Chronic Obstructive Pulmonary Disease

Russell Acevedo, MD, FAARC, FCCP, FCCM

Crouse Health

Agenda

- Introductions
- Our partners
- Session 5: COPD
- Upcoming sessions

HANYS Care Connections Team

Kathleen Rauch, RN, MSHQS, BSN, CPHQ
Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care

Christina Miller-Foster, MPA
Senior Director,
Quality Advocacy, Research and Innovation

Morgan Black, MPA
Director,
Care Connections

Maria Baum, MS, RN, CPHQ
Project Manager,
Western New York

Kira Cramer, MBA
Project Manager,
New York City

Rachael Brust, MBA
Project Manager,
North Country

Jonathan Serrano
Communications Coordinator

Theresa Green, PhD, MBA
Associate Director, Associate Professor,
Center for Community Health & Prevention
Public Health Sciences URMC, SON

Our partners

OUR FUNDER

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members. With Care Connections, we strive to build hospital-community partnerships and share evidence-based chronic disease prevention and management strategies to address healthcare access barriers at the local level.

OUR PARTNER

DataGen®, Inc. develops custom analytics for participants to help them understand healthcare access barriers and the chronic disease burden in their communities so they can develop tailored interventions.

Today’s presenter

Russell Acevedo, MD, FAARC, FCCP, FCCM

Crouse Health

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

Improving COPD Care Through In-Patient Disease Management

Russ Acevedo, MD, FAARC, FCCP, FCCM

Medical Director, ICU and Respiratory Care, retired
Crouse Hospital

Clinical Professor of Medicine
Upstate Medical University

Syracuse, NY

CROUSE HEALTH

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

Improving COPD Care Through In-Patient Disease Management

Disclosures:
Consultant, Monaghan Medical

There was no industry support for any of the protocols

CROUSE HEALTH

What if I told you…

…that in addition to your present clinical responsibilities you would be asked to:

- Perform a full disease management assessment
- Anxiety and depression screens
- Nutritional and functionality screens
- Quality of life assessments
- Discharge planning and education
- Home visits
- …and more!

RESPIRATORY

The Problem: COPD

- COPD is the third leading cause of death and has the third highest 30-day readmission rate
- Clinicians commonly do not provide patients with COPD evidence-based care
- Only 33% of US patients hospitalized for COPD receive guideline-indicated care

The Problem: COPD

- Primary and secondary COPD account for an average of 2,400 Crouse Hospital admissions per year
- COPD care is fractionated in a Hospitalist model with little continuity across the continuum
- COPD 30-day all-cause readmissions are included in reimbursement penalties

The Problem: COPD

- Patients are not being adequately assessed for the knowledge of and ability to use their inhaled medications
- Major co-morbid conditions go unrecognized or untreated
- Issues exist with transition to home and adherence to medications, devices, follow-up appointments and life-style changes

Where Our Story Begins

- 1999: Y2K
- Health Alliance:
  - Crouse
  - Community General
- April 2000:
  - Crouse files for bankruptcy
  - RT department understaffed
  - 45K liquid nebulized meds per year
  - Staffing unable to administer the prescribed medications

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

What We Did

- In 2001, we systematically reviewed our medications and device use to maximize RT time management
- Breath Actuated Nebulizers were introduced to replace small volume nebulizers to decrease administration time
- Aerosols with longer duration of action replaced Racemic Albuterol and Ipratropium to decrease treatment loads
- Goal is to reach the ceiling effect as quickly as possible and maintain it as long as possible to decrease total treatment administration time.

Bronchodilator Protocols

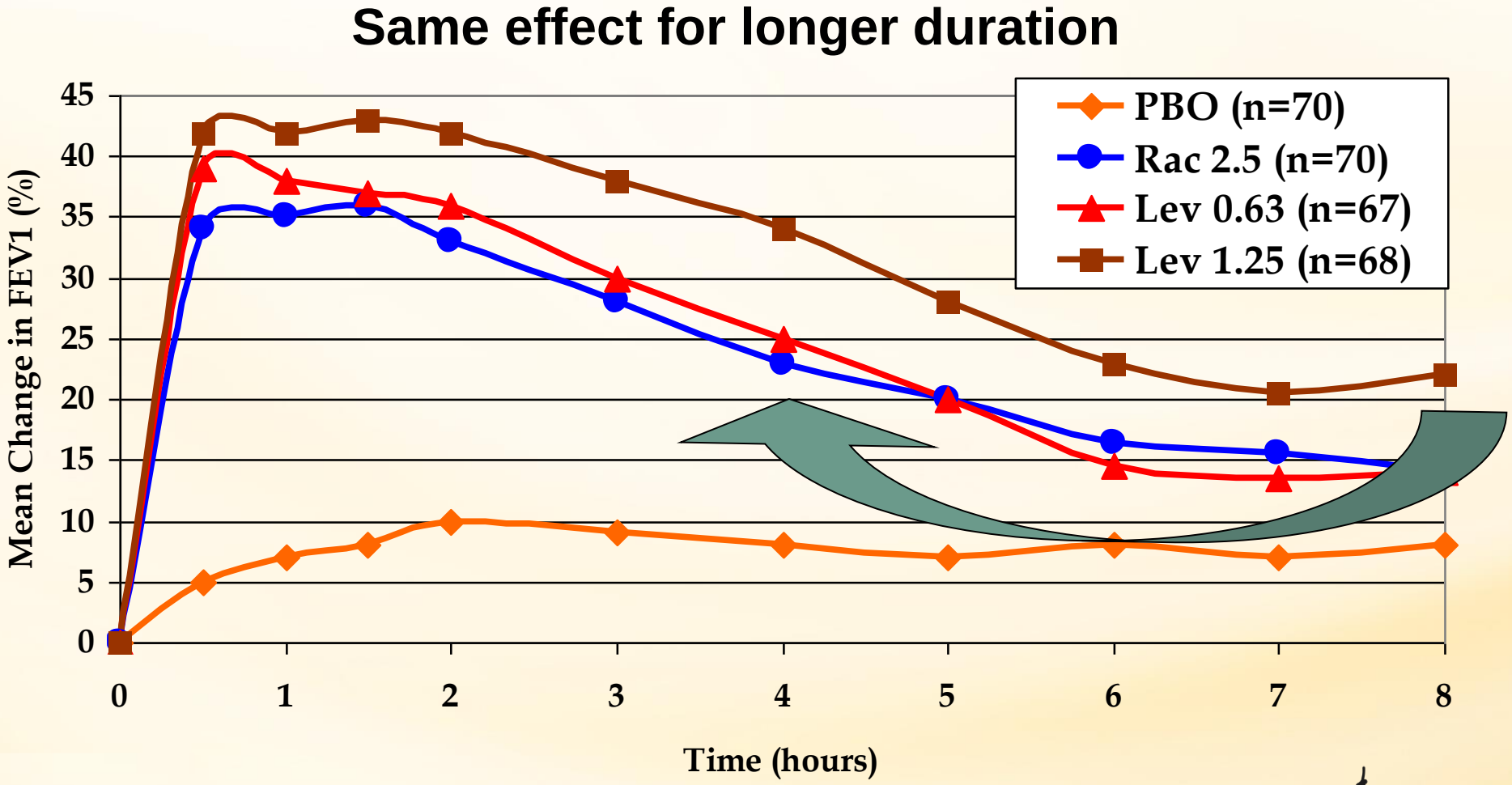
2001	Present
• Standard updraft nebulizer • Racemic Albuterol and Ipratropium Q4h and Q2h prn • 45,000 treatments • Administration time 15 min per patient 6 times = • **1.5 hours / day**	• Breath actuated nebulizers • Levalbuterol 2.5 - 3 min 3 times daily • Tiotropium 2 min once daily • Arformoterol 3 - 4 min once or twice daily • **< 15 min / day**

"Uncontrolled variation is the enemy of quality."

