Should Respiratory Therapists Care About ‘ObamaCare’?

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The Way It’s ‘Spose to Be

- Safe—avoiding injuries from care intended to help patients
- Effective—providing evidence-based services to those likely to benefit/refraining from providing ineffective services
- Patient-centered—providing care that is respectful of/responsive to patient preferences, needs, and values
- Timely—reducing waits and harmful delays for care
- Efficient—avoiding waste, including waste of equipment, supplies, energy, and ideas
- Equitable—providing care that does not vary in quality due to factors such as gender, ethnicity, geography, and SES

Where We Are -
The Ongoing Three-Way Battle

QUALITY

COST

ACCESS

Are We Losing the Battle?

“American spends twice as much as other developed countries on healthcare, but we get lower quality, less efficiency and have the least equitable system”


UH-Lecture Series #16
Affordable Care Act
aka ‘Obamacare’

| PL 111-148 | Patient Protection & Affordable Care Act |
| PL 111-152 | Health Care and Education Reconciliation Act of 2010 |

Affordable Care Act - Titles

- Title I: Affordable Health Care for All
- Title II: Role of Public Programs
- Title III: Improving Quality & Efficacy
- Title IV: Disease Prevention
- Title V: Health Care Workforce
- Title VI: Transparency, Accountability, and Competition
- Title VII: Access to Innovative Therapies
- Title VIII: CLASS Act
- Title IX: Funding for Health Care
- Title X: Miscellaneous Improvements
Title I: Health Care for All

- **Primary Goals**
  - Streamline the US health care system
  - Provide services consistent with needs
  - Improve quality and efficiency
  - Make health insurance affordable
  - Make health care accessible for all

- **Primary Regulator** – DHHS

- **Key Coverage Provisions**
  - Every American must have health insurance by 2014
  - Those with pre-existing conditions must be covered
  - Those previously unable to obtain insurance will be able to secure it via health exchanges
  - Those within 400% of the poverty level will be given tax credits to help cover insurance premiums

Title V: Health Care Workforce

- **Goal:** To develop an integrated workforce that supports high-quality, accessible health care, as overseen by a National Health Care Workforce Commission
- **Priority:** matching health workforce training capacity with demand
- **Includes** respiratory therapists (under “allied health professionals”)
- **Focuses on** disease prevention & mgmt, health promotion, behavioral & community-based health, evidence-based care
- **Encourages** health care career pathways (including apprentice-ship programs), founded on 21st century skills
- **Provides** loan forgiveness programs, including for allied health professionals
- **Makes available** scholarships for mid-career public and allied health professionals to receive advanced training

- **Supports** curricula for cultural competency, disease prevention, reducing disparities, and working with the disabled
- **Awards** grants to promote healthy behaviors and outcomes for the medically underserved via community health workers
- **Supports** recruitment of individuals from minority, disadvantaged, or rural populations into the health professions
- **Provides** tuition loan repayment assistance for individuals serving as health professions faculty
- **Supports** interdisciplinary training (via AHECs)
- **Funds** delivery of CE for health professionals, especially those providing care in underserved areas
- **Supports** identification and application of key national indicators related to the health care workforce
Digging Deeper: Impact of Obamacare

- System
  - Safety and Quality Assurance
  - Chronic Disease Management
  - Community-Based Care
- Practitioners
  - ‘21st Century’ Skills
  - Information Technology
  - Evidence-Based Practice
  - Multidisciplinary/Team-Based Care

Safety and Quality

- Safety (First Do No Harm)
  - Avoid Errors of Omission
  - Avoid Errors of Commission
- Best Practices (Optimize Care)
  - Evidence-Based Care (e.g. Protocols)
- Reliability (Reduced Variability)
  - Process Improvement Methods
  - Examples: Lean, Six Sigma

Not a Pretty Picture

- Only ~50% of adults receive recommended care
- 6-15 million injuries/yr due to adverse events
  - About 14% of Medicare patients harmed during care*
  - Each year, more than 80,000 central line infections occur, resulting in about 28,000 deaths
  - On average 40 surgeries (still!) are performed on the wrong patient or on the wrong site every week
- 70-190K deaths/yr due to preventable errors
- Social cost of all inpatient adverse medical events between $350-900 billion*
- At least 1 in 4 adverse events is preventable
System Perspective

“Commercial air travel didn’t get safer by exhorting pilots to please not crash. It got safer by designing planes and air travel systems that support pilots and others to succeed in a very, very complex environment. We can do that in health care, too.”

