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To: National Institutes of Health, National Heart, Lung and Blood Institute (NHLBI)

Subject: COPD National Action Plan

As the national professional organization with a membership of over 47,000 respiratory therapists who treat patients with chronic respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD) and whose organizational activities impact over 170,000 practicing respiratory therapists across the country, the American Association for Respiratory Care (AARC) appreciates the opportunity to have been part of the COPD Town Hall meeting designed to gather input on what should be included in the first ever COPD National Action Plan.

The NHLBI is to be commended for bringing together a diverse group of stakeholders with expertise in this area and for developing a comprehensive action plan that is long overdue. Since respiratory therapist members of the AARC were instrumental in the creation of the document, we believe the draft plan is well-balanced and captures the elements discussed at the meeting. The AARC supports the goals and objectives as outlined with some minor modifications noted in the section of our comment dealing with specific goals. Because respiratory therapists play a significant role in the treatment and care of patients with COPD, their expertise is especially vital in carrying out a number of objectives in the draft plan that can lead to improved outcomes and better lives for those who suffer from COPD and which are discussed below.

Role of the Respiratory Therapist as part of the COPD National Action Plan

The primary focus of Goal 1 is "helping people with COPD, including their families and caregivers, recognize the disease through risk and symptom awareness, early detection, and diagnosis" while empowering them to self-manage their disease. Working with respiratory therapists who are the only allied health professionals educated and competency tested in all facets of pulmonary medicine, individuals suffering from COPD can learn to recognize and reduce the symptoms of their disease progression which can lead to improved health status.

Moreover, self-management teaches them to recognize and reduce the symptoms and triggers of COPD which can lead to reduced exacerbations and lower the cost of acute care.

In fact, a study[1] involving education and training by a respiratory therapist COPD Case Management Team under the supervision of a pulmonologist resulted in decreased healthcare utilization and improved patient outcomes. The program was designed to accomplish the following:

- Simplify patient education;
- Promote awareness of COPD;
- Assist in the proper diagnosis, staging, and treatment in accordance with the Global Initiative of Chronic Obstructive Lung Disease (GOLD) Guidelines;
- Support COPD patients and their family through the continuum of their disease; and,
- Provide a written action plan regarding discharge respiratory medications, rescue action plan and follow-up instructions.

Sixty patients were treated. Thirty-eight percent of patients in the study had very severe COPD, 43% had severe COPD and 17% had moderate COPD. Only 2% were assessed as having mild COPD. The average length of stay for an acute exacerbation of COPD was reduced by 28.7%; the rate at which patients were readmitted was reduced to 5%.

Further evidence of the impact respiratory therapists have on outcomes is evidenced by a one-year randomized controlled trial[2] at five Veterans Administration medical centers led by a respiratory therapist case manager implementing a simple disease management program. COPD-related hospitalizations and emergency department visits were reduced by 41%.

One of the important aspects of disease management for COPD patients is medication management and adherence. According to the Agency for Healthcare Research and Quality, medication non-adherence is very costly to the US health care system. Therefore, the AARC believes patient education and proper device selection for both inhalers and oxygen systems are critical for optimal clinical outcomes and cost effectiveness for those patients with COPD. Due to the complexities of inhaler devices and oxygen systems, respiratory therapists' expertise can minimize unnecessary, ineffective or wasteful interventions. Overall, proper device selection together with patient training and education on proper inhaler techniques and appropriate oxygen saturation levels can improve medication adherence and oxygen utilization.

A 2010 study[3] comparing the clinical performance of oxygen-conserving devices found the systems to be highly variable leading to inconsistences that interfere with oxygenation during exertion and contribute to limitations in patient exercise ability. Further, an evaluation[4] of an oxygen therapy clinic managed by respiratory therapists suggests that home oxygen patients

can significantly decrease inappropriate supplemental oxygen use which can result in significant cost savings while improving health-care delivery.

An important aspect of Goal 2 (2.A) is to "assess, create, and distribute education curricula aimed at improving COPD prevention, care and treatment" including the development and dissemination of continuing medical education courses and educational events.

The AARC is proud to offer a COPD Educator course that can facilitate meeting the objectives of Goal 2. For example, the course enables respiratory therapists to educate their patients about diagnosis, assessment, treatment, oxygen therapy, medication adherence and management, smoking cessation, and pulmonary rehabilitation among other things. With their solid background in respiratory physiology and pharmacology, respiratory therapists are most effective when it comes to employing their disease management skills for COPD patients. While we encourage AARC members to take the course, it is also available to other health care professionals. The course has had great success as determined by the number of respiratory therapists and registered nurses who have successfully completed it.