W. Edwards Deming
Basic Statistical Tools for Improving Quality

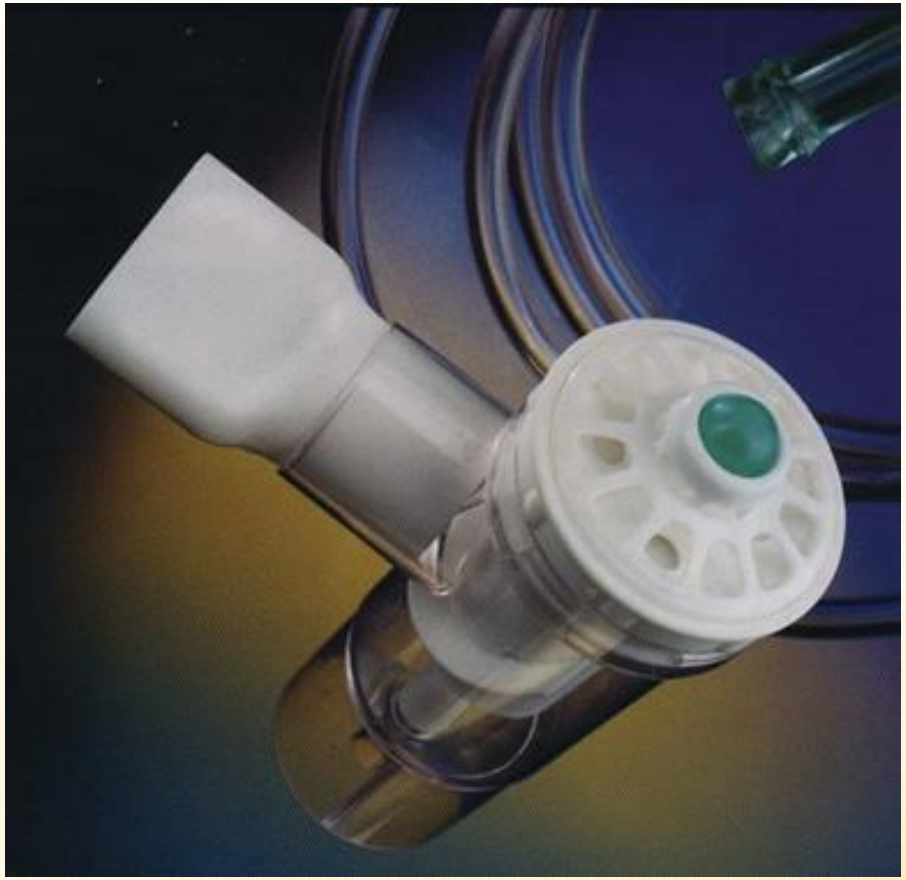
CROUSE HEALTH

Mean Percent Change from Baseline in FEV_1



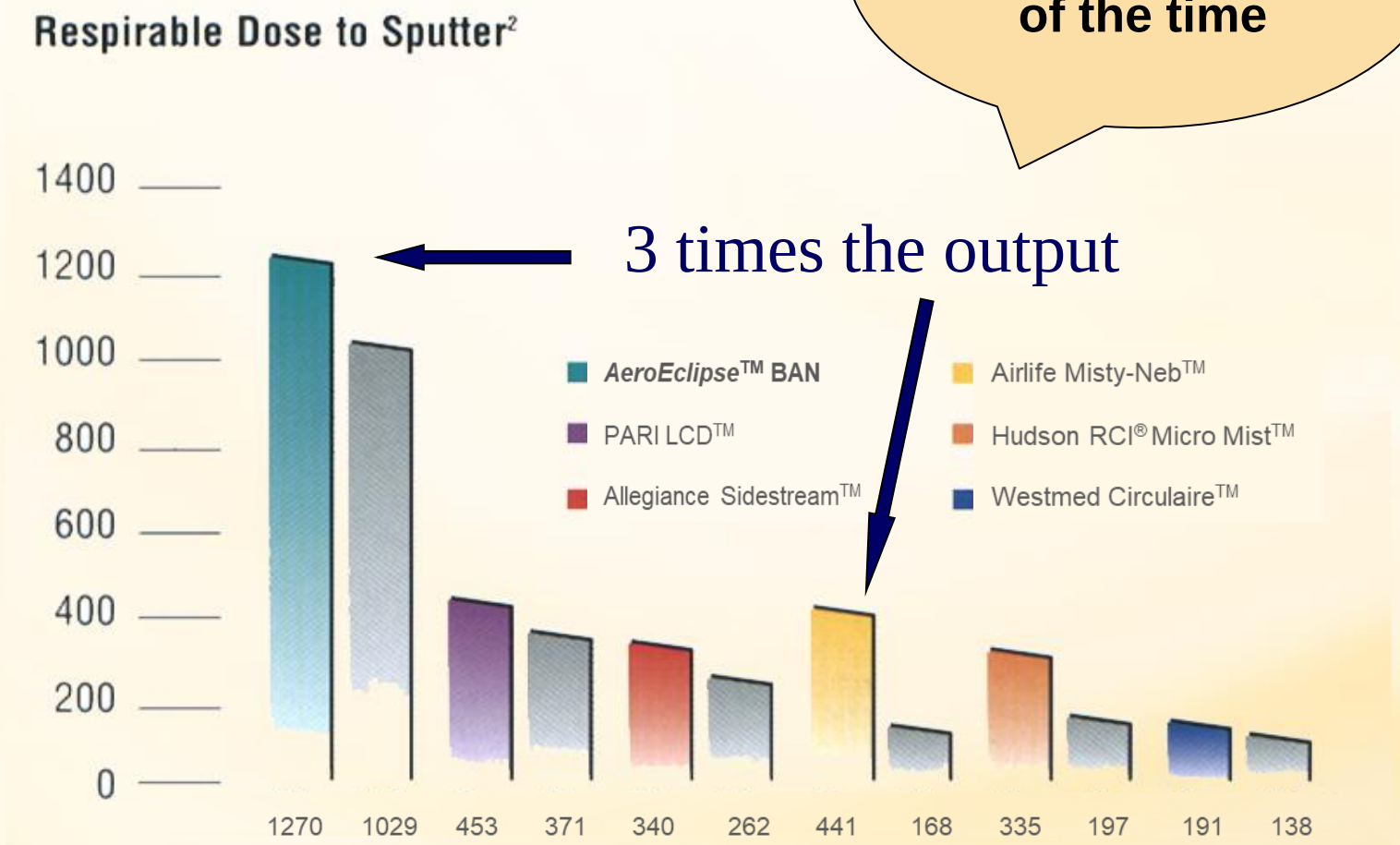
Nelson HS, et al. JACI 1998;102:943-52

Breath Actuated Nebulizer: AeroEclipse (BAN)



AeroEclipse

Same output delivered in 1/3 of the time



CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

Hess Resp Care 1999;44(10):1289

CROUSE HEALTH

What's the Dose??

