



NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

Care Coordination Newsletter

CC Spotlight

Kudos to the **Virginia Gay** team for being the first National Rural ACO community to complete their GPRO reporting for 2015. They have successfully completed the filing of their CMS assigned ranking report for their Quality Measures ahead of schedule.

The National Rural ACO deadline for GPRO submittal for our 2015 communities is February 26th. We want to not only celebrate Virginia Gay's accomplishment but to recognize the investment of labor and effort on everyone's part to get through their reporting of their quality measures. The Care Coordination Program Coaches and remaining National Rural ACO team appreciate your due diligence and commitment toward completing this goal. Your engagement in our weekly Quality Reporting webinars and calls has been outstanding and we are confident that all 30 communities will be successful in achieving the February 26th target.



Impacting Quality of Life for COPD Patients

Chronic Obstructive Pulmonary Disease (COPD) is any disorder that persistently obstructs bronchial airflow. COPD encompasses two related diseases -- chronic bronchitis and emphysema. Both of these diseases cause chronic obstruction of air flowing through the airways and in and out of the lungs. The condition is generally permanent, irreversible and progressive (often becoming worse over time). According to a Center for Disease Control May 2013 report, 2010 National Vital Statistics data revealed COPD to be the third leading cause of death in the U.S. COPD is often associated with other chronic conditions such as heart disease and diabetes. Patients with COPD are vulnerable to respiratory infections and when exacerbations occur, they often result in acute care hospitalization. Due to the debilitation that can occur episodically for this population, we must adjust the care and support activities based on their needs.

There are Patient Reported Outcomes (PRO) assessment tools available to assist the provider and the care management team determine symptom severity for this population. These subjective assessments can be used by patients to self-

Tip of the Month

The COPD Foundation is a non-profit organization whose mission is "to prevent and cure Chronic Obstructive Pulmonary Disease and to improve the lives of all people affected by COPD". This organization has numerous key subjects within their site ranging from advocacy and research to community where people affected with this disease can seek out information from others on how to cope with the disease. They have a free community site called "360 Social" where anyone can share information or request guidance/information from others. A recent post made by a patient rings true to the insight of what a COPD patient took away from a recent webinar offering: "One of the slides in the self-management webinar I just posted was particularly interesting to me and I thought I would share. The researcher asked more than 2,000 respondents what they wanted most from the healthcare system and here were their answers":

1. Give me hope/seem hopeful about my future
2. Let me make decisions and have input into my care
3. Focus on my wellness and not my illness
4. Act in a way that shows you believe I can recover
5. Listen to what I need instead of telling me what I need

monitor their condition and report findings to their Care Coordinator or Provider. This useful information can be instrumental in determining effectiveness of established medical treatment and medication management plans. They can assist with helping patients build attainable goals for treatment and recognize early warning signs for deterioration in status, potentially avoiding severe exacerbation episodes. Two valid and reliable PRO tools are the COPD Assessment Test (CAT) and the St. Georges Respiratory Questionnaire (SGRQ). The CAT is a more brief and less complex tool. They can be given to the patient to complete at home, at the time of the Care Coordination encounter, or by office staff preceding the scheduled provider visit. The information can be reviewed with the provider to help assess whether the current prescribed treatment plan is well aligned with the patients needs and helps strengthen the communication relationship with patients during their provider visit. By collecting information from the patient about their general health perceptions including impairment due to COPD, there is increased likelihood of informed decision making to occur between the provider and the patient.

A care team management partnership between Respiratory Therapists and the Care Coordinator also adds quality for COPD patients, providing them with additional coping strategies and tools. Ensuring that patients are given tools for regular breathing exercise training and rehabilitation programs to improve their physical activity along with coaching to effective administration and use of pulmonary medications can help minimize exacerbation episodes. Linking patients to support resources within the COPD patient community can also help them learn new skills to cope with their condition. The COPD Foundation has become a leader in providing numerous resources for patients, families and health care professionals. Their PRAXIS initiative (newly launched on September 28, 2015) is serving as a website for healthcare professionals interested in discussing and expanding their knowledge about how to reduce preventable hospital admissions. This site offers discussion boards and blogs to share information and promising practices within COPD care. They offer resources such as research articles, case studies and toolkits. Their learning center plans to hold live video presentations featuring speakers sharing implemented readmission reduction programs for COPD. Refer to our "tip of the month" column for more information about the COPD Foundation.

