful daughters. Their names are anger and courage; anger at the way things are, and courage to see that they do not remain the way they are."

St. Augustine of Hippo



Why Rural COPD?

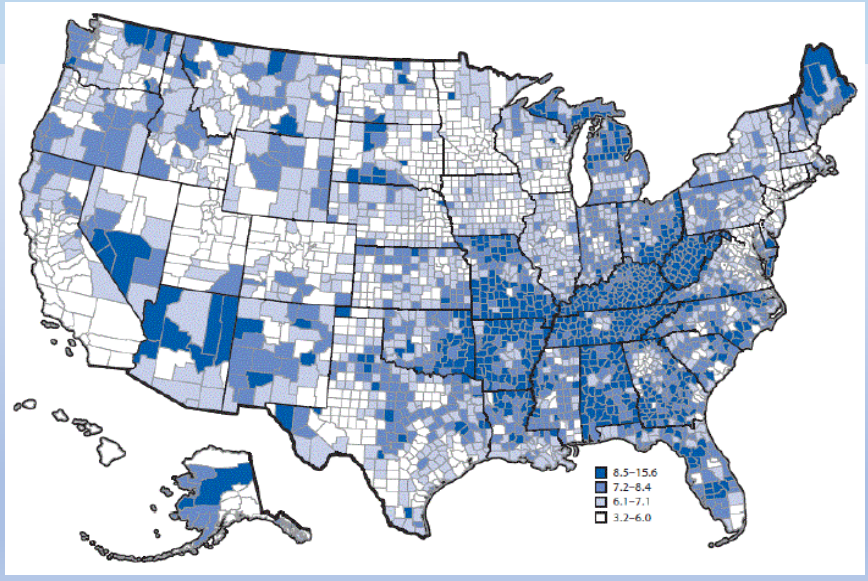


Figure: Unadjusted prevalence of COPD among adults ages 18+, by county – United States, 2015[1]

[1] Croft, Janet B., et al. "Urban-rural county and state differences in chronic obstructive pulmonary disease – United States, 2015." MMWR Report, 67.7 (2018): 205-211. DOI: 10.15585/mmwr.mm6707a1.

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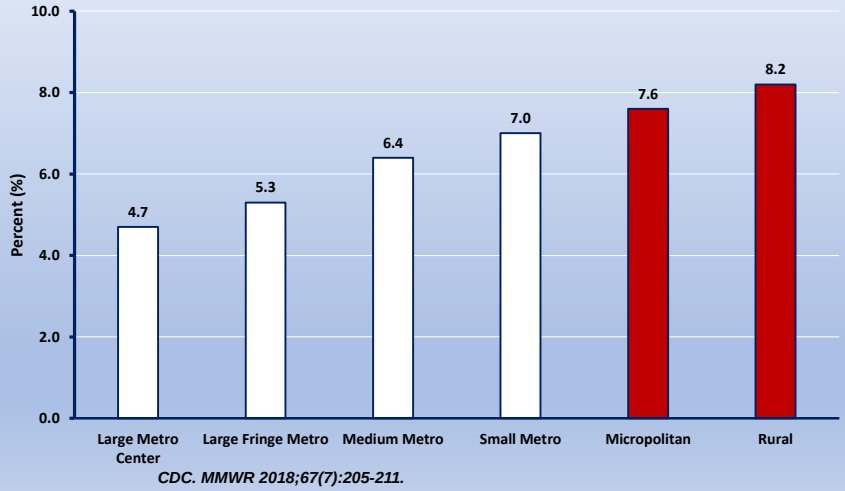
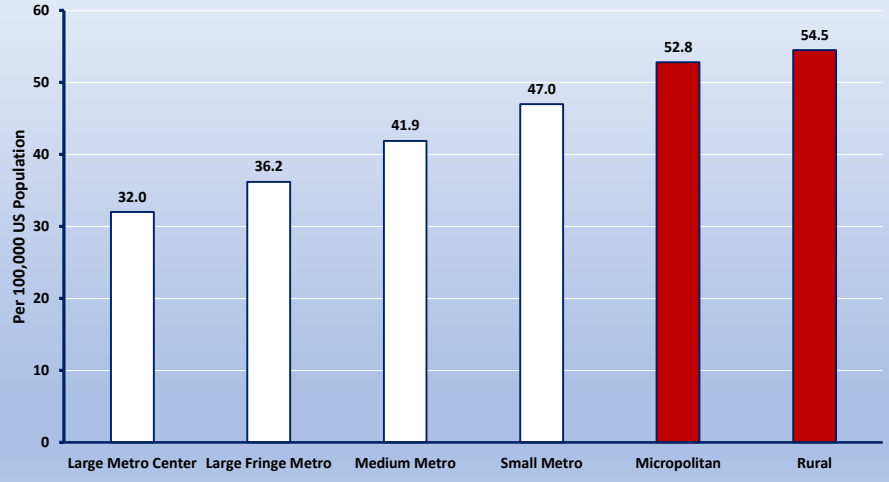
Doctor-diagnosed COPD among adults is higher in rural settings : BRFSS 2015



