# Pulmonary Rehabilitation in Rural Appalachia 2018
# The Appalachian Pulmonary Health Project

# The first 5 years
# 2013-2017

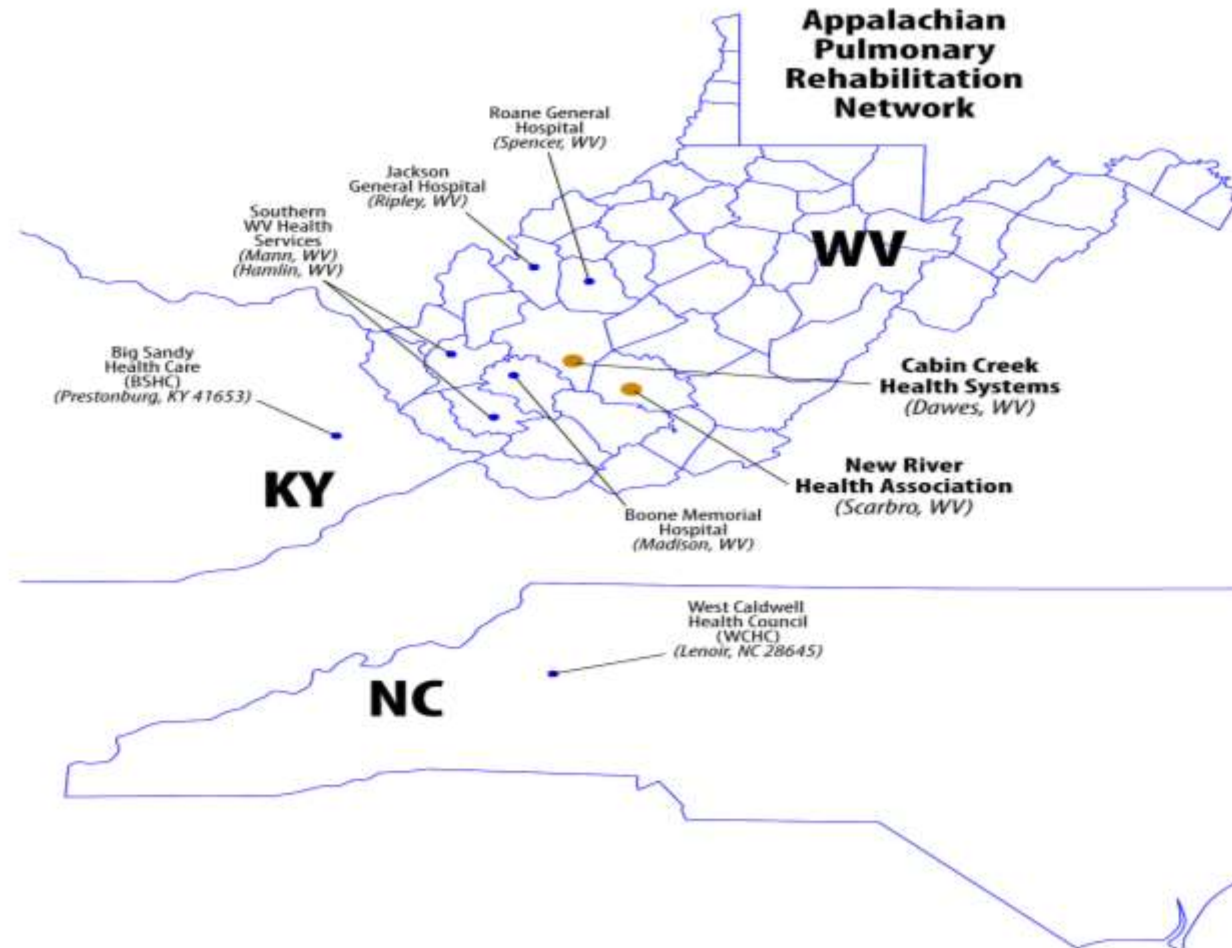
- Starting out
- The PDSA Cycle
- Networking