Racemic Albuterol

180 mcg

90 mcg

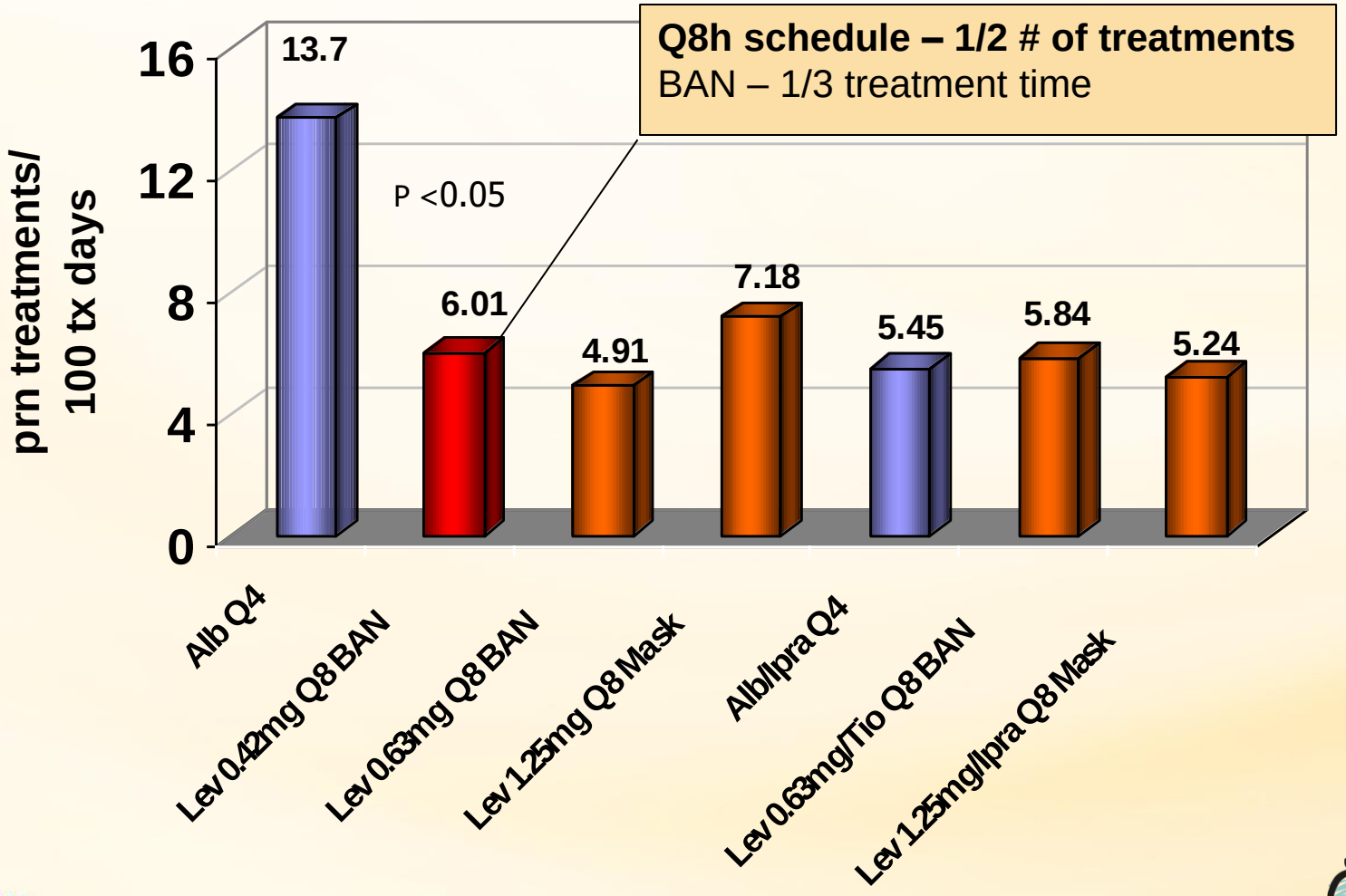
?? mcg

420 mcg (1 ml UD)
Levalbuterol

2500 mcg

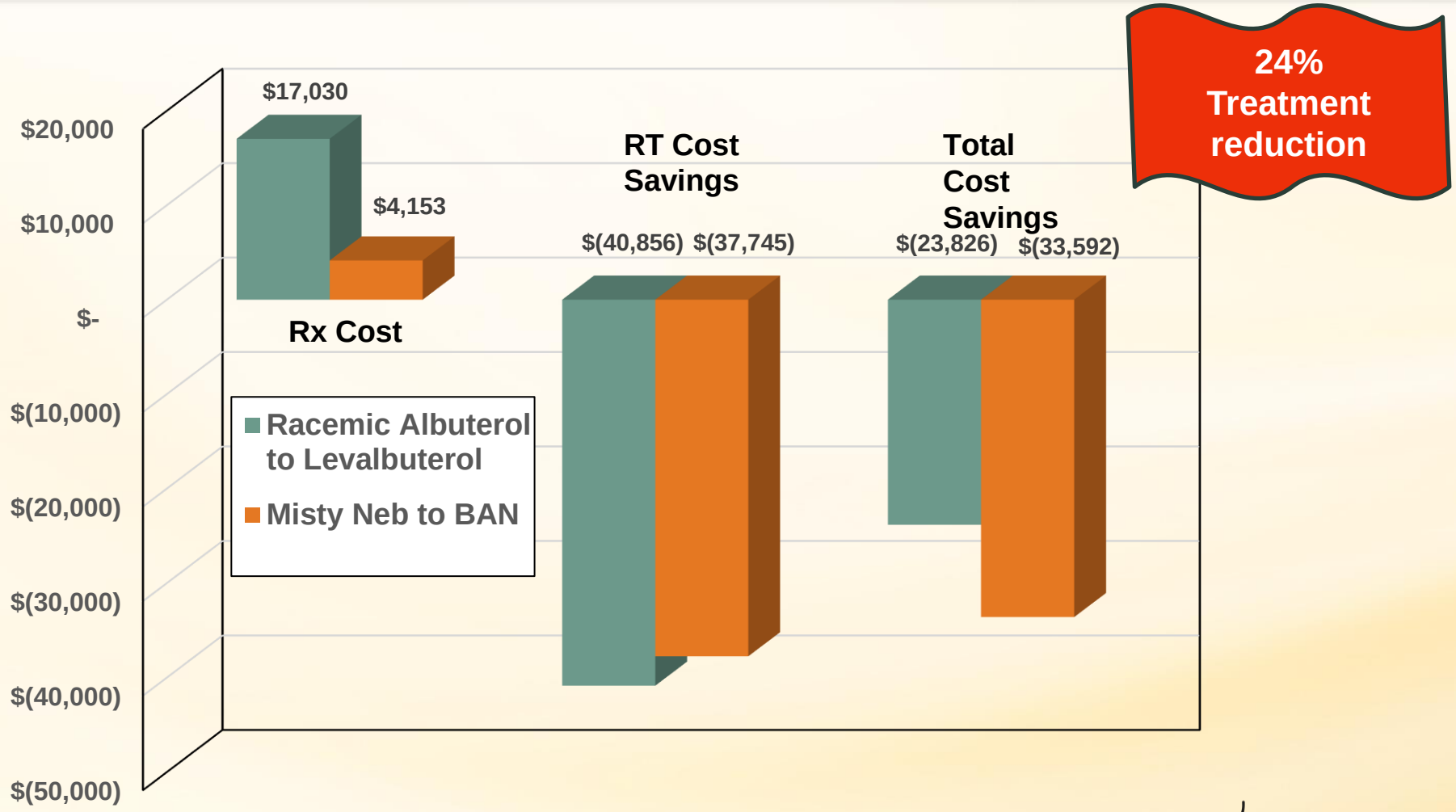
1250 mcg

Bronchodilator Protocol



CHEST 2006; 130:4, 182S

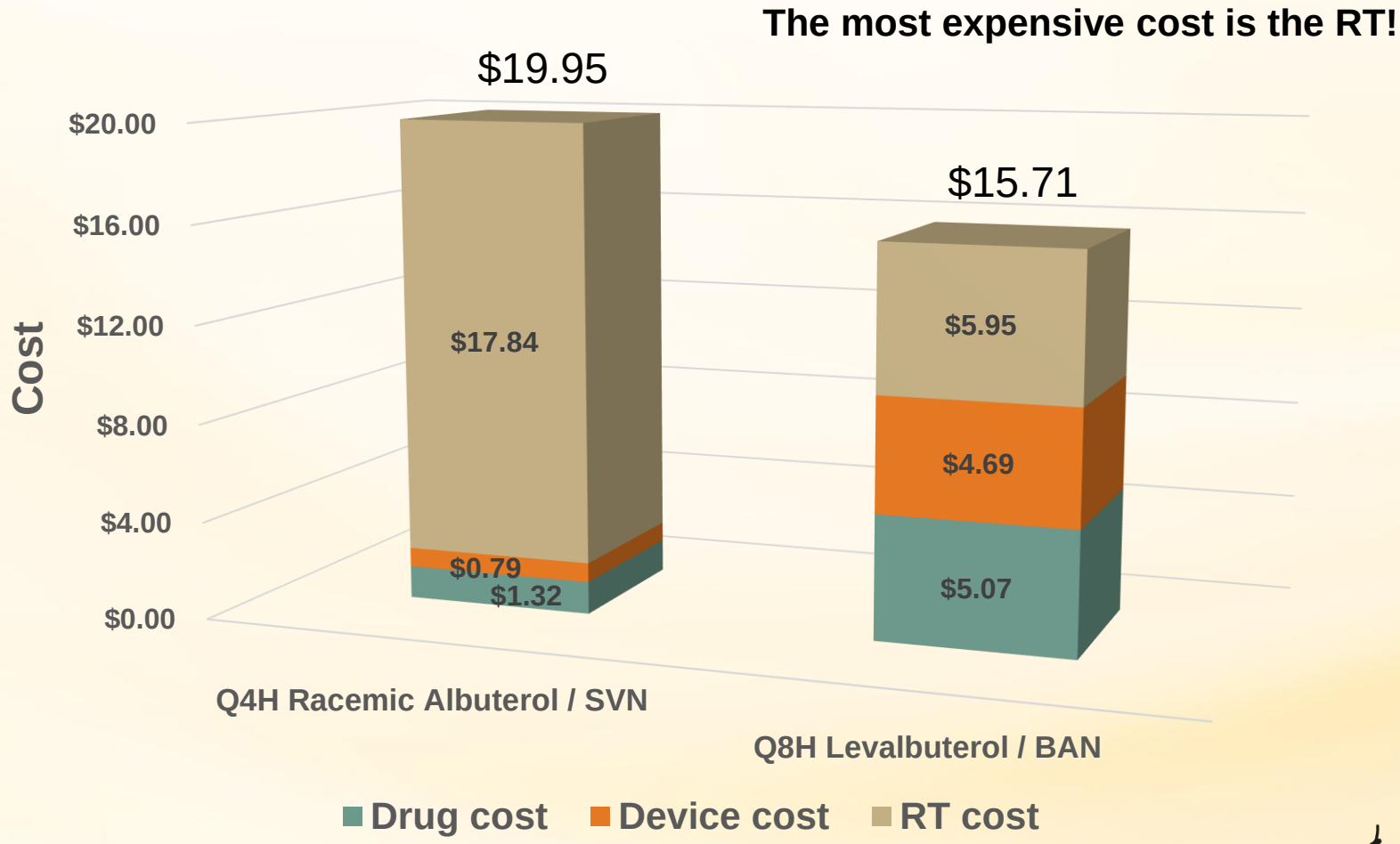
Bronchodilator Protocols
Total Cost Savings



CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Total Daily Treatment Cost / Patient



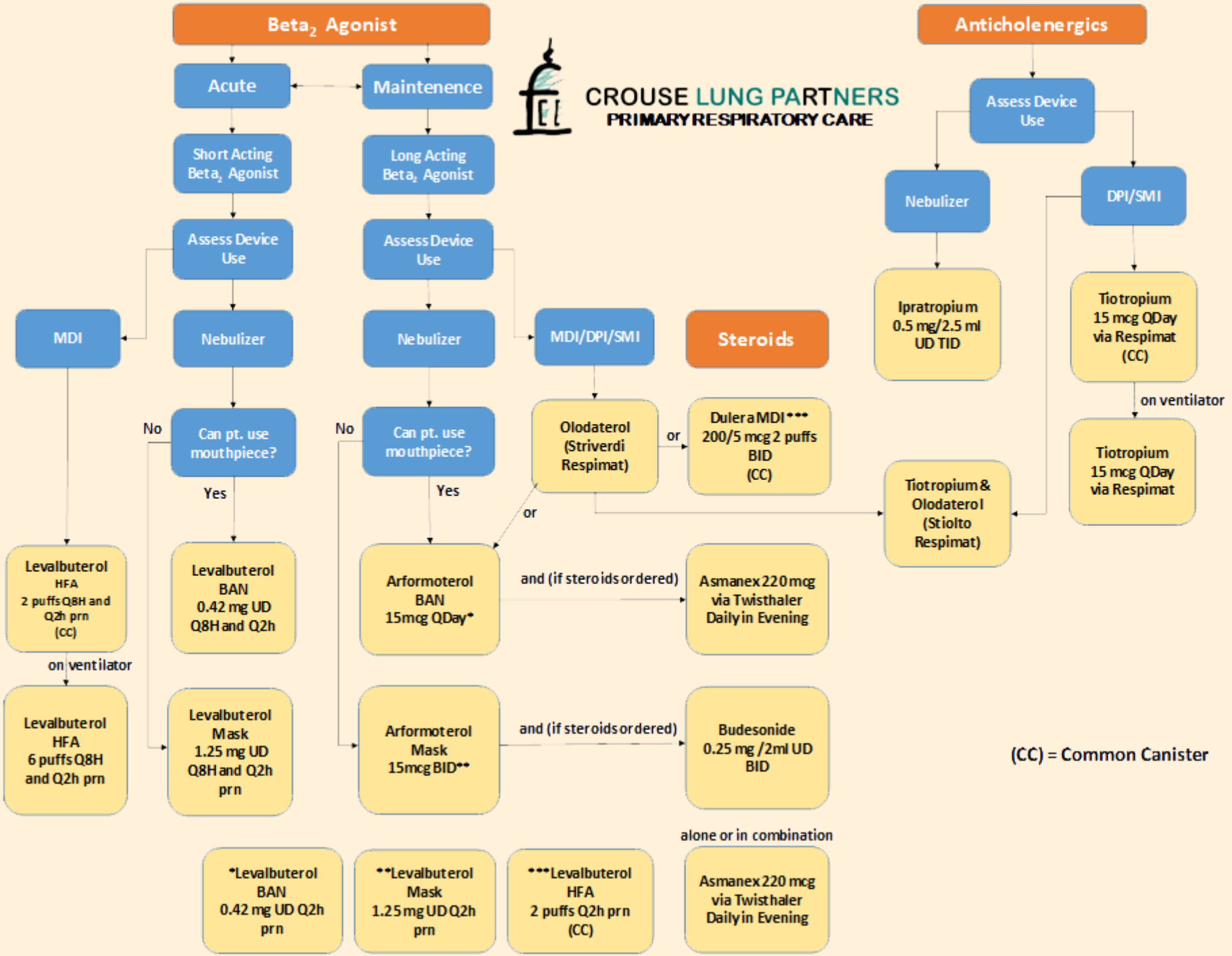
CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Financial Impact

Project Part	RT Dept Impact	Pharm Impact	Net Impact
Levalbuterol Q6h to Q8h	$ (14,919)	$ (4,460)	$ (19,379)
Tiotropium Conversion	$ (5,768)	$ 4,215	$ (1,553)
BAN Conversion	$ (4,174)		
Overall Impact (5 months)	$ (20,687)	$ (245)	$ (20,932)
Overall Impact (Annualized)	$ (49,649)	$ (588)	$ (50,237)

CHEST 2009;136:62S-e


Beta2 Agonist
Acute
Maintenence
Short Acting Beta2 Agonist
Long Acting Beta2 Agonist
Assess Device Use
Assess Device Use
MDI
Nebulizer
Nebulizer
MDI/DPI/SMI
Steroids
No
Can pt. use mouthpiece?
No
Can pt. use mouthpiece?
Yes
Yes
Olodaterol (Striverdi Respimat)
or
Dulera MDI*** 200/5 mcg 2 puffs BID (CC)
or
Levalbuterol HFA 2 puffs Q8H and Q2h prn (CC)
Levalbuterol BAN 0.42 mg UD Q8H and Q2h
Arformoterol BAN 15mcg QDay*
and (if steroids ordered)
Asmanex 220 mcg via Twisthaler Daily in Evening
on ventilator
Levalbuterol HFA 6 puffs Q8H and Q2h prn
Levalbuterol Mask 1.25 mg UD Q8H and Q2h prn
Arformoterol Mask 15mcg BID**
and (if steroids ordered)
Budesonide 0.25 mg /2ml UD BID
alone or in combination
Asmanex 220 mcg via Twisthaler Daily in Evening
*Levalbuterol BAN 0.42 mg UD Q2h prn
**Levalbuterol Mask 1.25 mg UD Q2h prn
***Levalbuterol HFA 2 puffs Q2h prn (CC)
CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE
Anticholenergics
Assess Device Use
Nebulizer
DPI/SMI
Ipratropium 0.5 mg/2.5 ml UD TID
Tiotropium 15 mcg QDay via Respimat (CC)
on ventilator
Tiotropium 15 mcg QDay via Respimat
Tiotropium & Olodaterol (Stiolto Respimat)
(CC) = Common Canister

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

The Lung Partners Project

In the animal self-help section

Lung Partners Overview

- The Primary RT is assigned a patient diagnosed with COPD at their admission and will follow them on all subsequent readmissions
- This will enable them to know the specific needs of their patient
  - Longitudinal model

Lung Partners Overview

- Critical Assessment Elements:
  - A full disease management assessment
  - Anxiety and depression screens
  - Nutritional and functionality screens
  - Quality of life assessments
  - Patient education
  - Discharge planning
    - Accountability model

Lung Partners Overview

- The Primary RT will be the communication link between the patient, their Hospitalist, their primary care physician and pulmonary specialist, if involved
  - Continuity model
- All are important in the transition of care!