- CMS Administrator Donald Berwick

National Quality Strategy

- Making care safer by reducing harm caused in the delivery of care (initial focus on nine problem areas)
- Ensuring that each person and family are engaged as partners in their care (aka patient-centered care)
- Promoting effective communication/coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models
Quality Initiatives

• Quality Demonstration Project (2005)
• Pay for Performance (aka ‘Value-Based Purchasing’)
  – Hospital IQR Program (2005)
  – Physician Quality Reporting System (2007)
  – Electronic Health Records Incentive Program (2009)
  – Accountable Care Organizations (2012)
  • HMO-like network of doctors + hospitals providing all health care needs for 5,000+ Medicare patients
  • Shared Savings Program – ACOs saving $ while meeting quality targets keep part of savings; those not doing so put themselves at financial risk
• Partnership for Patients (2011)
  – Preventing Harm
  – Improving Care Transitions

CQI Efforts Can Work!

• IHI 5 Million Lives Campaign
  – Involved more than 4,000 hospitals over 2 years
  – 65 hospitals went a year or more without a single case of VAP
  – 35 went a year or more without a central line–associated blood-stream infection
• AAP Asthma Pilot Project
  – 20%+ drop in ED visits and hospital admissions
  – % patients receiving optimal care rose from 35% to 85%
  – % of patients with well-controlled asthma rose from 58% to 72%
• In 2009 US hospitals provided life-prolonging, beta-blockers to heart attack patients 98% of the time

Chronic Disease Management

• Chronic diseases account for 75% of costs
• Very different from acute care, requiring
  – Multidisciplinary processes
  – Effective communication and collaboration
  – Carefully designed, evidence-based approaches
  – Automated information/decision support systems
Chronic Disease Management

• COPD
  - About 3 million deaths/year
  - 4th leading cause of death
  - Cost (US): $40-50 billion/yr
• Asthma
  - 34 million in US; 300 million (world)
  - 250,000 deaths/yr (world)
  - 217,000 ED visits/10.5 million physician office visits every year

Competencies Needed By RTs

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Disease-Management Skills

• Assessment
  - Physical examination and history
  - Family-assistance capabilities
  - Conditions in the home
• Ability to respond to assessment findings
  - Does the physician need to be contacted?
  - Should a protocol be initiated?
  - Critical thinking skills essential
• Ability to communicate appropriately
  - Clarity and accuracy essential
  - Across all age groups and education levels
  - Accurate documentation is critical
• Ability to assess/apply research evidence
  - Capable of applying standards and guidelines
  - Ability to deviate from guidelines when appropriate
• Clear understanding of health care finance

Chronic Care Model

Community-Based Care
- Medical ‘Home’ as the Focus for Care
  - An integrated, evidence-based, information-driven, patient-centered system for chronic care management
  - Provides self-care education, support for family caregivers, proactive monitoring, transitional services, and coordination with community resources
- Interdisciplinary Community Health Teams
  - Provide the patient’s medical home
  - Includes PCPs, nurses, nutritionists, social workers and behavioral health professionals
  - Supported by HRSA grant program (Sec. 2252) to provide training in medical home models that coordinate both physical and mental health services

Impact on Practitioners
- Respiratory care will be an important in all care venues
- Clinical decisions will be increasingly data-driven
- Most care will be delivered via evidence-based protocols
- RTs will need evidence-based practice skills
- Care teams will become the standard for service delivery
- Patients/families will be better informed and engaged
- A diverse population will require cultural competency
- As new technologies evolve, RT research must increase
- Financing changes will drive changes in disease mgmt
- RTs’ knowledge, socialization, training, and skills will need to be aligned with all these factors and changes
Impact on Practitioners