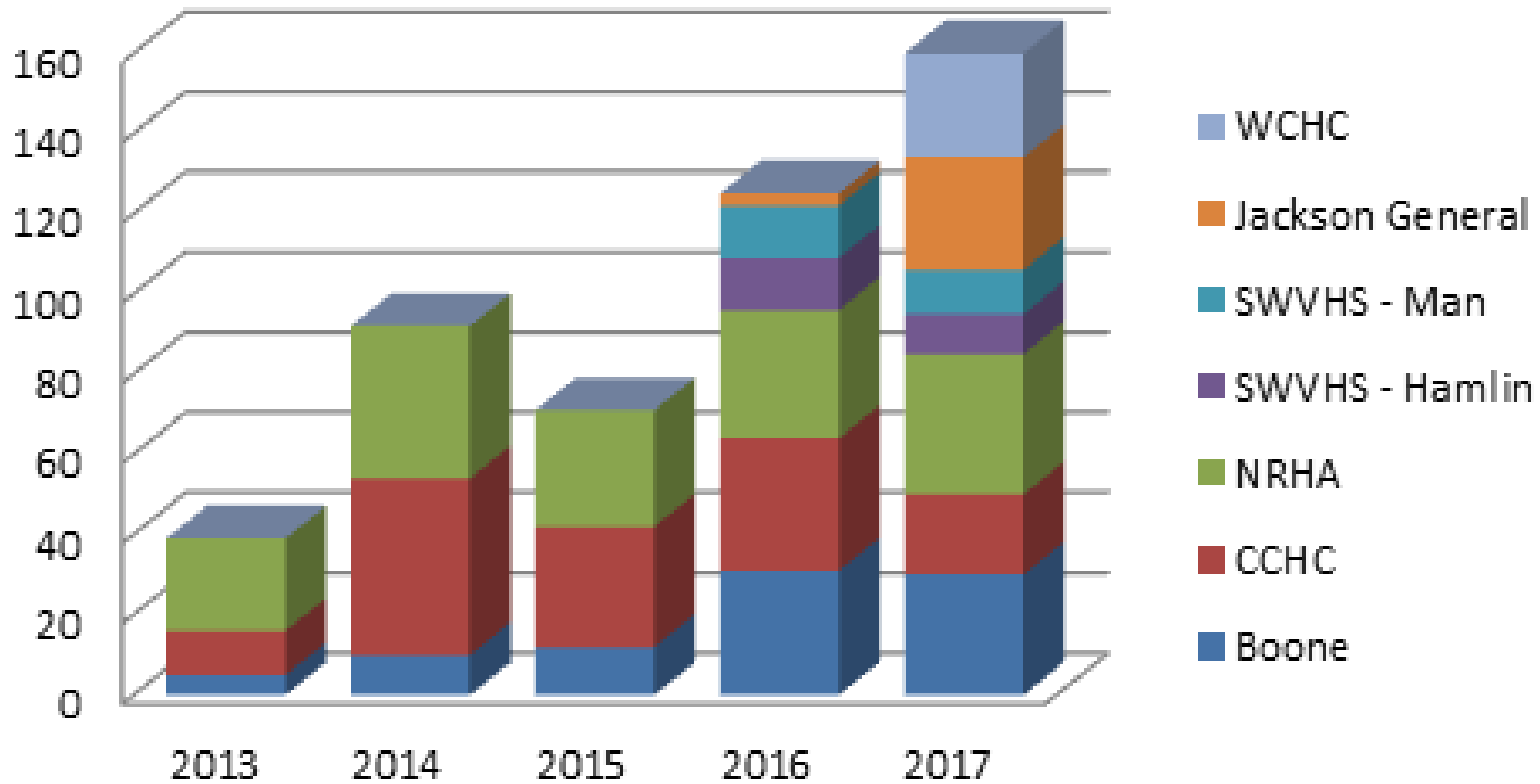
# Rural Pulmonary Rehab

In Autumn 2013, three sites in rural WV received funding from Dorney-Koppel, Benedum and others to provide Pulmonary Rehabilitation services.