Lung Partners
Primary Respiratory Care

Crouse Hospital

Hospitalist

Primary Care Physicians

RT

Skilled Nursing Facility

Home

Capitated contract

PACE CNY
A Program of All-inclusive Care for the Elderly

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

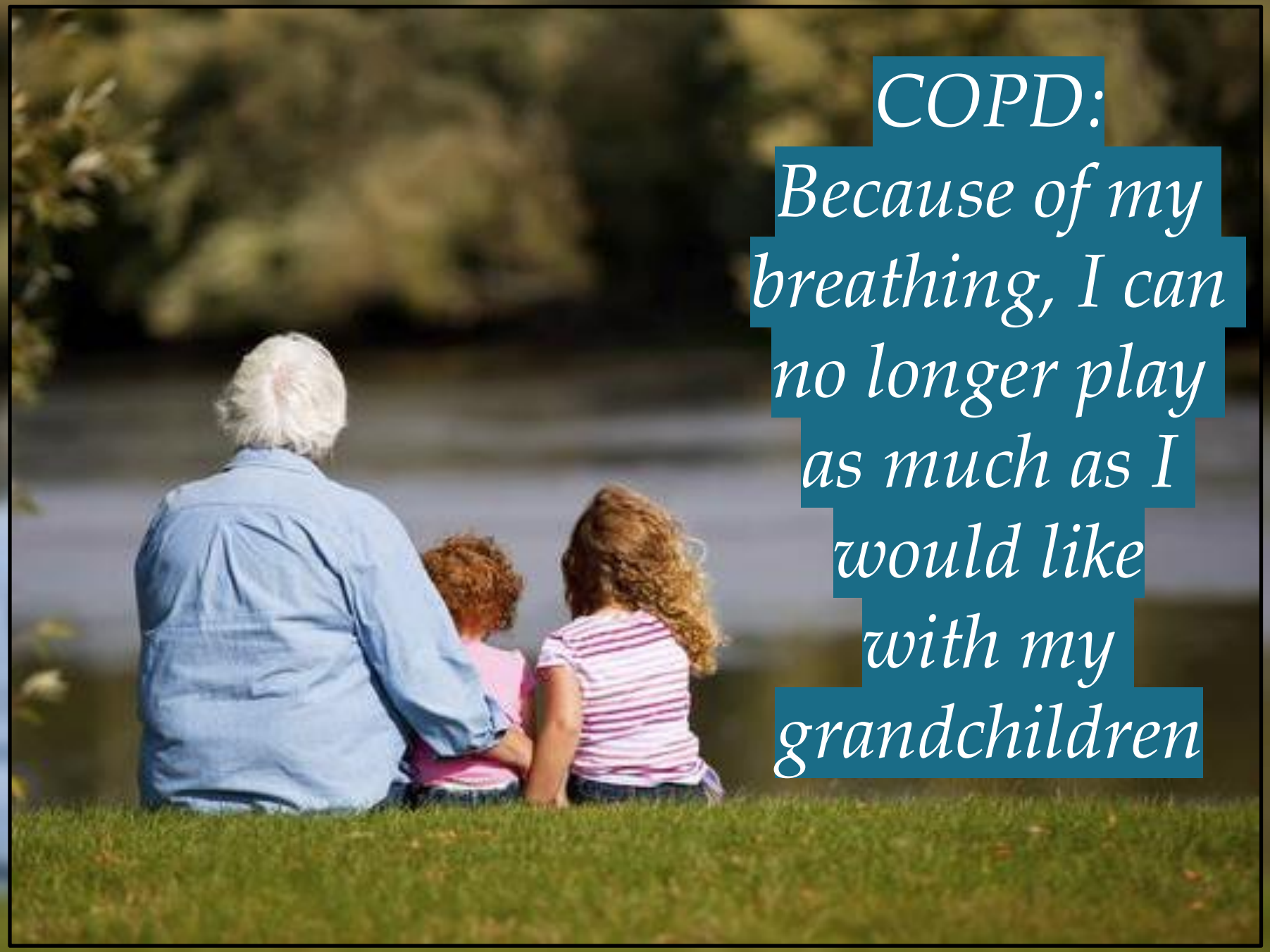
Why are we doing this?

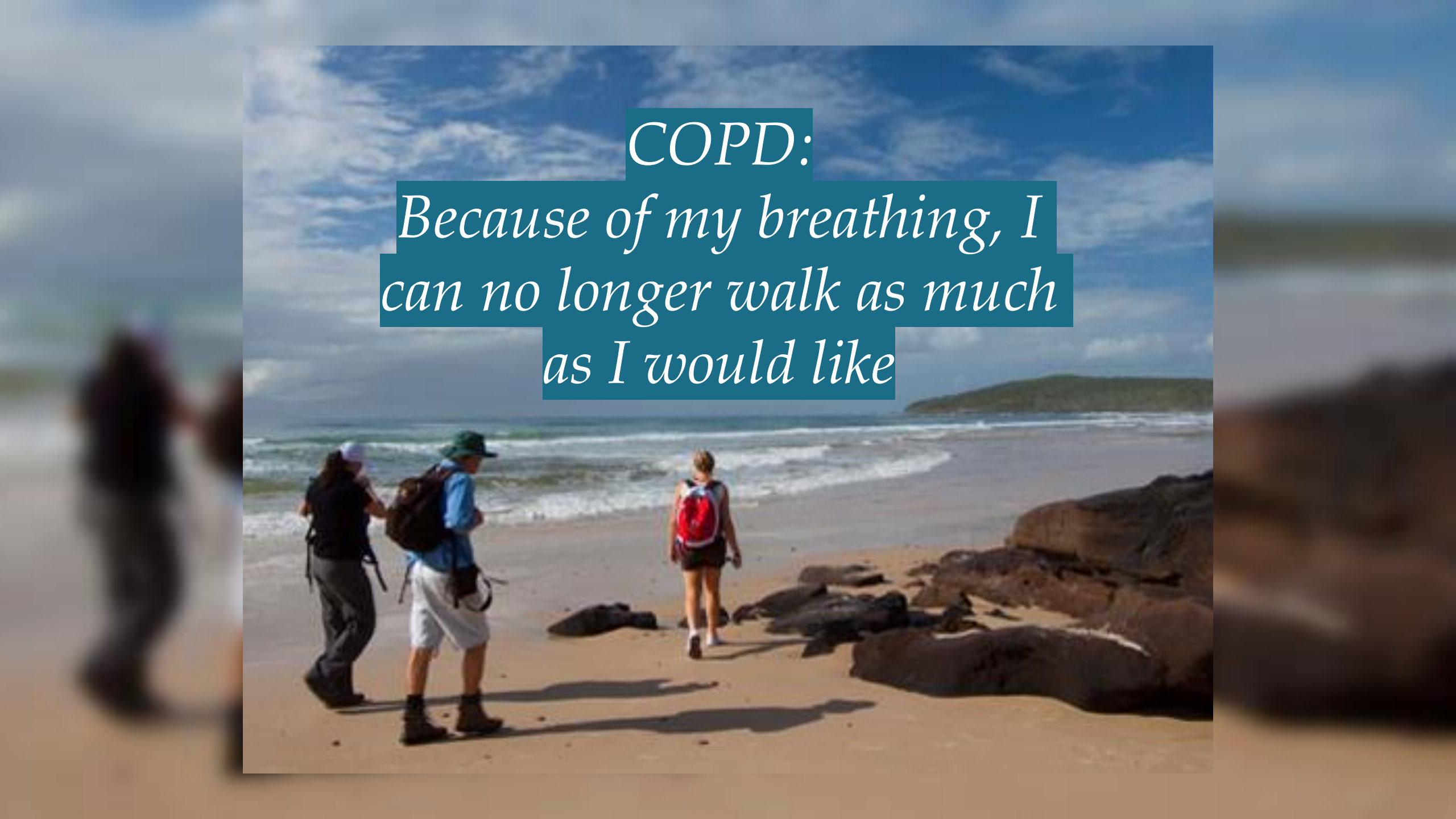
- Improve the lung health and quality of life of COPD patients
- Decrease cost per case
- Decrease LOS of COPD patients
- Reduce COPD readmissions
  - 64.3% of Pneumonia readmissions
  - 58.4% of Heart Failure readmissions

Why are we doing this?

- Facilitate the transfer of information between the hospital's clinical staff and the primary care physician
- Reduce fractionation of care
- To deliver care consistent with national COPD guidelines
- This could be *fun!*

COPD: Because of my breathing, I can only play 9 holes of golf, not my usual 18 holes


COPD:
Because of my breathing, I can no longer play as much as I would like with my grandchildren


COPD:
Because of my breathing, I
can no longer walk as much
as I would like

Disease Manager Role

- Assess use of inhalational devices
- Review medication list, specifically looking for duplications
- Obtain PFTs and stage per GOLD* guidelines
- Only 16% of COPD patients have PFTs
- Assessing medications and other interventions based on COPD stage

*Global Initiative for Obstructive Lung Disease

Aerosol Device Use Assessment

HOUSE M.D.

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

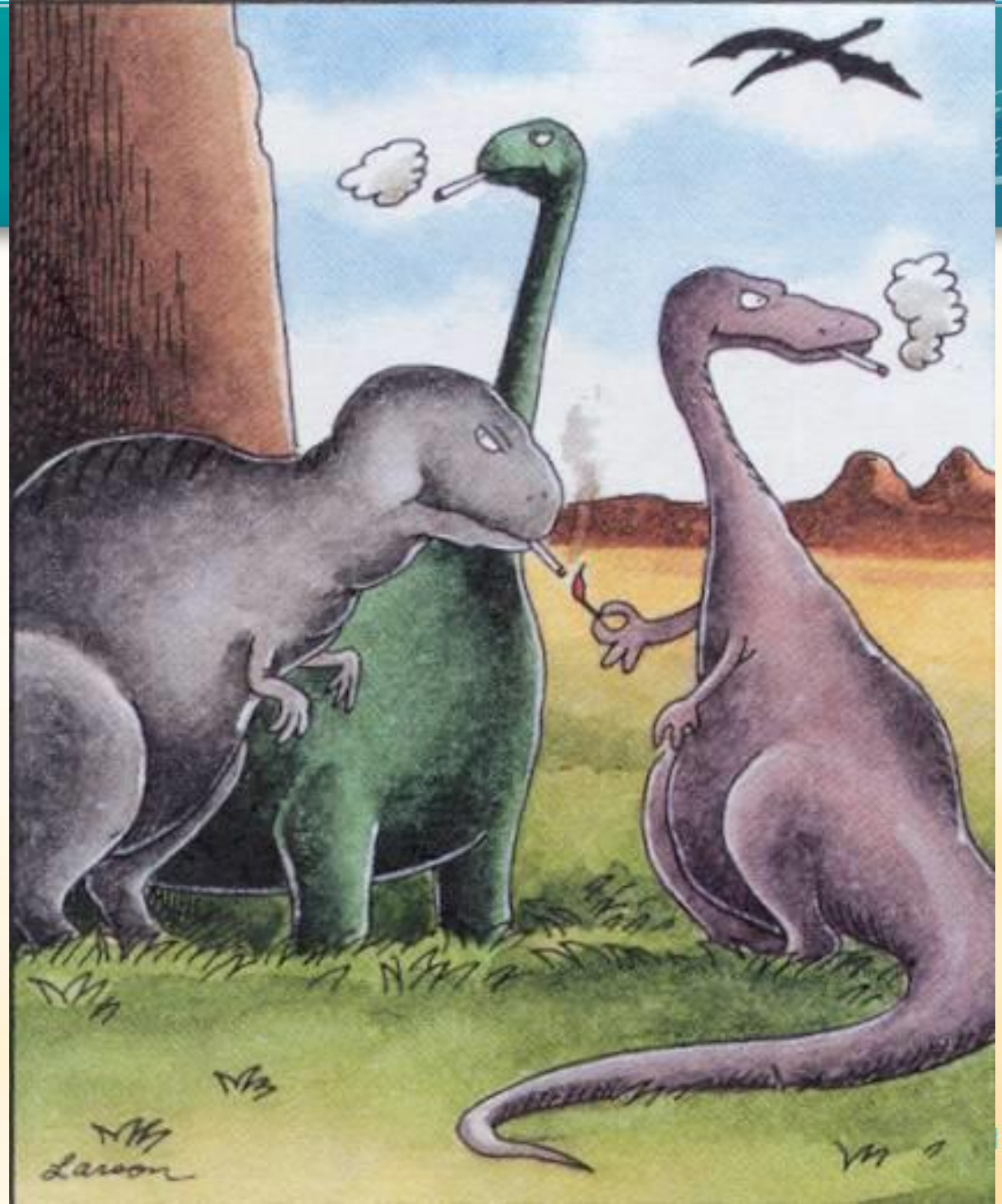
Disease Manager Role

- Oxygen delivery, weaning and assessing need for outpatient oxygen
- Matching delivery devices to patient's abilities
  - In-check dial

Disease Manager Role

- Assess ambulation, nutritional status and screen for depression and anxiety
- Address smoking cessation needs
- Arrange for inpatient or outpatient PFTs or sleep studies if needed
- Advance Directives

The real reason dinosaurs became extinct!



Disease Manager Role

- Educate on home action-plan and self-management tools
- Patients are educated on the differences between rescue and maintenance medications
- Post discharge phone follow-up
- 24/7 call in number

Your name:

Today's date:

CAT
COPD Assessment Test

How is your COPD? Take the COPD Assessment Test™ (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. Your answers, and test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question.

