Kentucky Society for Respiratory Care

Making the Connection

Kentucky Society for Respiratory Care
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Re-Imagining Traditional RT Clinical Practice: A 30,000 Foot View

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Disclosure

Professional relationship with

- **Monaghan Medical Corporation**
- **Mylan Pharmaceutical**

Career-long member/supporter of

- **AARC (AARConnect)**
- **State affiliates**

What is *The 30,000 Foot View*?

- **An office cliché first popularized by David Allen in the early 2000s**
  - **A *macro* overview; Understanding the *Big Picture***
  - **To help develop & guide business *strategy***
- **Basis for asking:**

  What do we want to do . . . (and need to do) . . . within next 12-24 months, to make "this" happen"?
- **Influence of "*Confirmation Bias*"**
- **Sit back . . . Keep an open mind, and . . . try to grasp the Big Picture**

Objectives

- Describe the three dimensions of the *Triple Aim* and its relevance to health care delivery reform;
- Review the impact of CMS' delivery and payment reforms on ***traditional*** RT clinical practice, and
- List areas where RTs can contribute value during the transformation of the Nation's health care delivery system.

Health Care Reform via ACA

Two Parallel Paths

POLITICAL

IMPROVE

Access & Coverage

STRUCTURAL

OVERHAUL

Delivery & Payment

Delivery & Payment Reform

No *repeal or replace* for *Delivery & Payment Reform !!*

DELIVERY & PAYMENT REFORM IS ALL ABOUT:

- **Making care patient-centered**
- **Linking payment to safe & effective outcomes**
- **Emphasizing value vs. volume**

"There is no turning back to an unsustainable system that pays for procedures and sickness. The new equation is paying for outcomes and wellness."

Alex M Azar, Secretary of HHS, March 2018

Top *FIVE* Concerns In *"The C-Suite"*

2017-18 ACHE Survey - 299 CEOs Responded

- Financial
- Government mandates
- Patient safety & quality
- Personnel
- Patient satisfaction

"Clinician burnout and resulting turnover are big issues, for both physicians and frontline caregivers.

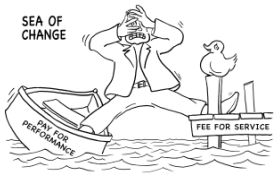
This is being driven by lifestyle changes of the younger workforce, as well as the demands of EHRs and increasing regulatory burden"

Rick Hinds, CFO, UC Health, Cincinnati

Top *TWO* Concerns Hospital CEOs

2017 ACHE Survey - 299 CEOs

- Financial
  - Medicaid reimbursement (63%)
  - Increasing costs of care (60%)
  - Reducing operating costs (55%)
- Government mandates
  - CMS regulations (67%)
  - CMS audits (57%)
  - Cost of compliance (51%)



The Triple Aim

Institute for Healthcare Improvement; 2007; Cambridge, MA

- The simultaneous pursuit of:
  - Improving patient experience of care
  - Improving health of populations
  - Reducing per capita cost of health care

"I intend to guide CMS toward the Triple Aim as our highest-level goal = better care, better health, and lower *per capita* costs."

Donald Berwick, MD
Administrator, Centers for Medicare and Medicaid
Address at America's Health Insurance Plans – Medicare Conference, 9/13/10

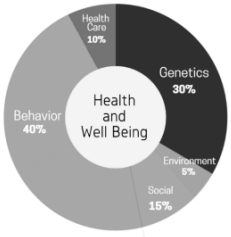
The Triple Aim

Institute for Healthcare Improvement; 2007; Cambridge, MA

- **Improve experience of care *(aka patient engagement):***
  - ***Patient-centered** **Safe** **Efficient***
  - ***Effective** **Timely** **Equitable***
- **Improve health of populations:**
  - ***Long-term - - Address upstream causes of chronic ill health (poor nutrition, unwise lifestyle choices, economic disparity, etc.)***
  - ***Short-term - - Focus on high-risk patient populations***
- **Lower per capita cost of care:**
  - ***Reduce unnecessary care, inefficiencies, needless hassles***
  - ***NOT by withholding needed and necessary care***

