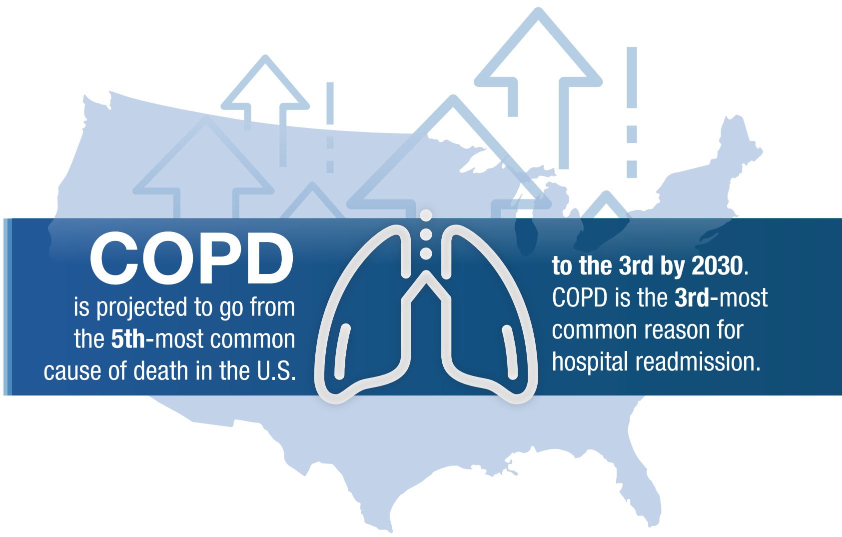
Reducing Respiratory Failure Readmissions

While COPD Is on the Rise

Diagnoses of Chronic Obstructive Pulmonary Disease (COPD) have been on the rise since the early 2000s. By 2030, it is projected to be the third-most common cause of death, according to the World Health Organization. It's already the third-most common reason for hospital readmission.

In order to encourage health systems to improve outcomes for COPD patients, the Centers for Medicare and Medicaid Services (CMS) included COPD in the Hospital Readmissions Reduction Program (HRRP) back in 2014, which can penalize hospitals for excessive 30-day readmissions in an effort to encourage providers to tackle the problem. However, five years later, few published COPD readmission reduction programs have emerged, leading to continued inconsistency across health systems and little movement in the readmission rate.

Without innovative action, the care costs of COPD in today's value-based care world will rise right along with its prevalence. In this whitepaper, we examine the strategies providers and physicians should consider to help improve outcomes and reduce costly readmissions for this at-risk population.



The COPD Problem

COPD incidence is on the rise, and fast. Here are the stats:[1,2]

- COPD is projected to go from the fifth-most common cause of death in the U.S. to the third by 2030.
- COPD is the third-most common reason for hospital readmission.
- Thirty-day hospital readmissions related to COPD are high, at 22%.
- For patients who require ICU treatment for COPD, the ICU readmission is even higher—about 25%.
- COPD is often a multimorbidity. By 2030, about 40% of people 65 and older will suffer from three or more chronic conditions. Recognizing this, COPD is now described as a syndrome rather than a single disease.

This is creating a surge in demand for acute-care facilities that have the ability to successfully treat these medically complex and seriously ill patients, particularly those in need of assistive breathing devices.

Improving COPD Outcomes

While no single readmission reduction program has emerged as superior, individual hospitals have been implementing their own best practices in an effort to avoid CMS penalties. Here are a few case studies[1] and the most impactful strategies providers could consider for their own care enhancements.

An emphasis on care management.

One 200-bed community hospital employed a dedicated COPD care manager to communicate with patients, document care plans, facilitate referrals and visit patients at home two to three days after discharge. After a year, hospital administrators credited this care management program with a drastic decline in COPD readmissions—from 12% to 6.7%.

Meanwhile, an 800-bed university hospital in the same health system chose to implement standardized electronic treatment pathways and readmission risk calculations. The academic hospital recorded only modest reductions in COPD readmissions at the year mark, citing low utilization and rigid order sets as the reasons.

Multidisciplinary focus on COPD.

An academic hospital in an underserved area took aim at CMS Hospital Readmission Reduction Program (HRRP), by taking a page out of other chronic disease handbooks, assembling an interprofessional team focused on COPD. Led by a dedicated, advanced-practice nurse, the team developed a systematic approach to ensure all patients admitted to the hospital with COPD received a pulmonary consultation. After comparing data from six months prior to the program implementation and six months after, they found that COPD readmissions dropped nearly 50%.

Referral to pulmonary rehabilitation.

In a review for a joint statement by the American Thoracic Society and the European Respiratory Society, researchers found mixed results in pulmonary rehabilitation's effect on 30-day, all-cause readmission rates but a nearly 50% reduction in readmissions in the long term. This is unsurprising considering pulmonary rehab typically is conducted over a period of weeks, or even months. These results indicate that pulmonary rehab is essential to long-term readmission reduction and patient outcomes.

Identification of high-risk patients.