- Cabin Creek Health Systems (an FQHC)
- New River Health Association (an FQHC)
- Boone Memorial Hospital (a critical access hospital

# Appalachian Pulmonary Rehabilitation Network (APRN)
# 8 organizations, 9 sites, 3 states
November 2017




PR Intakes by year by facility
160
140
120
100
80
60
40
20
0
2013
2014
2015
2016
2017
WCHC
Jackson General
SWVHS - Man
SWVHS - Hamlin
NRHA
CCHC
Boone

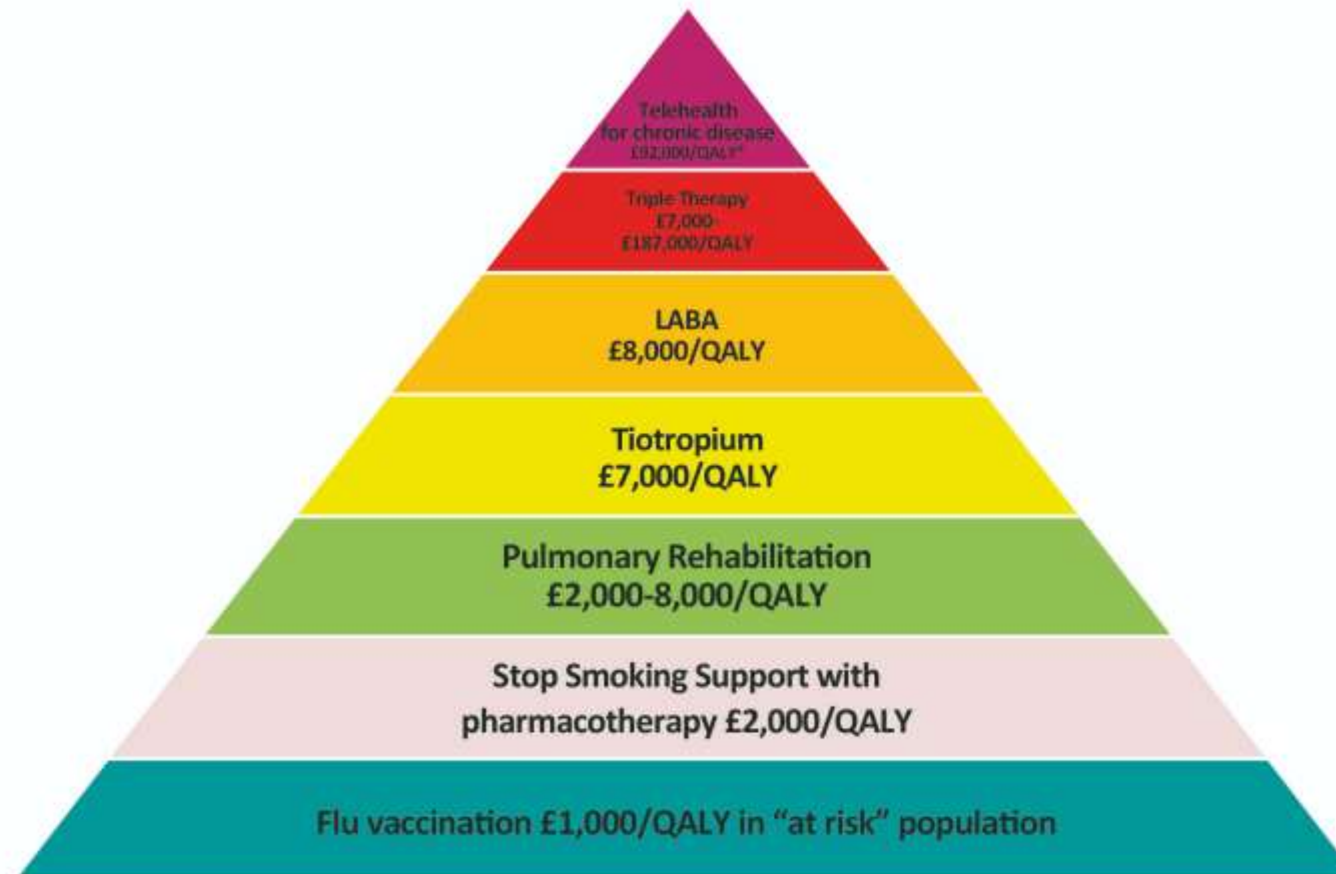
# GADPRP-WV. Clinical outcomes for first 20 months. N=111

