

Hospital Readmissions – Managing COPD Patients Post Discharge

As part of its Hospital Readmissions Reduction Program (HRPP), the Centers for Medicare and Medicaid Services (CMS) announced in the August 19, 2013 *Federal Register* (beginning on p. 50649) that it would include COPD readmissions beginning October 1, 2014. That determination by CMS has triggered significant activity by the pulmonary medicine community as it prepares for that implementation later this year.

Background & Overview: The proposed addition of COPD to the existing readmission reduction program formally signals what many in the pulmonary community have anticipated since the initial inclusion of congestive heart failure, myocardial infarction and pneumonia as the first set of conditions CMS implemented October 1, 2012. The statutorily mandated program is designed to reduce excess readmissions in selected disease categories where data cited by CMS signal notable room for improvement. For COPD, hospital readmissions within 30 days for “all causes” range from approximately 17% to 25%.

CMS readily acknowledges that each hospital has its own unique case-mix that impacts readmissions, and therefore CMS used its extensive data base to establish initial, individual thresholds for hospitals based on three years of data 2010-12. CMS also recognizes that not all readmissions are problematic – some are unavoidable, some are planned, and certain others are also excluded. The CMS goal is reduction, not reduction to zero.

For the pulmonary community, this raises several important challenges not only for itself and its primary partner, the hospital community, but also others such as the device and pharmaceutical communities as well as other providers that are involved with management of patients post discharge. Perhaps the most important single question raised is, “What tools do physicians, hospitals, and other providers actually have to manage these patients?” And that question leads to corollary matters –

- Are physicians and others fully aware of the tools that are in place for effective post discharge chronic care management?
- What tools should physicians have that are not readily available?
- And are there coverage and payment barriers that hinder implementation of new and innovative tools?

To address these questions, the National Association for Medical Direction of Respiratory Care (NAMDRC) convened a multi society conference in early March, 2014 to address these issues. Participants included the American College of Chest Physicians, the American Thoracic Society, the American Association for Respiratory Care, the American Hospital Association, the American Telemedicine Association, and the American Academy of Physician Assistants. Additional input was provided by other interested parties, including: independent physicians, device companies, pharmaceutical companies, and one national DME company.

As a result of that vigorous discussion, the group was able to identify numerous variables that should be disseminated to the pulmonary medicine community and the broad hospital community impacted by the Hospital Readmission Reduction Program.

Key components of the Program:

- The planned implementation date is October 1, 2014, with the specifics to be included in the final rule for hospital inpatient prospective payment, published by CMS in the summer of 2014. The proposed rule is expected in Spring, 2014.
- The program is likely to impact “all cause” readmissions within 30 days of COPD discharges, with limited exceptions.
- The penalties for not reducing readmissions to CMS levels, which will be identified in the final rule later this year, may go as high as 1% of all Medicare revenue, not just revenue tied to these specific readmissions. That penalty is expected to increase to 2% the following year, and 3% the following year after that and beyond.

Some of the specific challenges:

- CMS readily acknowledges that there are, for all practical purposes, no clinical practice guidelines or accepted standards of care to guide physicians and hospitals in preventing all cause readmissions after a hospital stay for COPD exacerbations. CMS is hopeful that the pulmonary community will circulate information tied to “best practices” as a key educational tool.
- Home monitoring technologies are perceived to perhaps be effective but the absence of coverage and payment presents clear challenges. There is also a paucity of peer reviewed data that support effectiveness (or lack thereof) in hospital readmissions applications.
- If the national hospital readmission rate for COPD is somewhere between 17% and 25%, that means that between 75% and 83% of COPD discharges are managed without a readmission within 30 days of discharge. The huge challenge is: “Is differentiation between these two groups possible such that limited resources are channeled effectively?”

Recommendations from the Multi Society Discussion:

With the goal of care coordination between providing physicians, hospitals and others with specific evidence based tools that will help manage these COPD discharges, the general consensus evolved into three specific sets of findings:

- Tools are already in place and fairly well recognized but, for a variety of reasons, may not be universally implemented;

- Tools that are not in place nationally but have been shown to be effective in limited local and regional pilot programs to reduce COPD all cause readmissions need to be widely disseminated;
- Some available tools that are not in place primarily because of legislative and/or regulatory barriers that inhibit or otherwise discourage effective patient management.

