Pulmonary Rehabilitation Program Management: Enhancing Services and Exploring New Opportunities (6/25/15): Q&A with Trina Limberg

- *Are PFT's periodically performed and are they reimbursable?*
  No- PFTs are a qualifying test – i.e. results for COPD (use of G0424). Studies have shown that PFT results do not change post PR intervention so there is no clinical justification to obtain repeated PFTs.

- *What do you with patients that say they can only attend 4 sessions?*
  Create an ITP for that patient and prioritize the education and implementation for home exercise. I call this Boot Camp rehab—it's short in duration, all training is targeted to need to know info—no fluff.
  Topics may include:
  1) Intro to A & P as it relates to DX- breathing tech instruction
  2) Use of inhaled meds and various devices
  3) Importance of O2 use (when indicated) and home exercise instruction for the HEP (home exercise plan)
  4) Self-Care- exacerbation prevention, recognition of s/s and when to call MD, use of ABX/Steroids
  5) Optional when indicated: secretion clearance device use and/or smoking cessation support

  Implement supervised exercise (every session), use the opportunity to improve understanding of oxygenation, pacing and breathing retraining skills—build confidence (self-efficacy).

- *Do you have a questionnaire that the pt. can show the rationing of their dollars i.e. health care vs. other financial needs?*
  No, we do not measure this; this is by observation only.

- *Any pulmonary rehab at patient's home? Do other university consortium hospitals have the same issues?*
  At present there is no health care coverage for PR in the home, or support for RTs. I can only speculate if others in university settings are experiencing similar issues. I have yet to meet a colleague that feels they have been appropriately resources for their patient volume.

- *What is the delay for adding staff? i.e. 30 days?*
  Flexing staff is so fluid that it occurs on a weekly basis based on patient volume. We pay close attention to cancelled appointments as well as "no shows" mainly because they kill the staffing plan and program viability. Our administrative assistant places reminder calls in the am for the next day—this also helps us adjust to changes. If you are asking how long it takes to get a new hire approved, interviewed and scheduled for orientation, beyond 30 days. If I hire a perdium it's much faster (no high level admin. approval required) and easier to convert to a career position if we meet 1,000 hours in a given year, this is how I was able to bypass the position control board (within UC—FTEs are tightly controlled) and get my RT reclassed to a career flexed position.

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- *How does the 50-100% flex work with your FTEs? Do you schedule them from inpatient RRT dept.? What do your competencies look like?*
  All of the RT's listed on the PEOPLE slide were hired into PR and work under my supervision they do not float to the acute care area. When I schedule them for the COPD/Airway clinic they clock in under the RT cost center budget for those given hours—we did the same thing when support the ALS clinic for PFT testing. Our competencies are focused around the ones listed in the JCRP article referenced in the talk. The job cards are for RTs in general (org wide), I have revised ours to include the major aspects of PR care—assessment, developing care plans (ITPs), exercising patients and providing education.

- *Does your administration consider you a revenue generator (i.e. contribute profit) or are you a cost center (that doesn't at least break even)?*
  The best way I can answer this is to say our reimbursement rate is about 40% of charge. This year we will finish the fiscal year in the black. Admittedly, we are still valued for our fee for service business; as we move to cost savings models and hospitals strive to avoid readmission penalties our value will be measured differently in the coming months/years. I see this as a disease management opportunity for us all.

- *What is your wait time for new patients to start the program?*
  At present it's 1-2 months, as all of you know we schedule admissions and patients get sick so we shift those waiting and admit them sooner. We also start patients in one-on-one sessions when they have a medical need to start before a group class is available. For example, lung transplant candidates, patients w. very severe hypoxemia that so often need more assessment and changes in the home and portable O2 systems, post AECOPD.

- *Does our team use breathing retainers with the patients during education?*
  When you say breathing retainers I'm assuming you are referring to inspiratory muscle training, we do not use them in patients how do not demonstrate respiratory muscle weakness as evidenced by MIP and MEP values. It is not uncommon to see lower MIPs and MEPs in patients with severe obstruction and elevated RVs (hyperinflation)—this is more due to a mechanical issue so we do not use them in this population. The data is mixed on the benefits of using these devices, in my opinion there are only so many things we can add to the patient's daily routine, walking and strength training far outweigh use of an inspiratory muscle trainer (just my opinion). Mortality in COPD patients increase with reduced activity levels, hence the need to just move.

- *How do you schedule you physician supervision?*
  We work with our two docs and pull in other faculty members (pulmonologists) when they are not available.

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- *How do you build a healthy referral base?*
  Honestly, I think quality care and word of mouth (from patients and their families) has been the most important factor to growing our business. Here is our webpage should you want to visit it (has about a 3 min video) http://health.ucsd.edu/specialties/pulmonary/Pages/rehab.aspx. We engage referring physicians in a way that supports their management of the patient, granted it's hard to do with those docs that are referring for dyspnea or no PFTs with a diagnosis of COPD. In those instances it takes diplomacy, as you know we are not doctors! The physicians in the large group HMO that we are contracted with—they ask patients about their experience here and they like the outcomes they see with their patients. Working w. your contracting office to let them know you exist so when they negotiate contracts they can include your service line. Our patient satisfaction rate for this past year is 94.7% I see the data for all ambulatory services, no other department has that level of satisfaction.

- *Do you get reimbursed for maintenance program?*
  Maintenance services are self-pay and patients are billed directly on a monthly basis. We do not provide O2 as those are added costs and time for staff to set up.

- *58% increase over this year is wonderful. Did you do a lot of marketing and if so how?*
  No traditional marketing per se, I did presentations to our pulmonary fellows, residents, transition nurses, and acute care RTs. Our biggest growth is in the community, non-UCSD referrals. I also gave presentations to the Medicaid medical directors from the largest plan and their high-risk case managers. It clearly makes a difference that we have been serving the community for such a long time and have been recognized as a quality program with great staff.

- *Do you suggest specific training from specific source to qualify RRTs for performing pulmonary rehab?*
  This is a great question; the problem being there is no central place to get training. Most RTs are not trained to obtain a detailed history, assess bone/joint limitations, let alone exercise severely impaired respiratory patients. We had a 2 day course at UCSD several years ago to help with the administration and clinical aspects of providing pulmonary rehabilitation – I'm interested in reviving the course as I believe there is a need for targeted training beyond the bits and pieces that one can get by attending professional meetings. That said the AACVPR and AARC are offering a joint pre-conference at the national AACVPR meeting Sept. 9-12 in Washington D.C. The AARC has provided the webinar because they recognize the need for additional training as well as offering the Chronic Disease Educator course. Please submit topics and interests to Shawna. In addition, any member can submit topics for the annual congress—pre-conference meetings on pulmonary rehab have been done in the distant past and they were very well attended.