| | Pre | Post | Mean change | |
|---|---|---|---|---|
| Dyspnea level. mMRC | 3 | 1.8 | -1.2 | <.001 |
| Six-minute walk test. Feet. | 760 | 1019 | 259 | <.001 |
| NIF. cmH20* | 78.2 | 88.7 | 10.5 | <.001 |
| Knowledge. Test Score. * | 15.8 | 17.7 | 1.9 | <.001 |
| SGRQ | 54.6 | 48.4 | -6.2 | <.001 |
| BODE index | 3.4 | 2.3 | -1.1 | <.001 |

# The COPD value pyramid

(developed by the London Respiratory Network with The London School of Economics and reproduced with permission from the London Respiratory Team report 2013).

This 'value' pyramid reflects what we currently know about the cost per QALY of some of the commonest interventions in COPD. It was devised as a tool for health care organisations to use to promote audit and to ensure adequate commissioning of nonpharmacological interventions.



# The next 5 years
# 2018-2022

- Consolidation
- Innovation
- Expansion

# Appalachian Pulmonary Health Project Goal statement

2018

- To work for the primary prevention of COPD.
- To expand access to quality-assured spirometry in rural areas.
- To expand access to pulmonary rehabilitation in rural areas.
- To provide care management for persons with chronic lung diseases.

# What is the “Innovation” in GADPRP?

- Pulmonary Rehab is not new. But pulmonary rehab in rural primary care centers and critical access hospitals is unprecedented. We want to publicize and spread this model to more of rural America.
- In this era of wonderful cures that few can afford and retreat from universal access to care, Pulm Rehab is a low-cost, low-tech, relationship-based treatment that works. And it works for patients and for payers.
- The ECHO model, using Zoom videoconferencing, links remote rural primary teams in continuous learning and collaborative practice.
- A business model that anticipates value-based reimbursement returns.