Social Determinants of Health

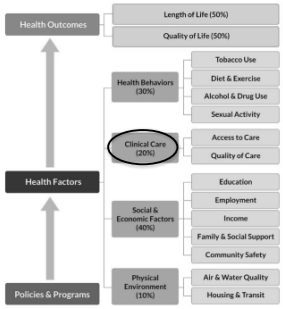
McGinnis et al. Health Affairs. 2002



$.25 of every health care dollar spent on diseases/disabilities resulting from potentially changeable personal behavior!

Social Determinants of Health

Countyhealthrankings.org



BUILDING A *CULTURE OF HEALTH*

- **Create awareness of multiple factors influencing health**
- **Provide reliable, sustainable *local* data to ID opportunities to improve health**
- **Engage & activate local sector leaders to create sustainable community changes**
- **Connect & empower community leaders working to improve health**

CMS' Delivery & Payment Reforms

- Slowing Medicare growth
  - Improving quality, safety, cost-effectiveness
    - Ensuring sustainability
  - Transitioning from *fee-for-service* to *pay-for-performance*
    - Lack of accountability with current system
    - Now, measurable outcomes meeting quality/safety standards
  - *"Carrot and Stick"* approach
    - Reward better providers; Penalize poorer performers

For ALL healthcare providers . . Healthcare Reform *is all about . .*

Delivery & Payment Reform!

Government Changes in Health Care

Moving Away from Fee-for-Service

- Hospital Readmission Reduction Program (PENALTY)
  - 30 days now (60-90 days later?)
  - 2019 - Account for SDH in safety net hospitals
- Hospital Acquired Conditions Reduction Program (PENALTY)
  - 2019 - 700 hospitals forfeiting 1%
  - Promoting a *Culture of Safety*
- Value-based Payment (BONUS or PENALTY)
  - 2019 - $1.9 billion in VBP to 1,550 hospitals

Government Changes in Health Care

Newly Emerging Environment of Care

TRADITIONAL EMPHASIS	NEWER EMPHASIS
Acute care	Chronic care
In-patient	Out-patient
Treat symptoms	Manage disease
Individual patient	At-risk populations
Billable procedures	Outcomes of care
Fee-for-service	Pay-for-performance

Fee-for-service = volume driven
Pay-for-performance = value driven

Impact of of Chronic Conditions

- Life-long condition
  - Account for 70% of all deaths in the US (1.7mm/yr.)
  - Not curable BUT controllable
  - Many patients have multiple conditions
- Chronic conditions overly expensive
  - ≥ ⅔ of $3.1 trillion annual expenditures
  - Many suffer frequent exacerbations
- Baby-Boomer generation
  - 2011- 2023 ≈ 2.5 million/year turn 65
    - 2017: 51 million; 2027: 73.5 million!!!
  - High prevalence of chronic disease

Impact of of Chronic Conditions

Medicare's Disproportionate Share - 2017

CATEGORY	DOLLARS	POPULATION
TOTAL MEDICARE SPENDING	$591 BILLION	58 MILLION
Spending 65+ (Fee-for-service)	$392 billion	49 million
⇨ Spending 65+ w/ 2 chronic conditions	$368 billion	32 million
⇨ Spending 65+ w/ ≥ 6 chronic conditions	$198 billion	6 million

More than 94% of Medicare FFS spending is for 65+ population with at least 2 chronic conditions.