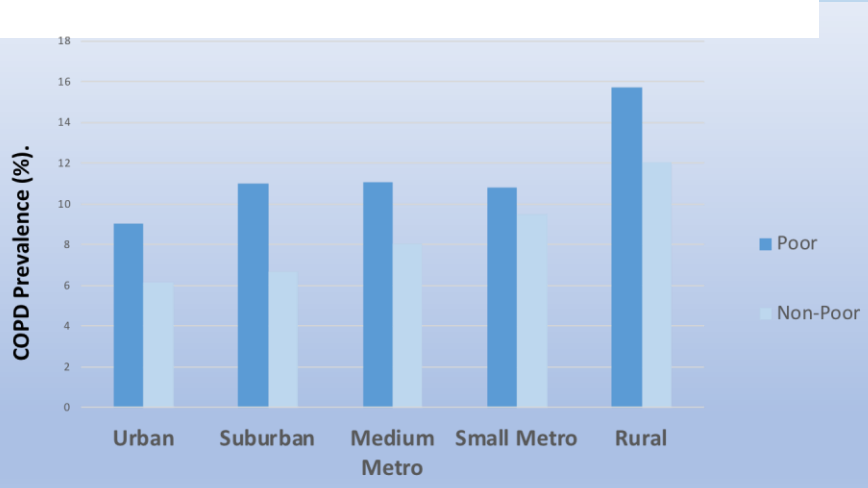
CDC. MMWR 2018;67(7):205-211.

Death rates for COPD are higher in rural settings: US Vital Statistics 2015



Source: CDC. MMWR 2018;67(7):205-211.

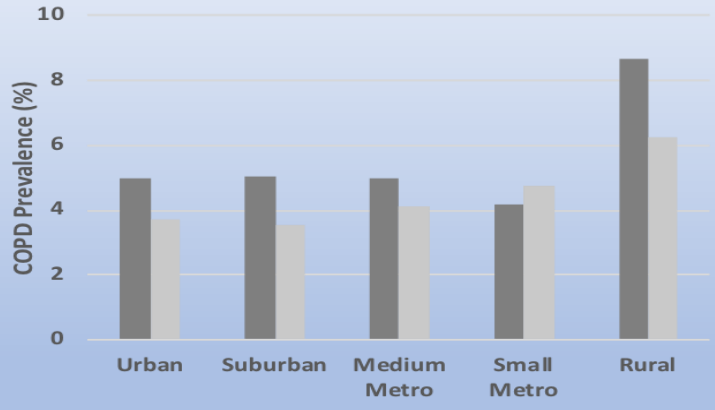
In a nationally representative sample, increased COPD prevalence in rural, poor regions



The prevalence of COPD was 8.4% nationwide with the highest prevalence of 15.7% in rural, poor communities.

Raju, Sarath, "Rural Residence and Poverty are Independent Risk Factors for COPD in the United States." *American journal of respiratory and critical care medicine* 2018

Residents in rural, poor regions had increased prevalence of COPD among never smokers



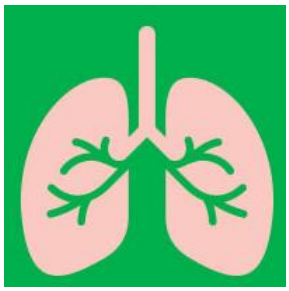
Among never smokers, community level use of coal for fuel was associated with COPD prevalence.

Raju, Sarath, "Rural Residence and Poverty are Independent Risk Factors for COPD in the United States." *American journal of respiratory and critical care medicine* 2018

"Hope is like a path in the countryside. Originally, there is nothing—but as people walk this way again and again, a path appears."