Example: I am very happy 0 X 2 3 4 5 I am very sad

		SCORE
I never cough	0 1 2 3 4 5	I cough all the time
I have no phlegm (mucus) in my chest at all	0 1 2 3 4 5	My chest is completely full of phlegm (mucus)
My chest does not feel tight at all	0 1 2 3 4 5	My chest feels very tight
When I walk up a hill or one flight of stairs I am not breathless	0 1 2 3 4 5	When I walk up a hill or one flight of stairs I am very breathless
I am not limited doing any activities at home	0 1 2 3 4 5	I am very limited doing activities at home
I am confident leaving my home despite my lung condition	0 1 2 3 4 5	I am not at all confident leaving my home because of my lung condition
I sleep soundly	0 1 2 3 4 5	I don't sleep soundly because of my lung condition
I have lots of energy	0 1 2 3 4 5	I have no energy at all
		TOTAL SCORE

Last Updated: February 24, 2012

PHQ-9 Depression

...eeks, how often have you ...y any of the following problems? ...dicate your answer"	Not at all	Several days	More than half the days	Nearly every day
...t or pleasure in doing things	0	1	2	3
...wn, depressed, or hopeless	0	1	2	3
...falling or staying asleep, or sleeping too ...	0	1	2	3
...g tired or having little energy	0	1	2	3
...appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column totals	___	+ ___	+ ___	+ ___

= Total Score ____

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer"	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	
2. Not being able to stop or control worrying	0			
3. Worrying too much about different things	0			
4. Trouble relaxing	0			
5. Being so restless that it is hard to sit still	0	1		
6. Becoming easily annoyed or irritable	0	1		
7. Feeling afraid as if something awful might happen	0	1		
Column totals:				

= Total Score ____

LUNG PARTNERS COPD ACTION PLAN

Green Zone

- Sleeping well.
- My sputum is clear/white and easily cleared in small amounts.
- I breathe without difficulty.
- I can do usual activities/exercise without tiring.
- Appetite is good.

What To Do

- Continue taking medications as prescribed.
- Keep all doctor appointments.
- Maintain routine activity.
- Use oxygen as prescribed.
- At all times, avoid cigarette smoke, inhaled irritants.

Yellow Zone

- Just don't feel well-unusually **restless/ anxious.**
- **My sputum is thicker** than normal or I am producing more sputum.
- I have a change in color of phlegm/mucus.
- I am more **short of breath** with routine activity.
- I wheeze or **cough** more than usual.
- New swelling in feet or ankles.
- I **tire easily** and cannot do usual activities without resting.
- I am not thinking clearly.
- **I am using my nebulizer/rescuhaler more than normal.**
- **Side effects** from medications.
- My medicine is not helping.
- **My appetite is not good.**
- I feel like I have a "chest cold".
- **Poor sleep** and my symptoms woke me up.
- **Gain** of 3-4 pounds over 1-2 days or 5 pounds in a week OR a gain of less weight than above AND also have any of the symptoms listed.
- **Bloated** abdomen
- Full feeling in abdomen
- I need to use **2 or more pillows** or sleep in a recliner to breathe comfortably.

What To Do

1. Write down (or have someone write for you) what your concerns are and why you feel something is wrong
   - BE VERY SPECIFIC - Write down exactly what your symptoms are, how long you have had them, and how they are different than usual ex: my sputum has changed to _____ color and I'm more short of breath.
     - any meds that have changed since your last visit.
     - any sick contacts.
2. Call your Pulmonologist. If you don't have a pulmonologist, call your regular doctor. Tell them:
   - Your name
   - Your doctor's name
   - Your history (ex: I have a history of COPD.)
   - What your symptoms are and how they have changed. ex: my sputum is now thick and _____ in color.
   - Anything you written down about your concerns.
   - You need an appointment today.
3. If you cannot have an appointment today, insist on talking to the Nurse Practitioner or Doctor.
4. Emphasize that your goal is to stay out of the hospital.
5. If you still can't get an appointment, call your transition coach at _____.

Red Zone

- I have trouble coughing up sputum.
- **Severe shortness of breath.**
- My sputum contains **blood.**
- Not able to do any activity because of breathing.
- I am confused.
- Not able to sleep because of breathing.
- **Fever or shaking chills.**
- It is difficult for me to wake up.
- **Chest pain.**
- A feeling of **impending doom.**

What To Do

CALL 911 NOW!

CROUSE HOSPITAL
LUNG PARTNERS™
Primary Respiratory Care

Form #102 (on demand) 4/25/11

When your patient gets dyspneic: Have an Action Plan

LUNG PARTNERS COPD ACTION PLAN

Green Zone

- Sleeping well.
- My sputum is clear/white and easily cleared in small amounts.
- I breathe without difficulty.
- I can do usual activities/exercise without tiring.
- Appetite is good.

What To Do

- Continue taking medications as prescribed.
- Keep all doctor appointments.
- Maintain routine activity.
- Use oxygen as prescribed.
- At all times, avoid cigarette smoke, inhaled irritants.

Red Zone

- I have trouble coughing up sputum.
- **Severe shortness of breath.**
- My sputum contains **blood**.
- Not able to do any activity because of breathing.
- I am confused.
- Not able to sleep because of breathing.
- **Fever or shaking chills.**
- It is difficult for me to wake up.
- **Chest pain.**
- A feeling of **impending doom.**

What To Do

CALL 911 NOW!

CROUSE HOSPITAL
LUNG PARTNERS™
Primary Respiratory Care

Form #102 (on demand) 4/25/11

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

Yellow Zone

- Just don't feel well-unusually **restless/ anxious.**
- **My sputum is thicker** than normal or I am producing more sputum.
- I have a change in color of phlegm/mucus.
- I am more **short of breath** with routine activity.
- I wheeze or **cough** more than usual.
- New swelling in feet or ankles.
- I **tire easily** and cannot do usual activities without resting.
- I am not thinking clearly.
- **I am using my nebulizer/rescuhaler more than normal.**
- **Side effects** from medications.
- My medicine is not helping.
- **My appetite is not good.**
- I feel like I have a "chest cold".
- **Poor sleep** and my symptoms woke me up.
- **Gain** of 3-4 pounds over 1-2 days or 5 pounds in a week OR a gain of less weight than above AND also have any of the symptoms listed.
- **Bloated** abdomen
- Full feeling in abdomen
- I need to use **2 or more pillows** or sleep in a recliner to breathe comfortably.

What To Do

1. Write down (or have someone write for you) what your concerns are and why you feel something is wrong
   - BE VERY SPECIFIC - Write down exactly what your symptoms are, how long you have had them, and how they are different than usual ex: my sputum has changed to _____ color and I'm more short of breath.
     - any meds that have changed since your last visit.
     - any sick contacts.
2. Call your Pulmonologist. If you don't have a pulmonologist, call your regular doctor. Tell them:
   - Your name
   - Your doctor's name
   - Your history (ex: I have a history of COPD.)
   - What your symptoms are and how they have changed. ex: my sputum is now thick and _____ in color.
   - Anything you written down about your concerns.
   - You need an appointment today.
3. If you cannot have an appointment today, insist on talking to the Nurse Practitioner or Doctor.
4. Emphasize that your goal is to stay out of the hospital.
5. If you still can't get an appointment, call your transition coach at _____.

Care Coordination

- Advanced Practice Nurse
- Dietician
- Hospice Care
- Occupational therapy
- Palliative Care
- Physical Therapist
- Psychiatrist
- Psychologist
- Pulmonary Rehabilitation program
- Pulmonologist
- Social Services
- Spiritual/Pastoral Care
- Thoracic Surgeon