# Goal 1 for 2018-2022

- Establish a representative, self-governing network advisory committee

# Goal 2

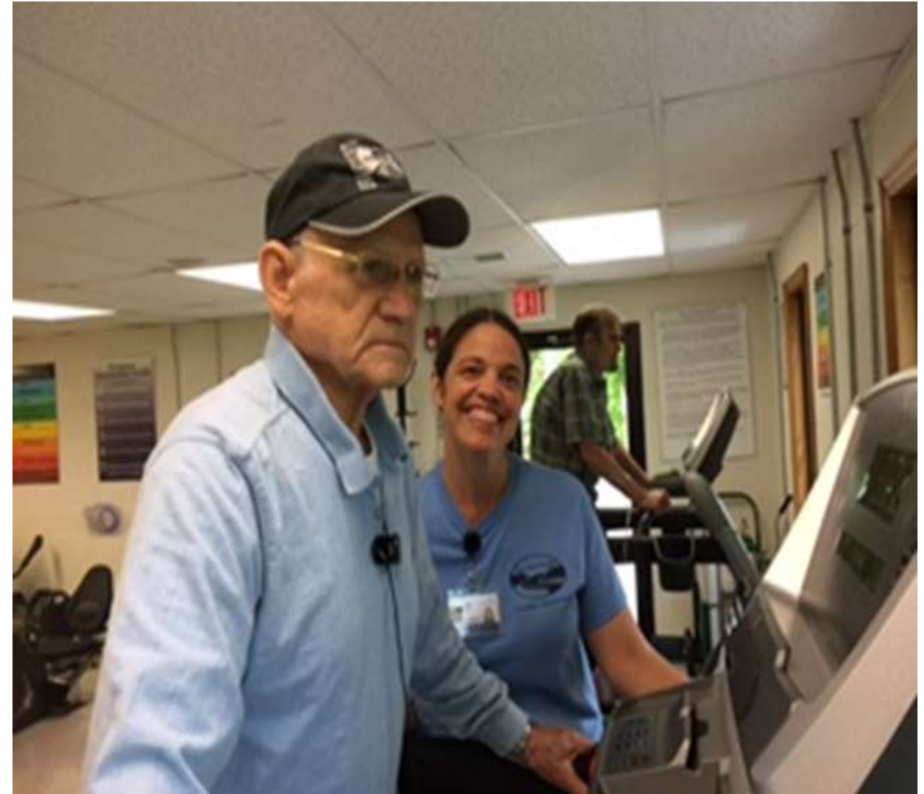
Obtain management services and a network home with a qualified non-profit organization

# Goal 3

- Employ one full-time field coordinator for every 10 sites.
- Along with key consultants.

# Goal 4

- Expanded evaluation and research with CAMC Institute using the CAPGate care coordination platform.
- With the West Virginia Clinical and Translational Sciences Institute.
- With the WV Practice Based Research Network.



# Goal 5

- Obtain 3 year funding of at least $150K per year.

- HRSA
- NIH
- Foundations

# Thinking Big

- Medicare for All by 2022
- The COPD National Action Plan and the national GADPRP
- An endowed network.  $3M @ 3% is $90K per year
- Incentives for sites meeting performance goals
- A national PR Economic Analysis Interest Group
- Our little network is playing a national leadership role in operations, outcomes research, and economic analysis

# Sustainable business models. Case 1

Rural critical access hospital (CAH)

Hospitals use Medicare OPPS Fee schedule

Pulmonary rehabilitation

Cardiac rehabilitatation

Sleep lab

Dept of Labor Fed Black Lung testing

# Pulmonary Rehab in health centers and physicians' offices. Including FQHC.

Non-hospital Pulm Rehab sites use Medicare Physicians Fee Schedule (PFS). Same CPT/HCPCS codes. Different payment levels.

An important issue for FQHCs starting out with Pulm Rehab is whether to apply to HRSA for a "Change-in-scope" that brings Respiratory services under FTCA coverage. But does it affect reimbursement?

# Sustainable business models.  Case 2

FQHC

Started without Scope change.   Out-of-scope.

Applied for and obtained change of scope 2017.  Now in-scope.

Billing Medicare and Medicaid by Part B, FQHC fee-for-service before and after scope change.

Collections 50% of costs first two years.

Obtained grant funding to help.  ACS.  Benedum.

Upgraded to Moderate complexity CLIA lab to add ABGs

With ABGs, added Dept of Labor, Fed Black Lung testing.

Collections now exceed costs.

# Sustainable business models.  Case 3

FQHC

Started with 2 year foundation funding.

Told by HRSA to not start until they obtained scope change.  So started in-scope.

Started at 2 sites in 2 rural WV counties.

So far, collections remain 50% of costs  (estimated).

Will need public or private grant support to offset costs.

# FQHC scope and billing status

APHP includes 5 FQHC's

Two are in-scope now

One has application pending

Two have not yet applied.

A clear benefit of scope change is FTCA coverage for PR and resp therapy services.  But there is uncertainty about how scope change affects Medicare and Medicaid billing.

# GADPRP Respiratory Therapists
## Quarterly Meeting 10 20 2017