Lu Xun, Chinese Essayist, Philosopher 1921

Rural Chronic Obstructive Pulmonary Disease Toolkit



November 20, 2019

Patricia Stauffer, MPH
NORC Walsh Center for Rural Health Analysis

The Walsh Center for Rural Health Analysis
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UNIVERSITY OF MINNESOTA RURAL HEALTH RESEARCH CENTER

Rural Health Outreach Tracking and Evaluation Program

- Funded by the Federal Office of Rural Health Policy (FORHP)
- NORC Walsh Center for Rural Health Analysis
  - Michael Meit, MA, MPH
  - Alana Knudson, PhD
  - Alycia Bayne, MPA
- University of Minnesota Rural Health Research Center
  - Ira Moscovice, PhD
  - Amanda Corbett, MPH
  - Carrie Henning-Smith, PhD, MSW, MPH
- National Organization of State Offices of Rural Health
- National Rural Health Association

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Rural Health Outreach Tracking and Evaluation Program

- Programs funded by the Outreach Authority of Section 330A of the Public Health Service Act seek to expand rural health care access, coordinate resources, and improve quality of care.

Rural Evidence-Based Toolkits

1. Identify evidence-based and promising community health programs in rural communities

2. Study experiences of these programs including facilitators of their success

3. Disseminate lessons learned through Evidence-Based Toolkits

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Evidence-Based Toolkit on COPD

- Rural communities are developing, expanding, and sustaining COPD programs.
- These programs focus on:
  - Prevention and Risk Reduction
  - Pharmacologic Treatment
  - Non-Pharmacologic Treatment
  - Palliative Care
- The toolkit is designed to disseminate promising practices and resources.

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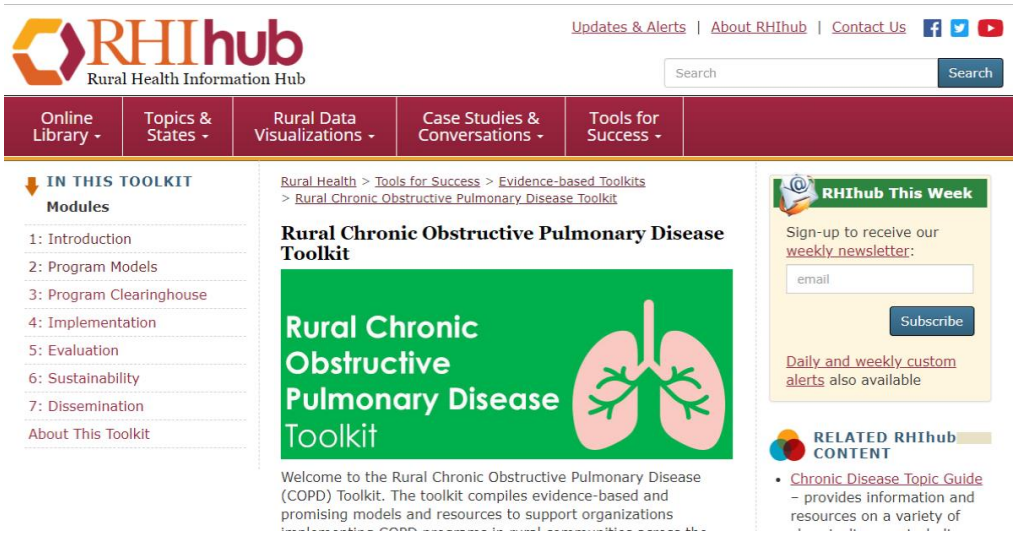
Rural Chronic Obstructive Pulmonary Disease Toolkit



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Organization of the Toolkit

IN THIS TOOLKIT

Modules

1: Introduction
2: Program Models
3: Program Clearinghouse
4: Implementation
5: Evaluation
6: Sustainability
7: Dissemination
About This Toolkit

2: Program Models

- Prevention and Risk Reduction Models
- Pharmacologic Treatment Models
- Non-Pharmacologic Treatment Models
- Palliative Care Models

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Prevention and Risk Reduction Models

1. **Smoking cessation** is one of the most effective ways to manage COPD symptoms among individuals who smoke.
2. Individuals with COPD are strongly recommended to receive influenza and pneumococcal **vaccines**.

3. **Early diagnosis** allows opportunities to decrease the rate of decline in lung function. Beginning treatment in the early stages of the disease can produce more favorable outcomes and improve quality of life.