Protocols

We freely share!
E-mail me at
russacevedomd@crouse.org

CROUSE LUNG PARTNERS

Primary Care Model for Respiratory Care Inpatient Disease Management

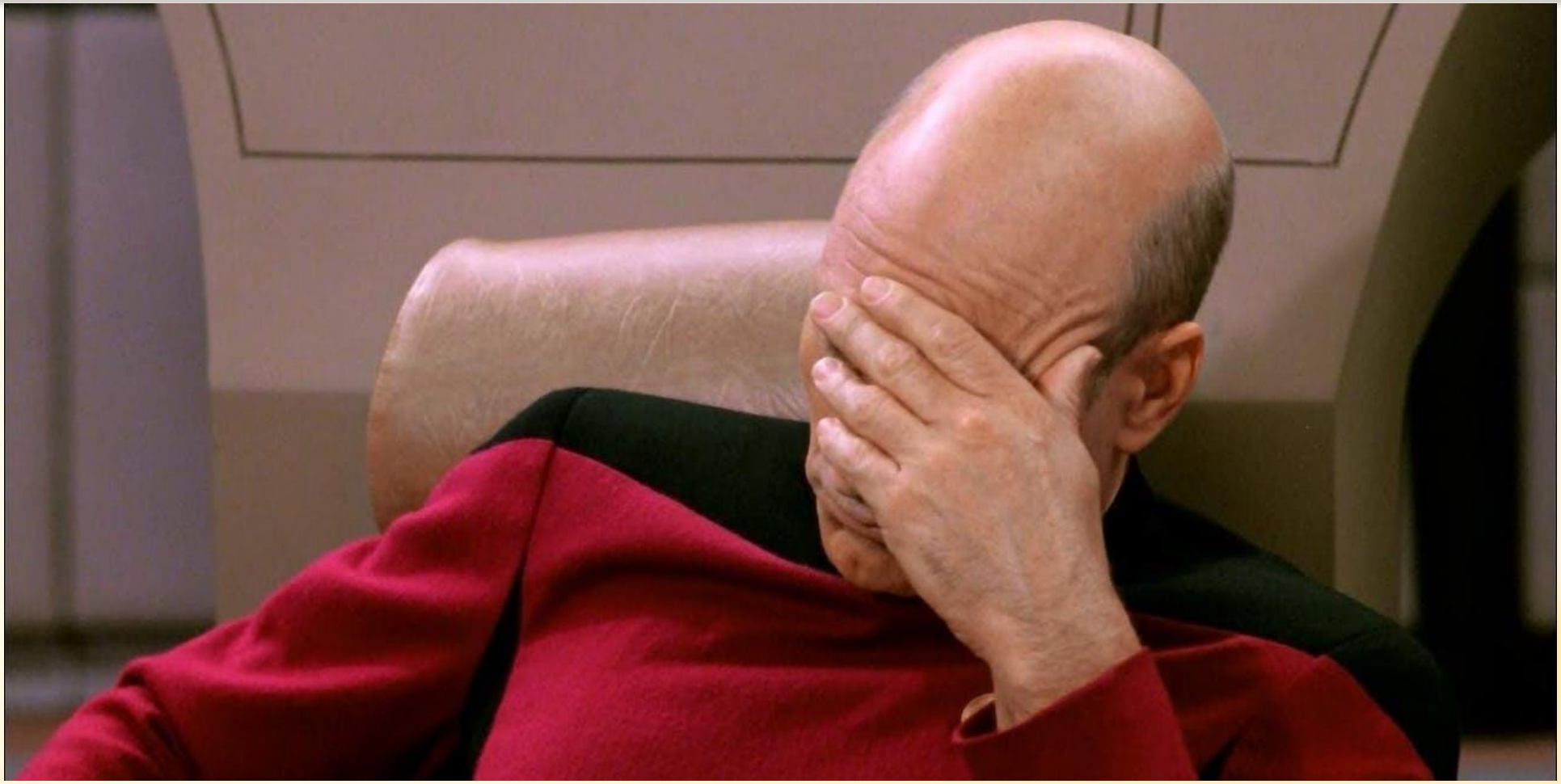
Partnership with Syracuse University

Whitman SCHOOL of MANAGEMENT
SYRACUSE UNIVERSITY®

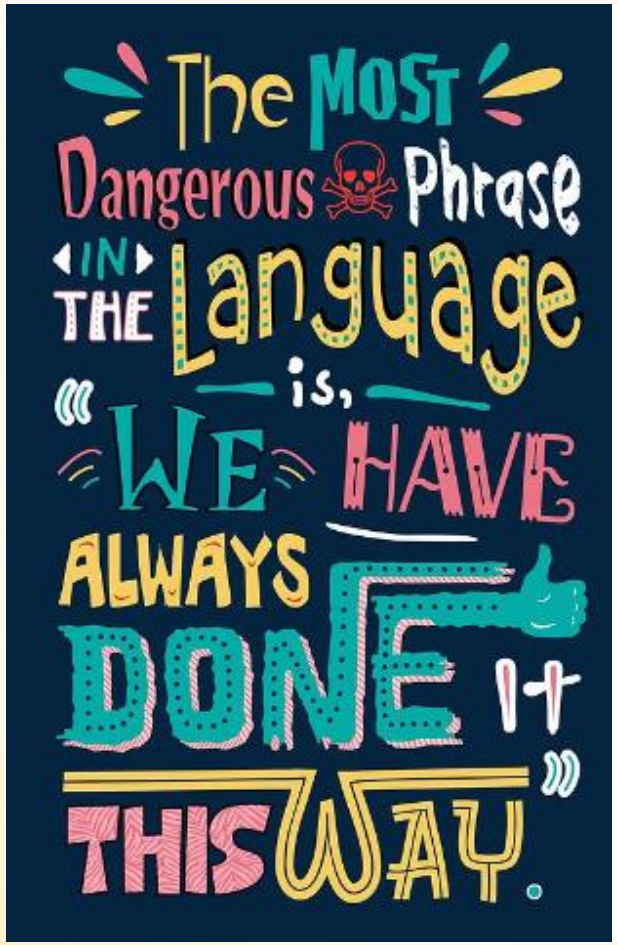
CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

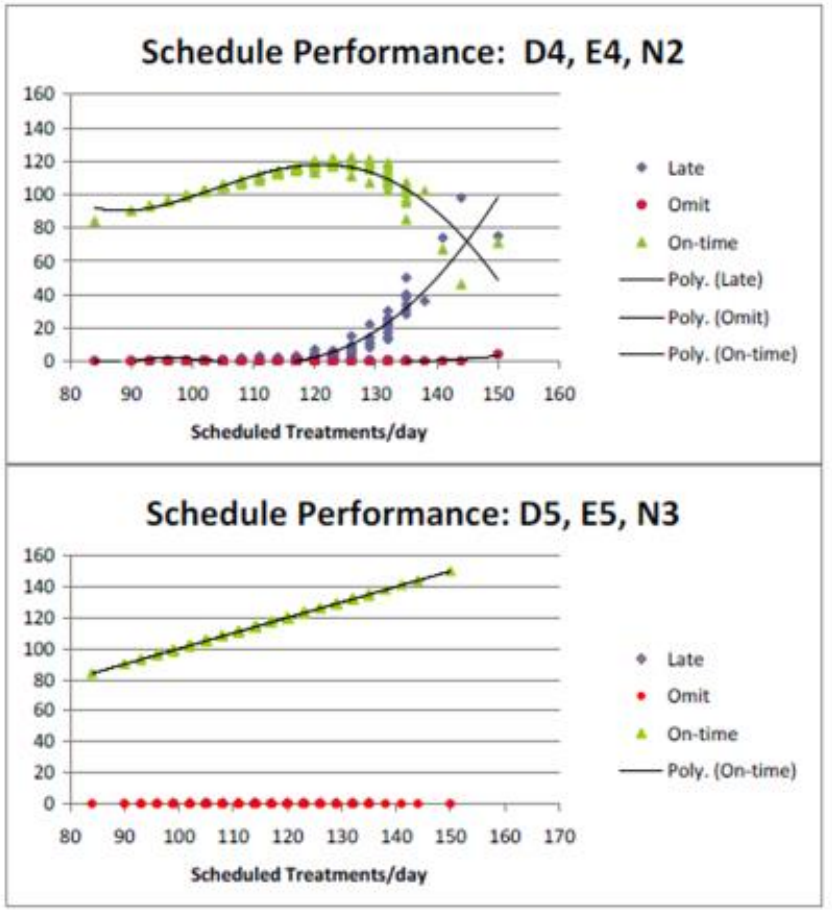
CROUSE HEALTH

Why are you doing this?