However, the sickest 6 million represent 12% of 65+ population
BUT . . . .
account for more than half of the spending on that group

The AARC Response

Moving The Profession Forward

- Top Priority – *Modernize scope of practice*
  - Continued expansion technology, clinical innovation
    - Requires advanced knowledge, skills & attributes
    - Goal: Have RTs practice at TOP OF OUR SCOPE !!
      - ✓ RT Consult Service vs. physician orders
  - Embrace concept of patient-centric care
  - Participate in multi-disciplinary care-teams
- 2015 Taskforce on Competencies Need for Entry into RT Professional Practice
  - AARC, CoARC, NBRC
  - Exhaustive list of domains & required competencies
    - 153 Developed *prior* to entry; 49 attained *after*

The AARC Response

Summary

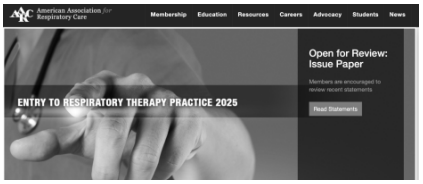
- Newer educational & licensing requirements
  - Entry level education: BS degree (minimum)
  - State licensure: RRT (CA, AZ, OH, NJ)
  - Existing workforce expected to adapt
    - State licensing vs. institutional requirements
    - Advance Practice Respiratory Therapist (APRT)
- AARC Goal:

  By 2020, ≥ 80% of RT workforce either have (or) be actively pursuing a higher degree
- CoARC Standard:

  Effective January 1, 2018, all new RT programs must offer a baccalaureate degree or higher

Moving the Profession Forward

January 2019



The AARC is committed to ensuring that all respiratory therapists entering practice in the year 2025 have a baccalaureate degree and the Registered Respiratory Therapist (RRT) credential

Changing The Way Health Care is Delivered

Transforming The Way We Practice

- Hospital's role in community being *reimagined*
- RT's role in hospital & community being *reimagined*
- US health care system notoriously *change adverse*
- Profound change is *disruptive; transformative*
- Transformative change is *stressful* (anxiety, uncertainty, fear)
- Disruptive change best in small *incremental steps*

Maintaining *status quo* during disruptive change can come at a steep price later on!

Replacing Common Practices with *Best Practices*

AREA	COMMON PRACTICE	BEST PRACTICE
ENTRY EDUCATION	Associate degree	Bachelor degree
STATE LICENSURE	CRT	RRT
CARE HIERARCHY	Physician	Patient
PRODUCTIVITY	Billable procedures	Relative value units
AEROSOL THERAPY	MD orders; *Stacking?*	RT to assess-treat-titrate
VENTILATOR MANAGEMENT	Sedate; Immobilize	ABCDEF bundle
POST-OP PULM COMPLICATIONS	IS; Mucomyst	Ambulate; Cough/DB; OPEP
PATIENT SAFETY	*No Harm – No Reporting*	Culture of Safety

Ventilator Liberation Bundle*

Role of RT ?

- ➔ **A** Assess, prevent and manage pain
- ➔ **B** Spontaneous breathing trials
- ➔ **C** Choice of analgesia and sedation
- ➔ **D** Assess, prevent and manage delirium
- ➔ **E** Early mobility and exercise
- ➔ **F** Family engagement

*** Ely, Wesley E. *The ABCDEF Bundle:* Science and Philosophy of How ICU Liberation Serves Patients and Families. *Crit Care Med, Feb 2017***

Summary

The Dawning of a New Era

- ✦ **Re-design traditional role to compete in *new environment of care* realities:**
  - ❖ **Align practice with newer expectations; Become *strategic***
    - ▪ **Hospital's responsibility no longer ends at discharge**
    - ▪ **Embrace expanding scope of practice**
    - ▪ **Explore/adopt innovative approaches to improve care delivery**
      - ✓ **Resist being *PENNY WISE AND POUND FOOLISH***
- ✦ **Proactive versus reactive**
  - ❖ **Historically RT tasks/responsibilities *delegated***
  - ❖ **Now a *BRAVE NEW WORLD***
    - ▪ **Take responsibility for our future**
    - ▪ **Strong, clinical, and visionary leadership essential**