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Pharmacologic Treatment Models

1. **Pharmacologic therapy**
   Long-acting bronchodilators
   Rescue medications
2. **Oxygen therapy**
   For patients with severe resting hypoxemia

Non-Pharmacologic Treatment Models

1. **Pulmonary rehabilitation** interventions focus on the adoption of and adherence to health-promoting behaviors.
   – Education
   – Exercise

2. **Chronic Care/Chronic Disease Management** programs are based on the Chronic Care Model. Structure and delivery may vary, but typically include: information about COPD, offering education about behavior change, and providing information about medication adherence and management.

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Palliative Care Models

- Designed to make symptomatic patients as comfortable as possible while managing their COPD.
- Typically occurs alongside treatment and can help relieve suffering by offering help with symptoms like shortness of breath, fatigue, pain, depression, and anxiety.
- The topic is frequently avoided, as many people confuse palliative care and hospice.

Lessons Learned

- Key barriers to COPD in rural areas:
  - Access to specialty pulmonary services
  - Transportation
- Comorbid conditions
  - Medication management and cost
- Planning for sustainability during program development is critical
- Occupational exposures related to farming and coal mining
- Considerations for different populations

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TOUCH
Teaching and Outreach in Underserved Communities and Health Improvement

COPD FOUNDATION

Our Concern:

Limited support for Skilled Nursing Facility (SNF) COPD patients and staff

TOUCH COPD HYPOTHESIS

COPD FOUNDATION

WHAT DO PATIENTS NEED?

WHAT WE FOUND

- Frequent, unplanned discharge back to hospital
- Limited reporting protocols for detection of status change
- Unsure of action when symptoms change or worsen
- Limited education for patients and families
- Providing support when discharging home

COPD FOUNDATION

WHAT ABOUT FOLLOW UP POST DISCHARGE?

Case Management usually does not follow up with patients discharged to SNF – our sickest patients.

WHAT DID WE DO?

- Found SNF partner East TN
- 5 Facilities
- Multidisciplinary Teams
- 2 webinars and 1 workshop

HELP WITH REPORTING

Stop and Watch Tool

Educated about COPD symptoms and recognizing exacerbations.

Encourage EVERYONE to use these.

Nurses, Dietary, Environmental Services, Family Members… Everyone

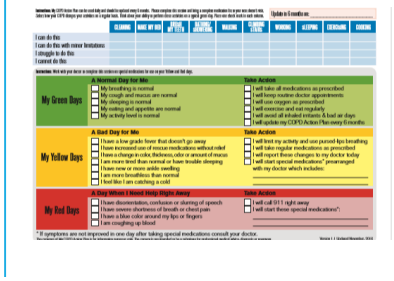
Stop and Watch
Early Warning Tool

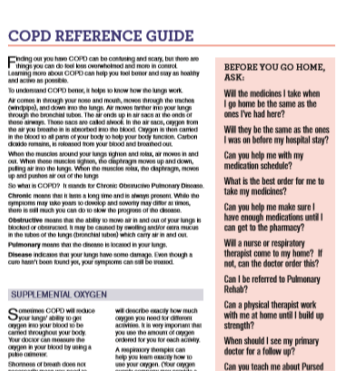
INTERACT
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

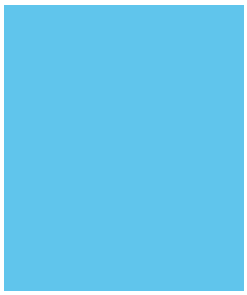


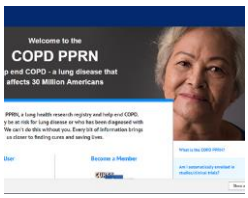


WHAT DID WE PROVIDE?

FOLLOW UP – SUPPORT AFTER DISCHARGE

Provided information to get patient connected to support network.