Improving communication among all key stakeholders involved in the life of the COPD patient is the key to self-management success with this population. We need to strive to strengthen our communication and make sure that the decision making is inclusive with the patient. These efforts will positively impact the quality and longevity of life for those dealing with this challenging disease.

Contact Information about the COPD Foundation

C.O.P.D. Information Line: 1-866-316-COPD (2673) General Office: 1-866-731-COPD (2673) iconinfo@copdfoundation.org

Reminder:

We will be rolling out our registration process Monday 2/8/16 for the Clinical Health Coach Training. Webinar presentation about training and registration on 2/8/16 at 9:00 A.M. PST. Invitation letter with details of how to register for training to follow later that day.



Patient Stories from the Field

Case #1: 53 year old man with myasthenia gravis and Stage 4 prostate cancer. Initial contact with the patient was through Transition Care Management after hospitalization for intractable nausea and vomiting. Then, the patient was seen in the ED twice in two weeks (both times on weekends) for nausea and vomiting associated with severe pain. The patient came in to see his PCP for his pain management appointment. The oncologist was contacted and made aware of the patient's problems with nausea, vomiting and pain. The patient had been cutting his fentanyl patch in half because he felt they were causing his nausea, but didn't realize that cutting the patch affects the rate of release of medication, raising the risk of adverse effects. The oncologist changed the patient's pain control plan in response to these new complications and in concert with the primary care provider and care coordinator. The patient's dose of Zofran was increased and changed to a scheduled vs. PRN dose. Pain medication was changed to morphine PO. The care coordinator provided focused medication education and worked with the patient and the oncologist on a

contingency plan if the new plan did not work. Since this intervention, the patient has had no further ED visits, and reports excellent pain and nausea control.

During the TCM interventions, a need was identified for advanced directives, medical power of attorney, and the patient noted he did not have a will. In a subsequent meeting, education was provided regarding advanced directives and medical power of attorney. The patient was provided with the forms, and patient and care coordinator role-played how he would discuss these items with his family. The patient is single, has an adult daughter who lives on the East Coast, and lives with his elderly parents. He has siblings who live nearby. After talking with his family, the patient designated his sister as his medical power of attorney, and discussed his wishes for end of life with all family members. He has chosen to use an online will preparation service to draw up a will. Ongoing care plan elements include future needs for hospice and continued pain control.

Case #2: 82 year old female suffering from depression and unhappy with her primary care provider. The care coordination team assisted the patient with finding an alternate provider that would best meet the needs of the patient. The patient is very pleased with her new provider and has an improved patient/provider relationship. While battling her depression, the patient was sleeping most of the day. With the new provider actively treating her depression, the patient is up and about during the day and experiencing a normal daily routine.

Case #3: 78 year old man with multiple chronic diseases including seizure disorder, rheumatoid arthritis, myelodysplasia, gastroparesis, dementia and CAD. He was recently hospitalized locally for pneumonia, was discharged, then re-hospitalized at a local tertiary facility for severe dehydration. The patient doesn't have adequate intake of fluids by mouth, and also has absorption problems related to the gastroparesis. His wife is dedicated to providing his care herself, though recently she accepted home health nurses to assist. After discharge from the tertiary hospital, the patient's wife arrived at the office of the PCP with a prescription for IV normal saline to be given three times a week. However, she wanted the patient to have the infusion locally, and the ordering doctor does not have privileges at the local community hospital. Home health does not do infusions of fluids only. In addition, the patient's usual PCP was out of town for the week. The care coordinator contacted another doctor in the practice who agreed to see the patient first thing the next morning. The care coordinator facilitated contact between the tertiary doctor and the local doctor, and assisted with arrangements to have the fluids administered in day surgery at the local hospital. Education was provided to patient and spouse on signs and symptoms of dehydration and actions to take. Home health was notified to provide increased nursing visits for monitoring of the patient's condition. The spouse was given support by the care coordinator through empathetic and active listening, building a trusting relationship and enabling the patient to get the assistance he needs to avoid repeated ED visits and hospitalizations.

Case #4: 60 year old male struggling to afford his medications and his oxygen on his income. The care coordination team in collaboration with the physician, made sure all the patient meds prescribed were at the lowest possible cost. In addition, they set the patient up with their claim aide staff who were successful in obtaining Medicaid benefits resulting in the patient being able to be successful in adherence to his medication and oxygen therapy prescribed regimen.

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