The “Swarm” - Six Sigma Project with Syracuse University

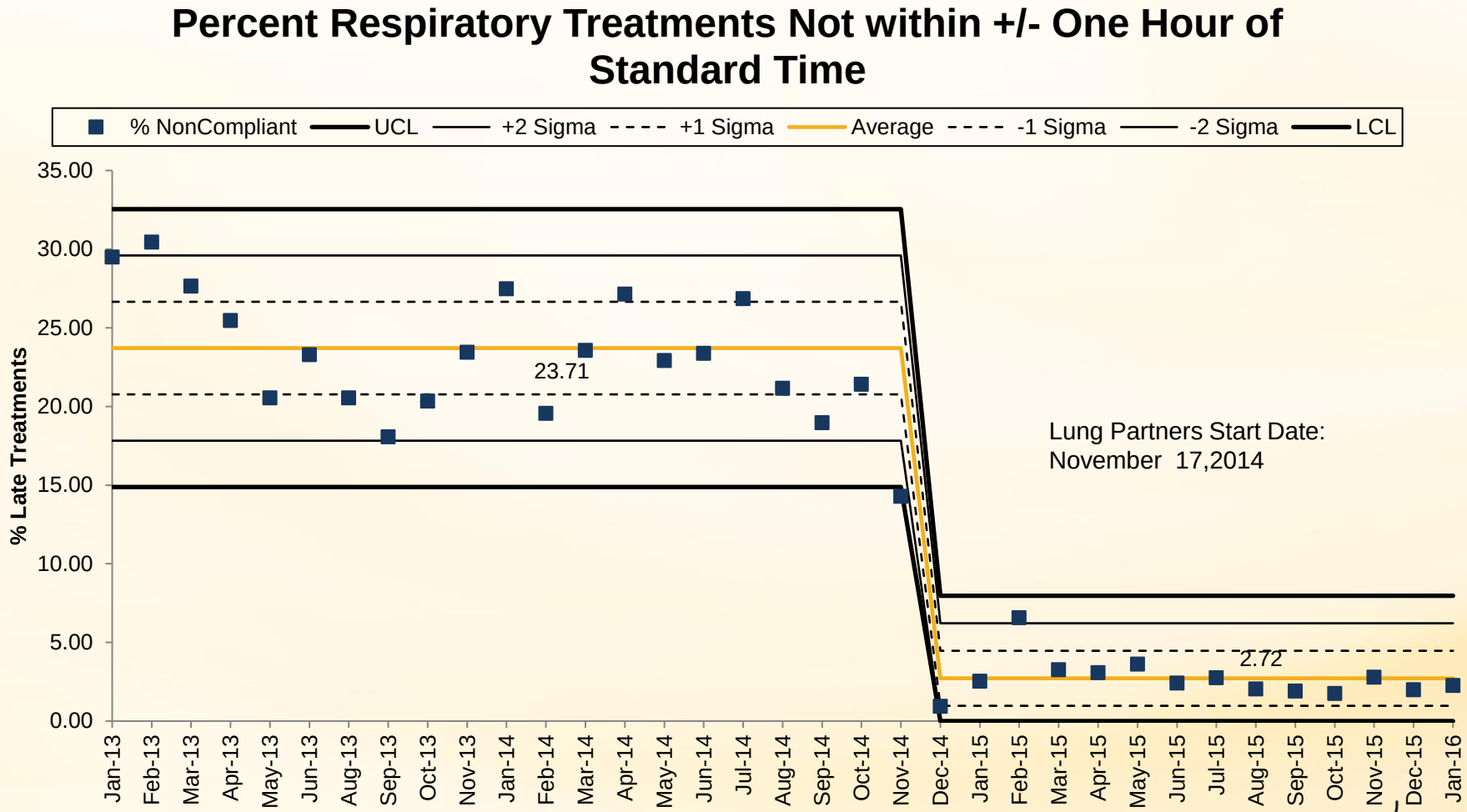




CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Decreased Late Treatments

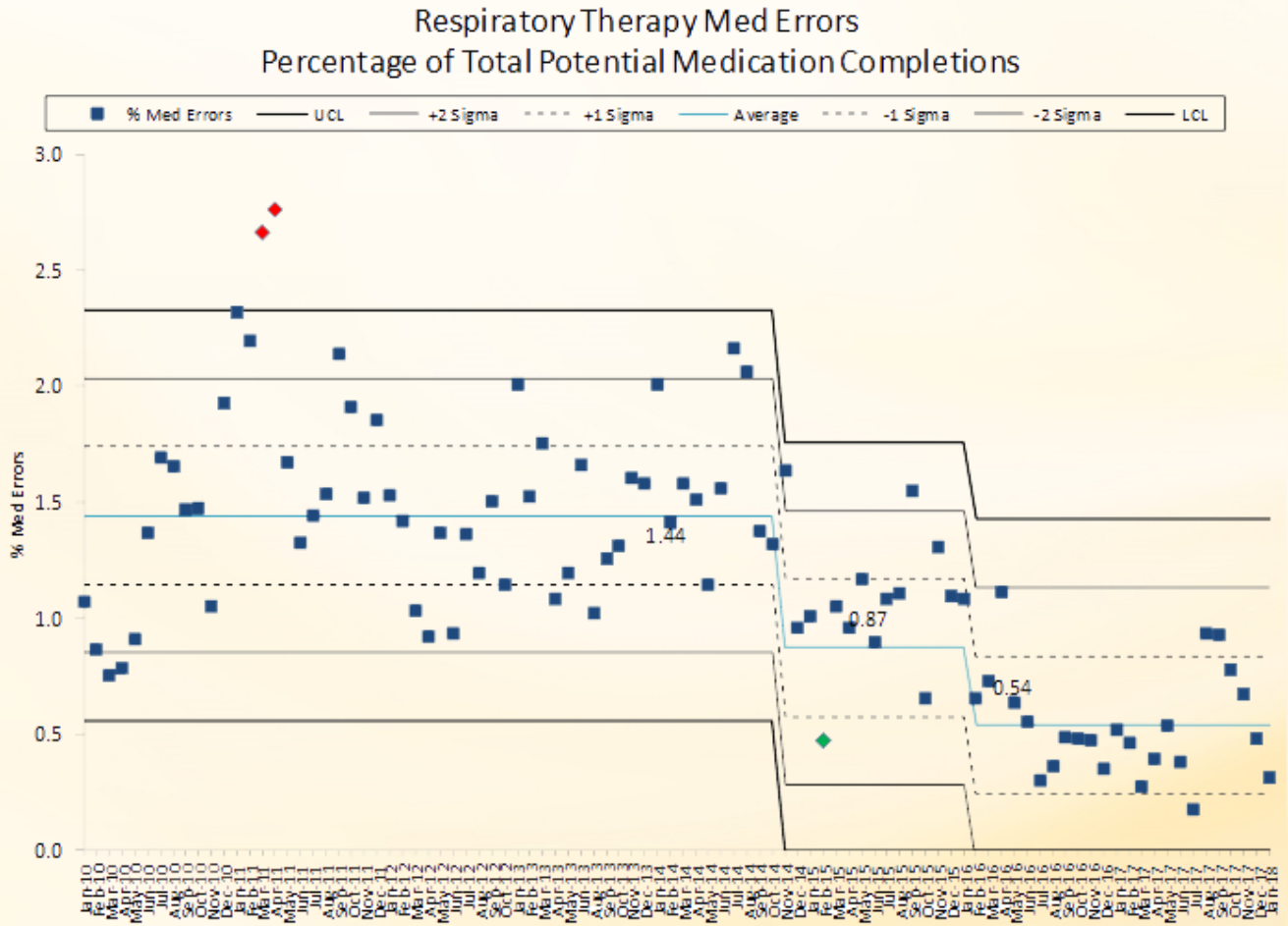


CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

AARC Open Forum 2015

CROUSE HEALTH

Medication Errors

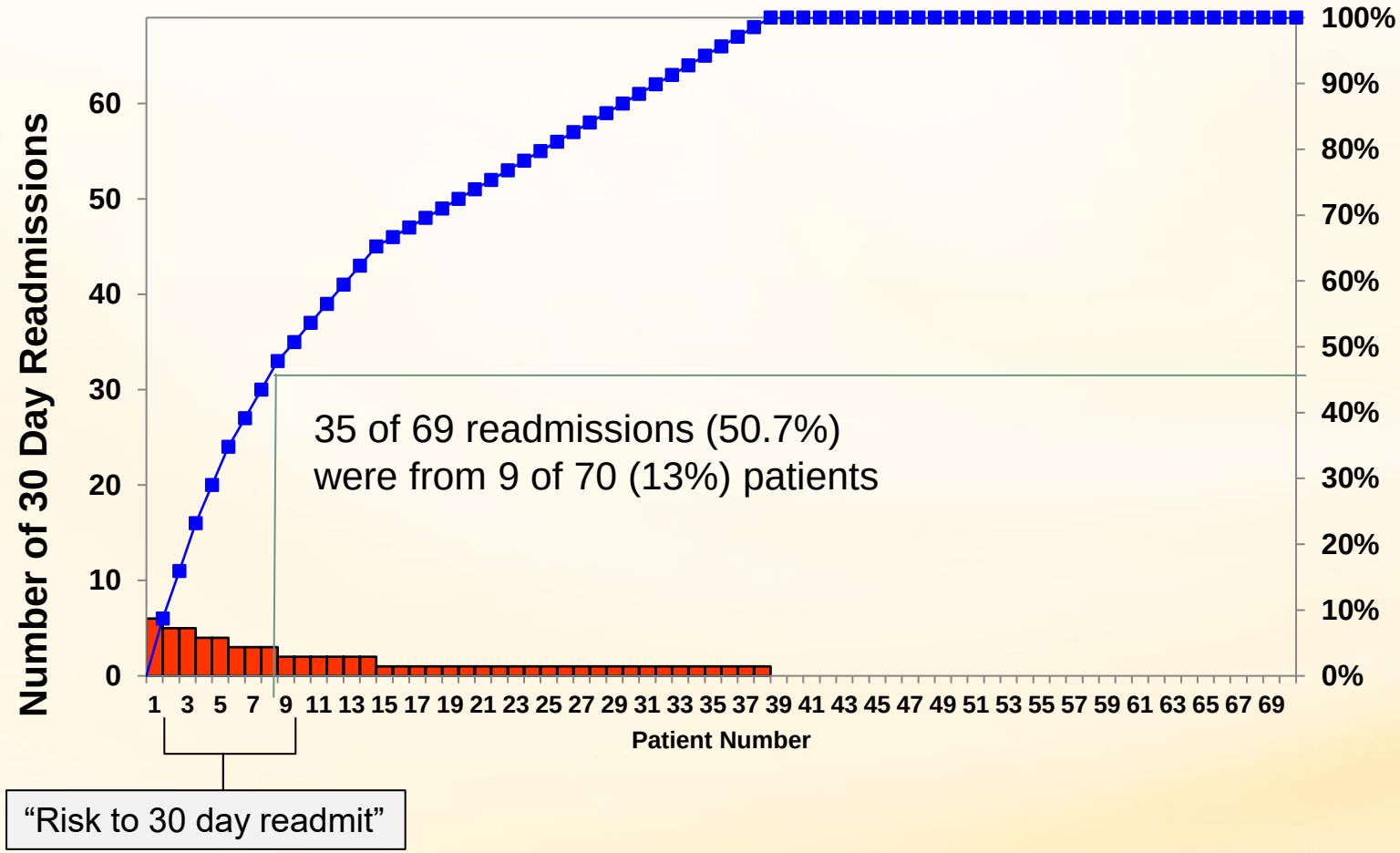


AARC Open Forum 2015

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Lung Partners 30 Day Readmissions

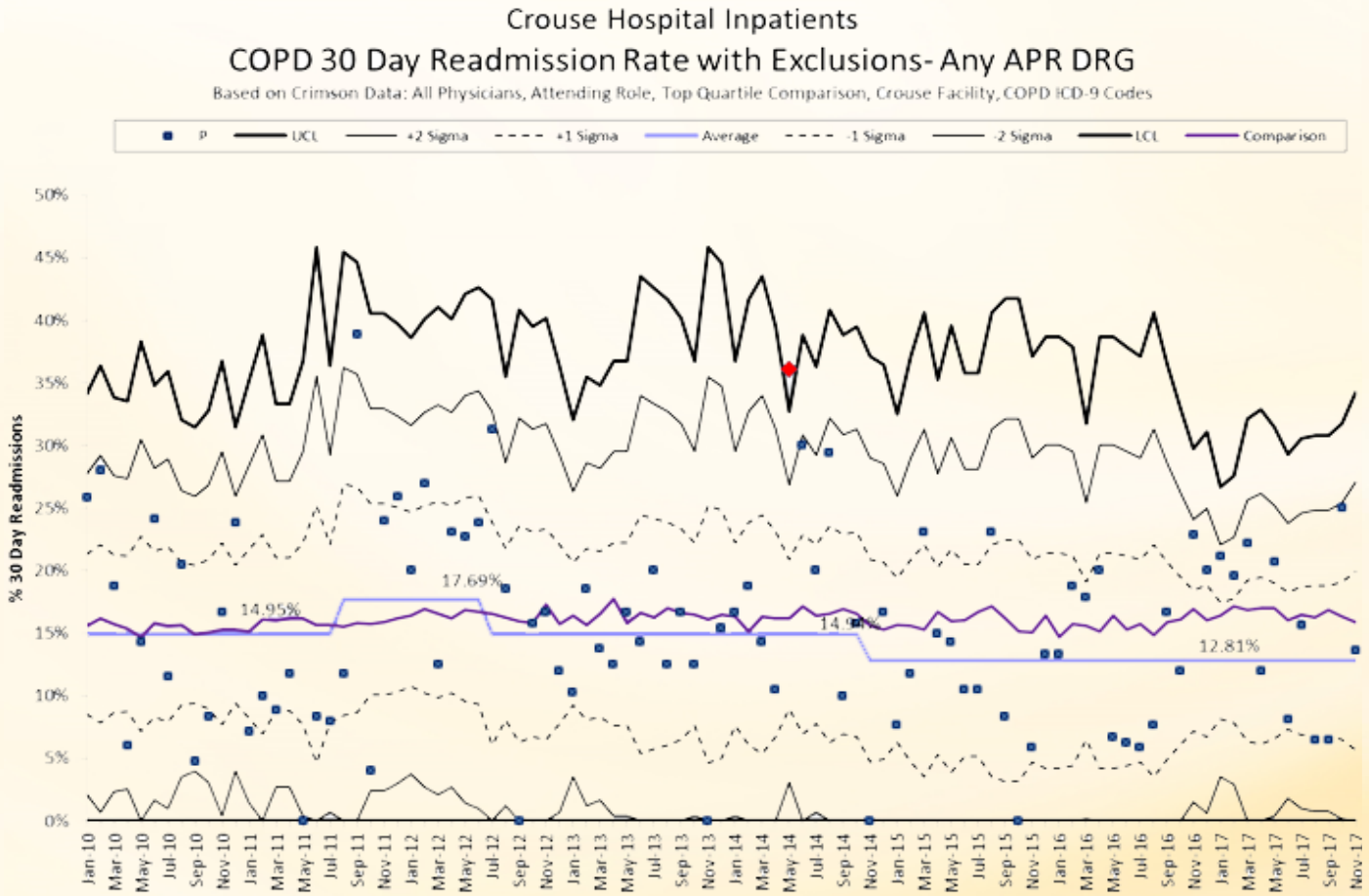


AARC Open Forum 2016

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Lung Partners Impact on Reduction in 30-Day Readmissions Rates