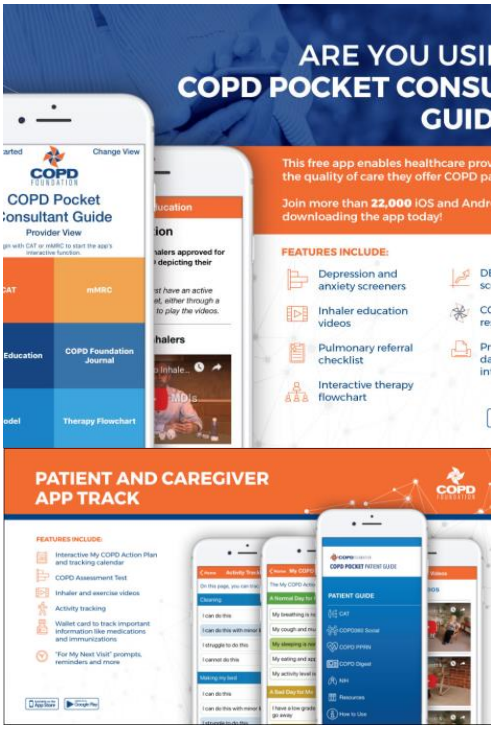


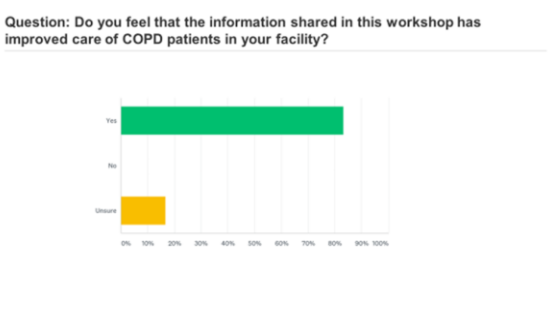


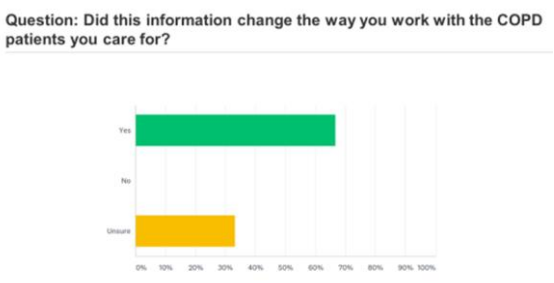
THE COPD POCKET CONSULTANT GUIDE APP

The newest version of the app, now available for download at the **APP STORE** and **GOOGLE PLAY**, has several exciting new features, including:

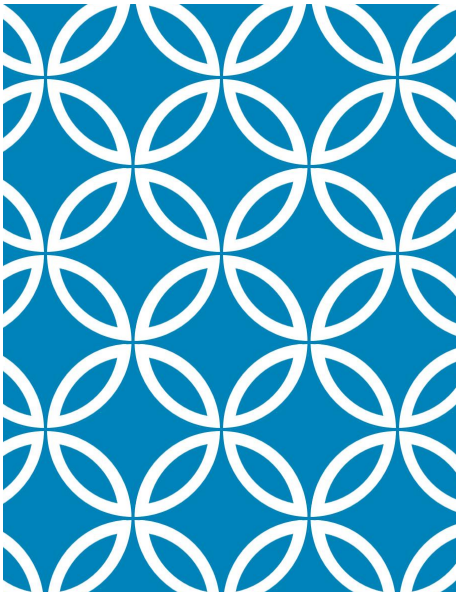
- An interactive "My COPD Action Plan" and tracking calendar
- Inhaler and exercise videos
- Activity tracking
- Wallet card to track important information, including medications and immunizations
- "For My Next Visit" prompts and reminders
- Information about the COPD Patient-Powered Research Network and COPD360social
- Direct access to the 25 latest articles posted in the COPD Foundation's patient blog, the COPD Digest







WHAT WERE THE RESULTS?



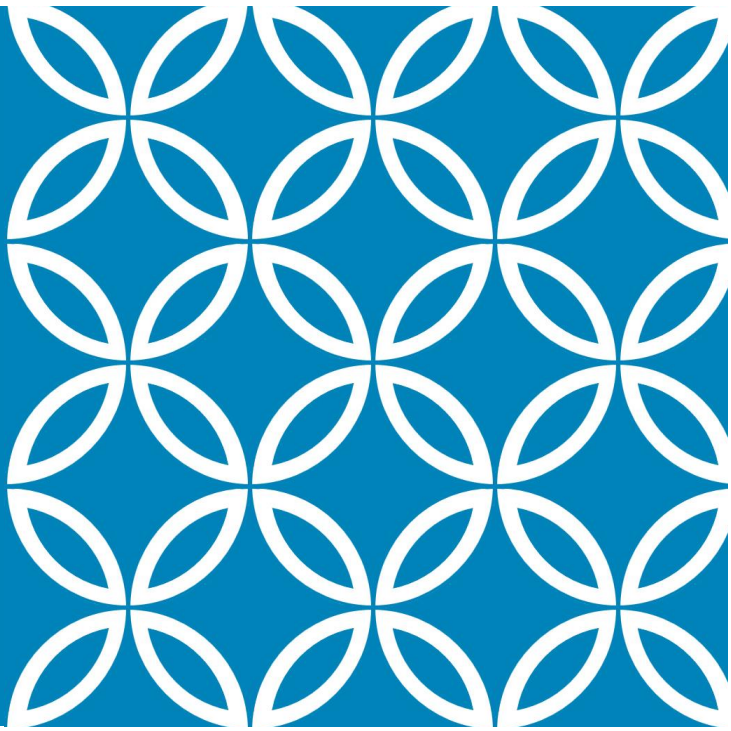
LESSONS LEARNED?