Tools That Are Currently Available to Assist in the Reduction of Hospital Readmissions Tied to COPD Discharges

There are several key approaches that physicians and hospitals should utilize to manage COPD related discharges with the goal of providing optimal therapy to reduce the risk of readmission. As previously emphasized, somewhere between 75% and 83% of these discharges **do not** result in a readmission within 30 days. Hospitals and physicians should use a specific range of resources to identify those at highest risk for readmission, and then focus on and aggressively manage this high risk subpopulation.

Prior to discharge: Coordination with the health care team, including discharge planners, respiratory therapists, physician assistants and others, along with patients' families should be integral to every COPD related discharge. Educating and empowering patients/families to manage COPD and co-morbid conditions is essential to effective patient care management.

- Ensure appropriate treatment for COPD exacerbations while hospitalized. GOLD Guidelines¹ recommend steroids, antibiotics for most patients, along with bronchodilators. Appropriate long acting maintenance therapy should be prescribed PRIOR to discharge.
- Educate patients on inhaler techniques, managing supplementary oxygen, drug regimens to improve respiratory status, pharmacologic (drug) and non-pharmacologic (e.g. purse lipped breathing) regimens and continuation of smoking cessation counseling
- Reconcile medications and ensure that the patient has access to these medicines at the time of discharge
- If spirometry has not been done to confirm the diagnosis of COPD, or has not been done recently, spirometry testing should be arranged shortly after the patient stabilizes from the COPD exacerbation to help stratify the severity of their disease (GOLD Grade classification).¹
- Assess activities of daily living (ADLs); a growing body of evidence indicates that patients who can demonstrate at least 4 ADLs are significantly less likely to experience readmission, while those who demonstrate two or less run notable risk for readmission
- Assessment of co-morbid conditions
- Referral to pulmonary rehab services
- Proper handoff- immediate communication of the Action Plan designed for the patient to those caring for the patient in an outpatient setting e.g. primary care provider and/or specialist (pulmonologist, cardiologist, diabetologist, etc., and ensure follow-up within a reasonable time period after day of discharge

Post discharge: There must be recognition that COPD patients experience more than COPD – the median number of comorbidities is 9.² There are now data that the majority of COPD readmissions within 30 days are for diseases other than COPD. A narrow focus on specific programs that integrate contact with patients and home monitoring may not be robust enough if the sole focus is management of COPD. Therefore, home health care (home health agencies, DME providers, respiratory therapists, etc.) are integral to successful management and must be included in any genuine effort to manage patients post discharge.

A well cited article from the *New England Journal of Medicine* shows that Medicare beneficiaries are often not seen in their 30 days after hospital discharge.³ Effective January 1, 2013, two transitional care CPT codes are available for physician/physician office billing and include certain non face-to-face contact. The codes are 99495 and 99496. Be aware that these codes are only billable by the **first** physician who submits a claim, regardless of specialty, patient need, etc. Therefore, it is possible that a patient with several co-morbid conditions may be contacted by a physician who is not managing the COPD component of illness. That physician may submit a transitional care code claim, precluding all other physicians from submitting subsequent bills.

A recent evidence based review appears in CHEST that examines pharmacologic as well as non pharmacologic measures to address acute exacerbations, but it should be noted that the examination does not focus on readmissions.⁴

There are numerous care models in place across the country, and many have been published as abstracts at medical conferences and in varied publications. In the absence of clinical practice guidelines and formal standards of care, hospital systems and physicians are faced with approaches that have some level of proven success but there is no assurance of 100% success in all environments.