As more and more focus is placed on reducing hospital readmissions, respiratory therapists are increasingly working with multidisciplinary teams to provide pulmonary disease management services. To further the respiratory therapist's role as well as other clinicians in this area, AARC has also developed a Pulmonary Disease Educator course we feel can lead to improved patient self-management of COPD and other respiratory conditions. This program was developed in partnership with the Allergy and Asthma Network Mothers of Asthmatics, COPD Foundation, American Association of Cardiovascular and Pulmonary Rehabilitation, Pulmonary Fibrosis Foundation, and Cystic Fibrosis Foundation to provide the necessary pulmonary disease management information health care providers need to improve long-term pulmonary disease care and improve patient quality of life.

Focusing on the key components of pulmonary disease education for COPD and other pulmonary diseases, the course provides instruction on pulmonary function technology, tobacco cessation, pulmonary rehabilitation, patient education, and many other vital areas of effective pulmonary disease management. Further, we have assembled a multidisciplinary faculty to ensure the course provides a comprehensive learning environment. The course is open to all health professionals who wish to learn more about effective pulmonary disease education and make a difference in the lives of our patients. Initially the course was presented live in Washington, DC, Dallas, and Chicago. We plan shortly to have it as part of AARC's educational resources on the Association's website at www.aarc.org.

Goal 2 (5.D) outlines the need to improve access and care for individuals with COPD with emphasis on adopting and promoting the use of oxygen therapy customized to their needs and lifestyle. As members of the discharge planning team working with their patient's health care practitioner, respiratory therapists can extend their expertise by assisting in the prescribed use of respiratory equipment, including documentation of medical necessity, as well as selection, patient education in equipment use, and confirmation of device availability upon discharge to home or the post-acute care venue.

The delivery of health care is shifting and with it comes increased evidence that telehealth and remote patient monitoring services for patients with chronic health conditions like COPD are beneficial and can lower costs by reducing healthcare utilization such as hospital readmissions and emergency department visits. Therefore, we support the draft plan's Goal 2 (5.E) that encourages the "development of COPD-specific technologies such as telehealth, wearable devices, and mobile technology applications."

The AARC is supporting legislation in Congress (i.e., H.R. 2948 – the Medicare Telehealth Parity Act) that would cover telehealth respiratory services and add respiratory therapists in addition to other professionals as telehealth providers. The bill also covers remote patient monitoring in incremental phases when furnished as chronic care management for patients with COPD. We believe respiratory therapists as telehealth providers can meet respiratory patients' unmet needs, improve access to care, improve health outcomes and reduce hospital readmissions through a comprehensive telehealth disease management program that includes:

- Education on self-management of the patient's disease;
- Education and training in the use of prescribed self-monitoring devices such as peak flow measurement and pulse oximetry;
- Education and training on the proper technique for use of aerosol medications with nebulizers, metered-dose inhalers, and dry-powdered inhalers;
- Direct observation and assessment of the patient's ability to self-administer aerosol medications;
- Smoking cessation counseling;
- Education and training on compliance with medications and respiratory devices such as oxygen equipment and nebulizers; and,
- Development of an action plan that enables patients to recognize the appropriate response to self-managing their chronic disease according to their symptoms.

Goal 4 focuses on the need to examine the many contributing risk factors and underlying mechanisms in COPD. This goal aims to improve the understanding of the different forms of the disease, along with its diagnosis and treatment, including the need to create a research agenda (4.1.B.2) that will lead to "improvements in the quality of COPD prevention strategies for

people at risk." Part of that agenda includes "developing and testing COPD interventions in-home and routine-care settings…"

We would note CMS has partnered with 18 new Accountable Care Organizations (ACOs) that are experienced in coordinating care for populations of patients and whose provider groups are ready to assume higher levels of financial risk and reward. Referred to as "Next Generation ACOs", the model offers several enhancements that can aid in addressing the needs of COPD patients and reducing their burden. Chief among the enhancements are 1) the expansion of telehealth services in an individual's home whether they are in a rural area or not, and 2) post-discharge home visits when the individual returns home after discharge from an inpatient facility. The home visits do not apply to those who are homebound and eligible for home health services. According to CMS, the ACO can request a waiver which allows the physician to contract with licensed clinicians (e.g., respiratory therapists) to provide a home visit under general supervision (e.g., furnished under the overall direction of the physician but his or her presence is not required during the performance of the service).