With more time, more data follow up with long-term improvement in readmission rates

Continued education provided for new hires and yearly skills testing.

THANK YOU

Stephanie Williams, BS RRT
Director of Community Programs
COPD Foundation



BAY RIVERS TELEHEALTH ALLIANCE

Tackling Chronic Illness Using Remote Patient Monitoring

Donna Dittman Hale, MHA, CTC, Executive Director

November 20,2019

BAY RIVERS TELEHEALTH ALLIANCE

BRTA's Mission: To serve communities by developing telehealth projects that: Improve access to health services; Engage patients as partners; Reduce professional isolation among health service providers; and Provide access to training and development of the health care workforce.

- Established in 2003
- Operating in 17 rural localities
- Manages 4 federal/state grants
  - Behavioral Telehealth
  - Remote Patient Monitoring
  - Area Health Education Center
  - School Based Telehealth Integration

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Bridges to Care Transitions: Preliminary Results

- 134 patients received Remote Patient Monitoring Services upon discharge
- 398 received Care Transitions Coaching and Chronic Disease Self Management(CDSM) Tele-Education
- 27 enrolled in Healthy IDEAS© Behavioral Health Coaching
- 2566 participated in community CDSM activities

2018 HRSA Rural Health Community Champion Award for Evidence Based Practices

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Findings

Status	Avoided (>1) Readmission	Readmission = 1	Readmissions >1	Unscheduled MD Visits
Grant patients (with coaches)	78%	19%	1%	13%
Non-grant patients	34%	47%	19%	10%

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Cost Savings

- The grant program saved approximately $344,000 or $3,510.20 per person in hospital readmission costs for 98 people.
- Chronic and diabetes self-management programs resulted in an additional $106,957 or $363.80 per person in savings through decreased ER visits and admissions.

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Inpatient Hospital Readmissions	Intervention		Comparison	
	Percent	Dollars	Percent	Dollars
High Risk	10%	$ 95,770	37%	$ 341,324
Congestive Heart Failure	7%	$ 43,715	19%	$ 115,408
Chronic Obstructive Pulmonary Disease	4%	$ 20,288	8%	$ 36,823
Pneumonia	0%	$ 6,492	3%	$ 17,139
Total	22%	$ 166,265	66%	$ 510,693

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Improve access to care | Health promotion & disease management | Improve mental health | Ensure sustainability

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Bridges to Cardiovascular Population Health: Key Program Components

Primary Care Practices

- Identify at risk patients with CHF
- Provide Care Management support for enrolled patients with use of virtual visits for in home support
- RPM Monitoring via Riverside Connected Care Center
- Diabetes Management Consultations

Coaching and Behavioral Health (Bay Aging & CSB)

- Home visit for Chronic Disease Self Management Education
- Consent Patients and support RPM use.
- PHQ9 and Behavioral Health Coaching as needed
- Behavioral Health Training and Services (CSB)

Training and Evaluation

- Process, Outcomes and ROI (RCEALH)
- Community Based CDSMP Training
- Rapid Cycle Quality Improvement (Project Team)