Of note, the current NQF COPD related standards include

Clinical Process/Effectiveness

- NQF 0091 - Chronic Obstructive Pulmonary Disease (COPD) Spirometry Evaluation
- NQF 0102 - Chronic Obstructive Pulmonary Disease (COPD) Bronchodilator Therapy

Preventative Care

- NQF 0041 - Preventive Care and Screening Influenza Immunization
- NQF 0043 - Preventive Care and Screening Pneumococcal Vaccination for Patients 65+ and older

Telehealth/telemedicine: There are several aspects to the telehealth component of managing COPD patients post discharge. First, there are a range of options of “what to monitor,” who reviews that information to ensure the focus on the declining patient, and what action can/should be taken to optimize care to avoid re-hospitalization.

While the technology may very well be in place, numerous challenges exist.

1. Are algorithms from device manufacturers genuinely separating the problematic patient from the stable patient?
2. Where are generated reports sent, by whom and to whom? No one wants to spend time reviewing reports of patients doing well (the 75 – 83% previously mentioned).
3. Once a problem is identified, where does responsibility for action lie? Family, physician, hospital, hospital staff, DME, outside contractor, etc?

4. Payment is sparse, if at all. Currently, only rural hospitals can genuinely benefit from the current Medicare telehealth/telemedicine policies.

DME Programs, Home Health Care and Specialized Contractors: Sophisticated suppliers, home health agencies and independent contractors have shown a certain level of promise in assisting hospitals address readmissions. Ideally, this care begins prior to discharge and is integrated immediately into the continuum of care as an outpatient. Unfortunately, the Medicare fee-for-service payment system does not incentivize this care model, leaving hospitals to make important financial determinations regarding the extent to which they need to invest their own resources to partner with companies that can assist in the management of patients post discharge.

It is important for hospitals to recognize the shifting paradigm away from fee-for-service and that they need to work with companies that are willing to work with them, in part, on a risk basis i.e. share in the reward for reduced readmissions and avoiding sizeable penalties for exceeding readmission thresholds. These companies do share some common approaches: effective identification of high risk patients prior to discharge; ongoing contact with the patient and family following discharge; monitoring of key clinical indicators post discharge; and aggressively ensuring compliance with the plan of care and related services.

¹ http://www.goldcopd.org/uploads/users/files/GOLD_Report_2014_Jan23.pdf

² [BMC Pulm Med.](#) 2012 Jul 9;12:26. doi: 10.1186/1471-2466-12-26. **The prevalence of clinically-relevant comorbid conditions in patients with physician-diagnosed COPD: a cross-sectional study using data from NHANES 1999-2008.**

³ *n engl j med* 360;14 nejm.1418 org april 2, 2009 **Rehospitalizations among Patients in the Medicare Fee-for-Service Program** Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

⁴ *CHEST* 2013; 143(5):1444–1454 **Preventing Acute Exacerbations and Hospital Admissions in COPD** Nathaniel Marchetti, DO , FCCP; Gerard J. Criner, MD , FCCP; and Richard K. Albert , MD

Action Items for the Pulmonary Medicine/Hospital Communities to Improve the Management of COPD Patients Post Hospital Discharge

Numerous actions can be taken to improve the current landscape and to help remove barriers to effective management of COPD patients following hospital discharge. These action items include:

1. Expansion of Medicare constraints for physician services tied to CPT codes 99495 and 99496. Because these codes can be used only once, on a first come-first served basis, for legitimate post discharge care for patients with a wide range of co-morbid conditions, payment for reasonable and necessary services can be problematic.
2. The statutory constraints and CMS implementation of the Hospital Readmission Reduction Program (HRRP) use a stick with no carrot. As part of the value based purchasing program, hospitals should be given adequate tools, and rewards, for outpatient management of post discharge COPD patients that, in many cases, are not in their care.
3. Changes to the Medicare competitive bidding program could improve the incentives for effective patient management of supplemental oxygen, CPAP, nebulizers and Part B medications, along with other COPD related treatment regimens.
4. Development of clinical practice guidelines/standards of care: This is a huge and costly undertaking for the pulmonary community, recognizing the paucity of information as well as the unavailability of funds to support appropriate research. The Center for Medicare and Medicaid Innovation may be a viable funding source, along with PQRI.