To date, there is only one tool available to help providers predict readmission risk specifically among COPD patients. The PEARL (previous admissions, eMRCD score, age, right-sided and left-sided heart failure) score was designed to and has proven succesful in identifying patients at risk for readmission within 90 days. But currently there is no model available for 30-day readmissions, which means there is still ample room for improvement when it comes to identifying at-risk patients.

Until an evidence-based readmission reduction program emerges as the clear solution for COPD patients, it will be up to each acute-care hospital to design and implement a protocol that works for their organization and patient population.

The Role LTAC Hospitals Play in Care for COPD Patients

Another key strategy for hospitals and health systems to consider to aid in reducing readmissions for COPD patients is to identify downstream partners who are experts in caring for complex pulmonary patients – such as long-term acute care (LTAC) hospitals.

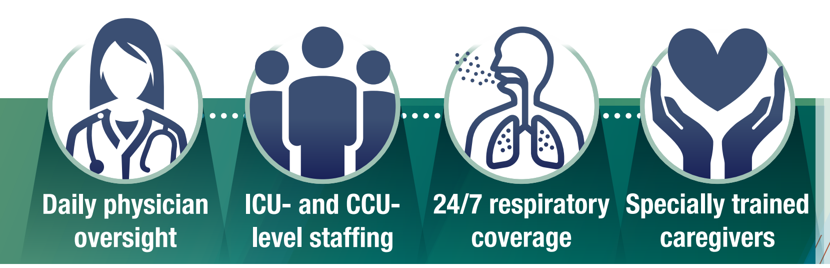
LTAC hospitals are in a unique position to care for COPD patients because they provide acute-level care to chronically, critically ill patients, with a particular competency for those with pulmonary issues. Further, the vast majority of COPD patients have multiple comorbidities, meaning they would benefit from seeing a physician or several specialty physicians every day, something LTAC hospitals offer.

While LTAC hospitals provide care for a very high-acuity, niche patient population, they play a vital role in aiding the efficient recovery of patients who have a high risk of readmission due to their clinical complexity. By transitioning these challenging patients to an LTAC hospital when it is the most appropriate site of care for their needs — rather than a skilled nursing facility or other post-acute care site — readmission rates can be lowered, patient outcomes can be improved and a significant portion of financial losses can be mitigated.

It is important for providers and physicians to identify partners who can provide expert care for complex pulmonary patients to help reduce readmissions and avoid penalties.

How Kindred Can Help Your COPD Patients

Acute care providers need partners who can continue to provide physician-directed care with the extended recovery time COPD patients — particularly those on mechanical ventilation — require. Kindred Hospitals specialize in the treatment of patients with complex medical issues who require intensive care and pulmonary rehabilitation in an acute hospital setting. With daily physician oversight, ICU- and CCU-level staffing, 24/7 respiratory coverage and specially trained caregivers, we work to improve functional outcomes, reduce costly readmissions and help patients transition home or to a lower level of care.



We are committed to pursuing innovations in care delivery and payment models to provide new tools and solutions to our patients and their families as well as to our provider and payer partners. Many of these resources and initiatives are designed to ensure efficient care management for each patient.

One such initiative is our effort to achieve disease-specific certification from The Joint Commission for Respiratory Failure in all Kindred Hospitals across the country. The certification recognizes healthcare organizations that provide comprehensive clinical programs across the continuum of care for respiratory failure. It evaluates how organizations use clinical outcomes and performance measures to identify opportunities to improve care, as well as to educate and prepare patients and their caregivers for discharge.

We have proven success in treating patients with pulmonary disease and respiratory failure, including a long history of liberating patients from mechanical ventilation and artificial airways. Our program structure and management protocol include:

- A review of every new admission for potential inclusion in the Respiratory Failure Program based on qualifying criteria
- Focused interdisciplinary care team and ventilator rounds for program participants
- Development of an individualized plan of care and creation of interdisciplinary goals targeting the patient's pulmonary needs
- Daily multidisciplinary assessment, evaluation, treatment and therapy following established clinical practice guidelines for:
    - Ventilator liberation
    - Early mobility
    - Oral care
    - Maintenance of skin integrity
- Disease-specific education for patients and their families while enrolled in the Respiratory Failure Program
- Structured performance measure and patient perception data tracking to assess and assure program quality and ongoing success

Additional care delivery innovations that help improve care for our respiratory failure patients include the **AfterCare** program and the **Move Early** mobility program. The AfterCare program features Registered Nurses telephonically reaching out to patients who discharge from our hospitals directly home, on a scheduled timeline, in order to identify and manage clinical gaps and medication regimens to prevent patient decline or rehospitalizations.

The Move Early program aims to get patients moving as early in their recovery as possible – including those on mechanical ventilation – to combat the many potential, and detrimental, side effects of immobility in the healing process.

In today's value-based care environment, and as more people develop COPD, we are committed to treating chronically, critically ill patients and to continued clinical growth with specific expertise in pulmonary care.

To learn more about how Kindred Hospitals can help care for your chronically, critically ill patients, visit kindredhospitals.com.

References

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2. Who.int. (2019). *WHO | Burden of COPD.* [online] Available at: https://www.who.int/respiratory/copd/burden/en/ [Accessed 25 Oct. 2019].