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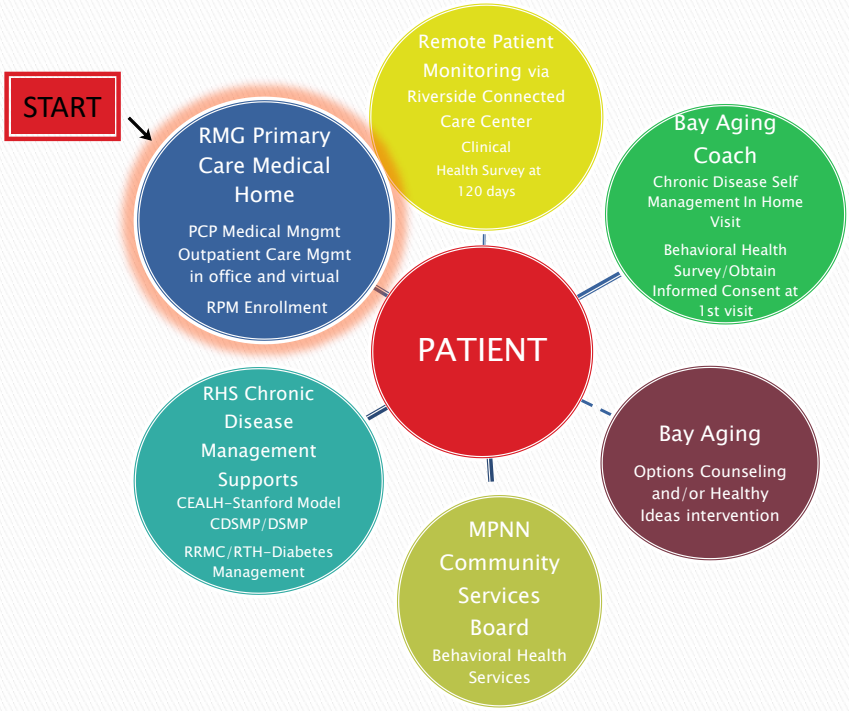

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Grant Inclusion Criteria

- Patient has an RMG PCP
- Patient lives in HRSA defined rural county
  - Essex, Northumberland, Middlesex, Richmond, Westmoreland, Lancaster
- Diagnosis of CHF, or CHF and Diabetes. COPD added by RMG
- Patient and/or caregiver is willing to participate in RPM and Health Coaching program

http://hpsafind.hrsa.gov/

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Reimbursement Strategies to Develop Sustainability

- Optimize current and future reimbursement models:
  - Commercial contracting
  - Medicare
    - RPM Billing Codes
    - 99490 Chronic Care Codes
    - ACP Billing
  - Medicaid
  - Tricare
- Retail RPM option with lower end equipment?

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CHF Patient Stratification

- HCC Potential Score >1.5 (70% of pts)
- On Diabetes Registry (40% of pts)
- LACE+ Score >59 (32% of pts)
- General Risk Score >6 (30% of pts)
- Hospital or ED Admission Risk >40% (34% of pts)

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Thank You!!

BAY RIVERS TELEHEALTH ALLIANCE

For More Information contact

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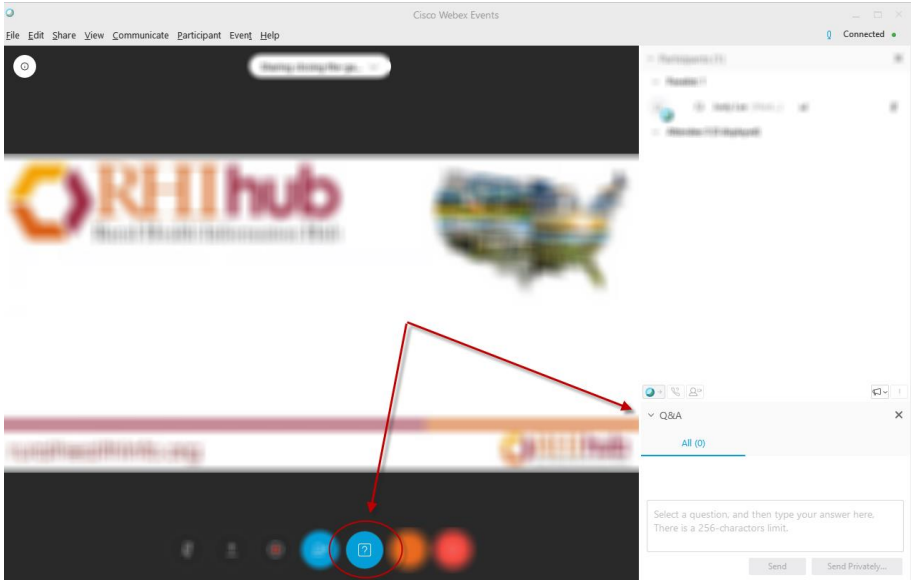
Questions?



Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website