Although this new payment model has limited provider participation at this time, we are encouraged that it offers new opportunities for respiratory therapists to work in physicians' practices and to be able to provide disease management services in the COPD patient's home. With significant reductions in payment for oxygen and other respiratory equipment due to competitive bidding, the role of the respiratory therapist in the home has been diminished over time and the need for their expertise to educate and train COPD patients on the complexities of the respiratory equipment they need in order to live is greater than ever.

The AARC strongly supports other objectives outlined in Goal 4 which include the development of a patient-centric COPD management plan tool designed to specifically address the needs of the individual patient. It is essential that patients know how to control their disease, what to do in case of an acute exacerbation, when to call a health care professional or when to go to the emergency department. It is important for respiratory therapy disease managers to be part of a collaborative effort with respect to developing a written, patient-centric COPD management plan. With recent improvements by the Centers for Medicare and Medicaid Services (CMS) in the discharge planning process and the best practice of using a multidisciplinary team approach as part of a well-designed discharge planning evaluation process, respiratory therapists are engaged more than ever to ensure that the patient's post-discharge respiratory care needs are identified.

Comments Specific to the Draft COPD National Action Plan Goals

We offer the following recommendation and comments relative to specific goals and objectives:

Goal 1.3.C: Support all 50 states and the District of Columbia in the development of statewide COPD education efforts and encourage the creation of public-private partnerships to spread the word.

> **Comment:** We recommend expanding this objective by adding "and facilitate development of more detailed state COPD Action Plans which include current economic and clinical burdens of all stakeholders, including but not limited to patients, providers, and payers." The intention is to ensure that State action plans are compatible with the COPD National Action Plan.

Goal 2.1.A.4: Promote guidelines and help incorporate them in primary health care settings. In addition, work with specialty medical organizations to develop a certification program that will support a trained workforce, including primary health care providers, in the medical evaluation, management, and treatment of people at risk for or diagnosed with COPD.

> **Comment:** In order to ensure compliance, we believe it is necessary that practice guidelines are not only adopted by payers but they are also enforced. We recommend NHBLI consider adding language that would accomplish this.

Goal 2.1.A.5: Collaborate with federal and nonfederal stakeholders to identify and disseminate current guidelines for best practices and new options for COPD prevention, care and treatment.

> **Comment:** We support the general objective; however, we believe it can be strengthened by either adding to or creating a new objective that results in conducting training for physicians or other practitioners so they are on board regarding compliance with the relevant guidelines.

Add a new Goal 2.1.6: Identify and pilot innovative service delivery models aimed at increasing patient access to pulmonary experts, treatments (e.g., oxygen, pulmonary rehabilitation), and programs, especially in medically underserved areas.

Comment: Since numerous objectives are aimed at primary care providers, we believe the addition of an objective along these lines can further increase access to pulmonary specialists whose care can further reduce the burden of COPD.

Goal 2.2.D: Ensure that the curricula are updated regularly to reflect evidence-based best practices for the diagnosis, care, and treatment of COPD as well as policies related to reimbursement and the efficient use of health care spending. Easy access to the curricula should also be ensured.

Comment: We believe an essential element is missing from this objective. It will be difficult to ensure that updates or revisions to curricula are effective if there is no process for feedback. Therefore, we suggest establishing a method for testing effectiveness, retention of education, and skills as well as impact on a patient's quality of life and health care resource utilization.

General Comments

- Short of "mandating" certain goals which we realize is not possible, we suggest considering a stronger word be used in place of "encourage" that adds more teeth to the goals (e.g., "cause")
- We suggest that it would be helpful to insert timelines into each goal and subset of goals so stakeholders have something to work toward.
- We recommend convening a follow-up conference in five years to measure goal progress and revise the COPD National Action Plan.

Conclusion

The AARC is excited about the opportunities to work with other stakeholders in carrying out the objectives of the COPD National Action Plan. We thank you for the opportunity to comment. With COPD listed as the third leading cause of death by the Centers for Disease Control and Prevention and the 4th most costly hospital readmission according to the Medicare Payment Advisory Commission, the AARC looks forward to being a partner in the effort to reduce the burden of COPD on our nation's health care system.

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President

References

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