• Multidisciplinary Care Teams
• ‘21st Century’ Skills
• Information and Technology Skills
• Evidence-Based Practice

21st Century Skills

• Core Subjects and 21st Century Themes
  – English/Reading, Math/Science, etc.
  – Interdisciplinary Themes: global awareness and civic, economic, health and environmental literacy
• Learning and Innovation Skills (the 4 ‘Cs’)
  – Creativity and Innovation
  – Critical Thinking and Problem Solving
  – Communication and Collaboration
• Information and Technology Skills
• Life and Career Skills

Life and Career Skills

• Flexibility and Adaptability
• Initiative and Self-Direction
• Social and Cross-Cultural Skills
• Productivity and Accountability
• Leadership and Responsibility
### Competencies Needed By RTs

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### Information Technology

- Need to automate and securely share clinical, financial, and administrative information
- IT Infrastructure to needed to support
  - Health care delivery
  - Consumer health
  - Quality measurement and improvement
  - Public accountability
  - Clinical and health services
  - Research
  - Education


### Information and Technology Skills

- **Information Literacy**
  - Access and evaluate Information
  - Use and manage Information
- **Media Literacy**
  - Analyze media
  - Create media products
- **Technological Literacy**
  - Use technology to research, organize, evaluate and communicate information
  - Use digital technologies, communication/networking tools and social networks to access, manage, integrate, evaluate and create information

An Information Literate Individual Can:

- Determine the extent of information needed
- Access needed information effectively and efficiently
- Evaluate information and its sources critically
- Incorporate selected information into one’s knowledge base
- Use information to accomplish a specific purpose
- Understand the economic, legal, and social issues surrounding the use of information
- Access and use information ethically and legally

- American Library Association

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Evidence-Based Practice

The integration of

- *individual clinical expertise* with the
- *best available external evidence from systematic research* and
- *patient’s values and expectations*

Steps in Evidence-Based Practice

1. Asking an answerable question
2. Searching for the best evidence
3. Critically-appraising the evidence
4. Integrating the evidence with one’s expertise and the patient’s needs
5. Evaluating one’s performance


Critically Appraising the Evidence

• For secondary sources
  – Differentiate EB vs. non-EB sources
  – Understand the basics of meta-analysis

• For primary sources
  – Apply levels of evidence
  • Level I – Large, well-designed RCTs (the “Gold Standard”)
  • Level II – small or weak RCTs, quasi-experiments (e.g., nonrandomized trials) and prospective cohort studies
  • Level III - Case series/reports; other
  – Assess the quality of research based on methodology

Evaluating One’s Performance

• Individual - Are you
  – posing good questions?
  – searching for the best evidence
  – critically appraising the literature?
  – applying these results to practice?

• Institution – Are practice policies and protocols
  – based on best available evidence?
  – continually updated based on new evidence?
  – continually audited by quality assurance committees?
Evidence-Based Practice:
Comparative Effectiveness Research

• Federal Coordinating Council for Comparative Effectiveness Research (2009). Was to:
  – Coordinate CER across the Federal government
  – Develop a Web-base CER inventory
  – Replaced by Outcomes Research Institute

• Patient-Centered Outcomes Research Institute
  (Affordable Care Act 2010)
  – Goal: to identify research priorities and conduct research comparing treatment effectiveness
  – Multi-stakeholder board, assisted by expert panels
  – Findings not to be construed as mandates, guidelines or recommendations for payment or treatment

Evidence and the Basis for ‘Medical Necessity’

Organizational Challenges

• To redesign processes to better serve the chronically ill
• To make effective use of information technologies
• To manage the growing knowledge base and ensure that all personnel have the skills they need
• To coordinate care across patient conditions, services, and settings over time
• To continually advance the effectiveness of teams
• To incorporate evidence-based care process and outcome measures into their daily work