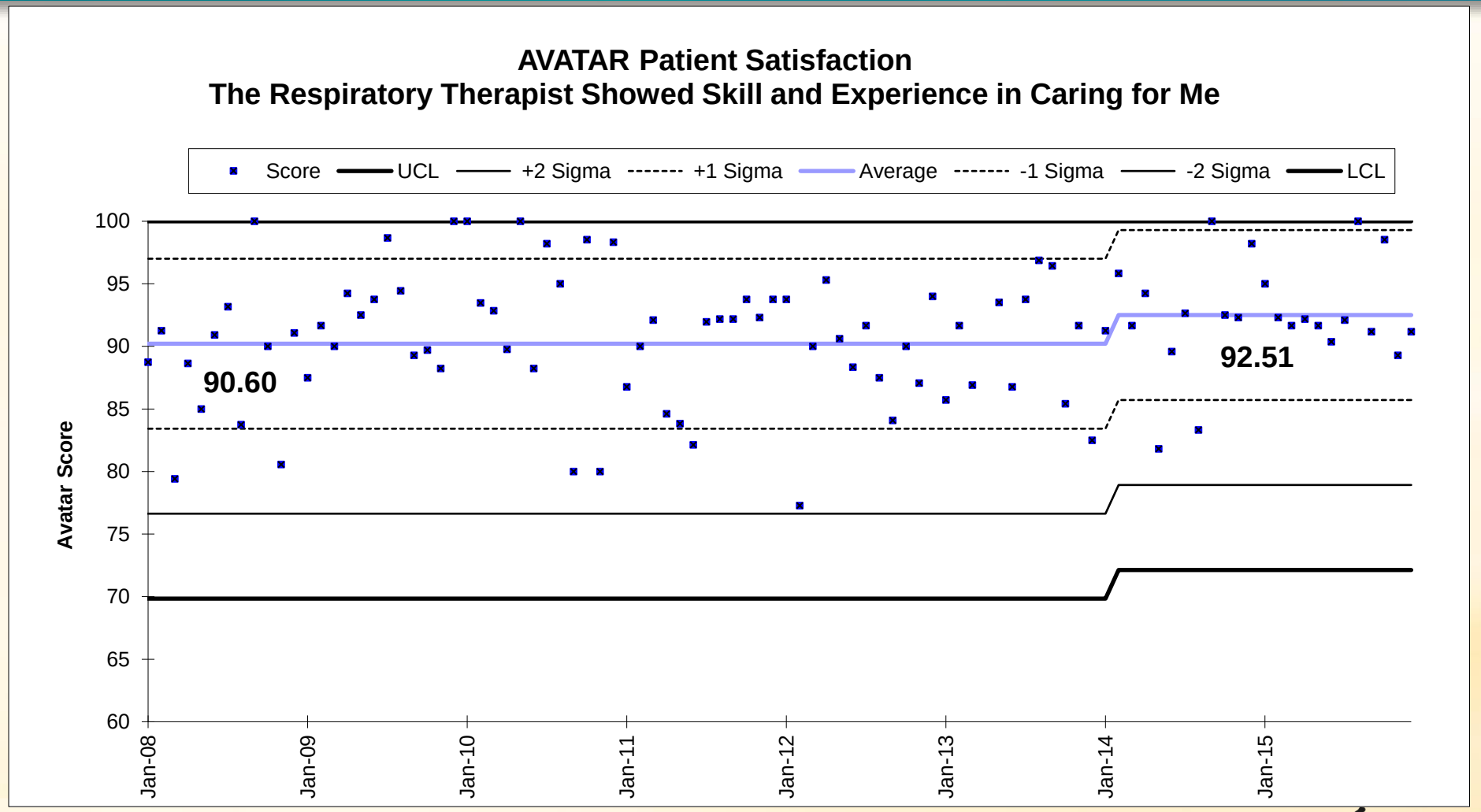
p= 0.045

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

AARC Open Forum 2016

CROUSE HEALTH

Patient Satisfaction



CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

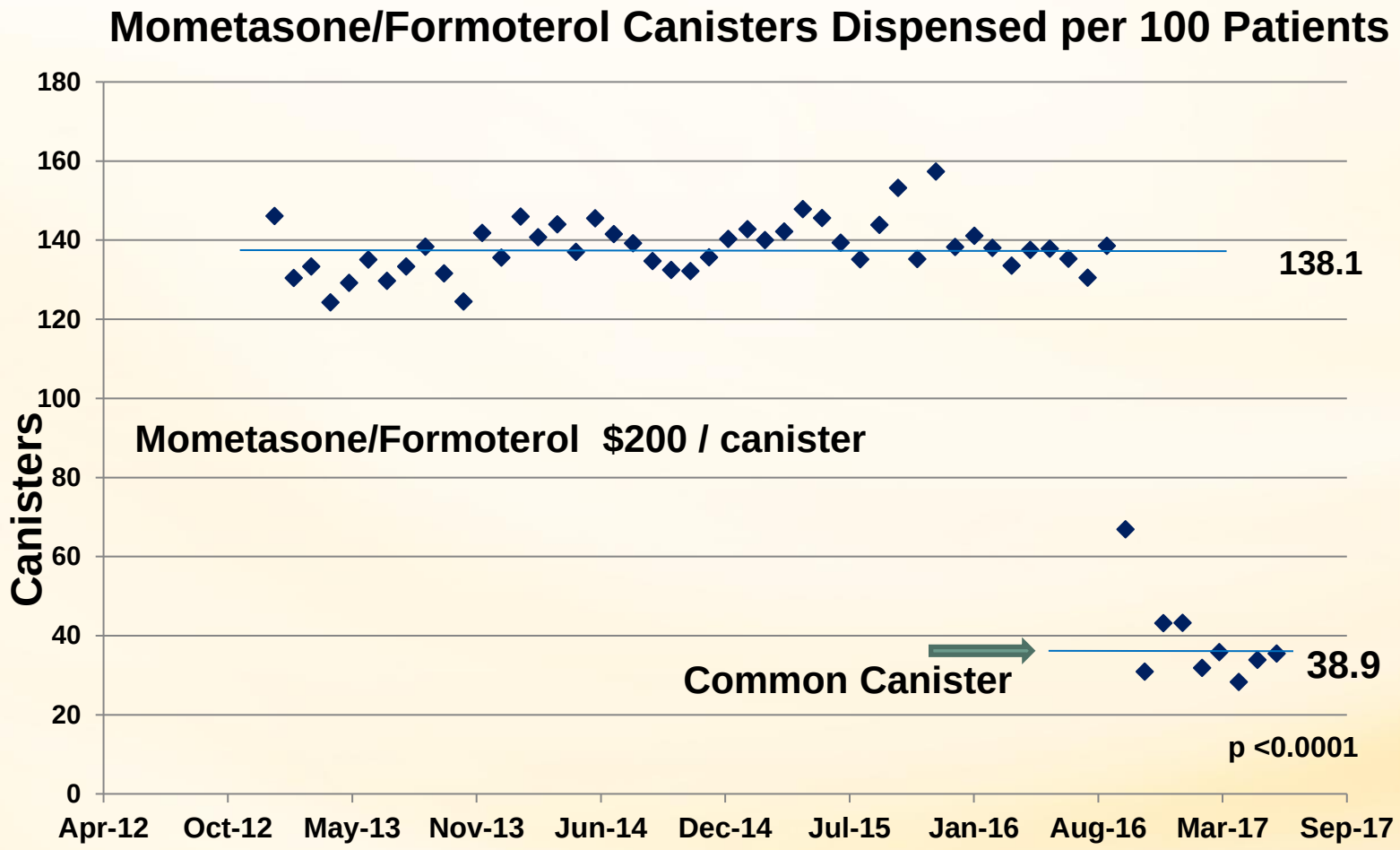
Delivery of Respiratory Care

- We did a focus study on how our non-RT staff were delivering respiratory care
- Errors discovered included
  - Discarding spacers at discharge
  - Incorrect MDI technique
  - Not using spacers consistently
  - Improper rinsing post anti-inflammatory MDIs
  - Handhaler errors included inability to use due to physical limitations
  - Patients swallowing the capsule
  - Improper extraction of drug from the capsule

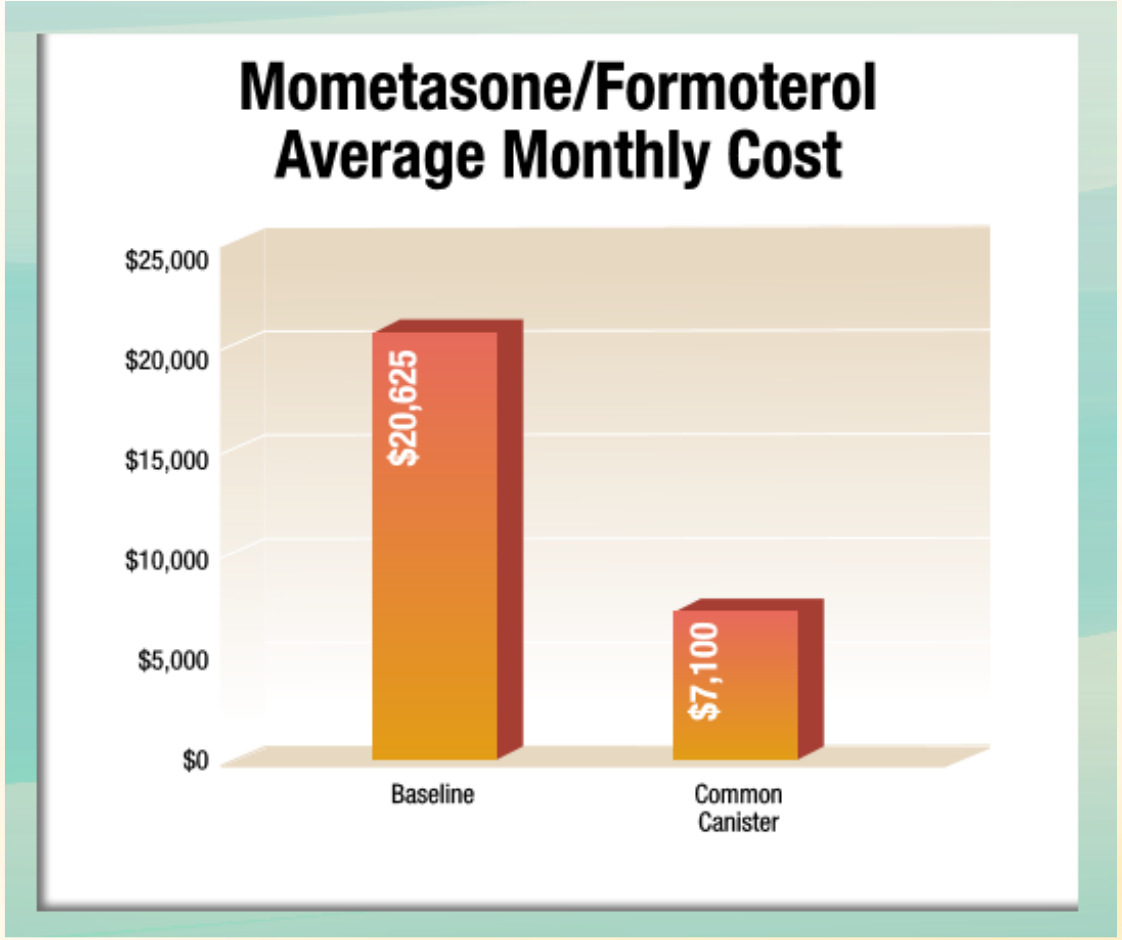
Common Canister

- All MDIs are delivered with a spacer
- With the short LOS of around 5-6 days, most of the drug in an MDI is wasted
- Multiple MDIs are dispensed per patient
- One MDI can be used for multiple patients

Common Canister



Common Canister



High Flow Nasal Cannula

Successful High Flow Nasal Cannula Use Outside of the Critical Care Areas

Wendy J. Fascia, MA, RRT, RT-NPS; Jennifer Pedley, BS, RRT; Russell A. Acevedo, MD, FAARC, FCCP, FCCM
Respiratory Care, Crouse Health, Syracuse, NY, United States

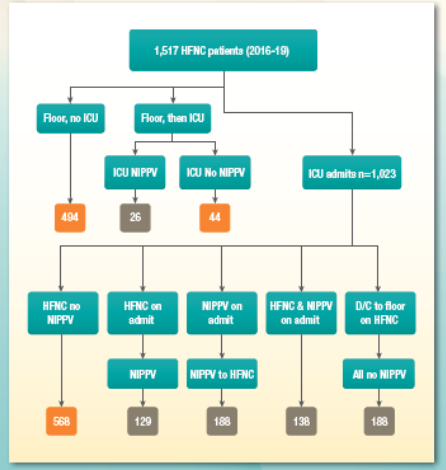
Background

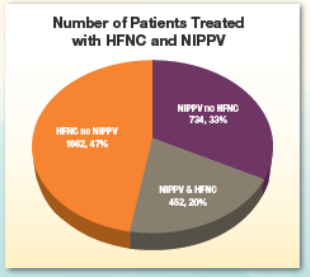
We continued to monitor and adjust our High Flow Nasal Cannula (HFNC) use in all areas. Our previous success of HFNC use outside of the critical care areas on our medical floors resulted in decreased ICU days and decreased noninvasive positive pressure ventilation (NIPPV) use. This study continues to evaluate the success of our HFNC use, including where to care for the patient, as well as whether we continue to use HFNC instead of NIPPV. Prior to our initiation of HFNC use on the medical floors, all patients on HFNC would have gone to the ICU on NIPPV.

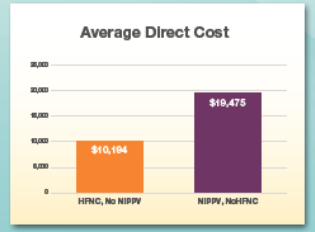
Methods

We evaluated all patients on HFNC from 1/1/2016 to 12/31/2019. We looked at where HFNC was initiated, whether it was used on the medical floors or whether an ICU admission was needed.

If an ICU transfer occurred, we then reviewed each case to determine if that patient required an escalation to NIPPV once in ICU. We then looked at the number of HFNC and NIPPV treatments from 1/1/2011 to 12/31/2019.

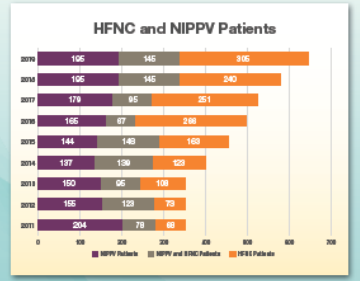


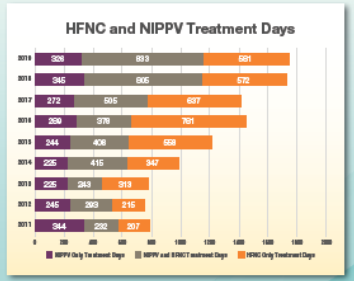


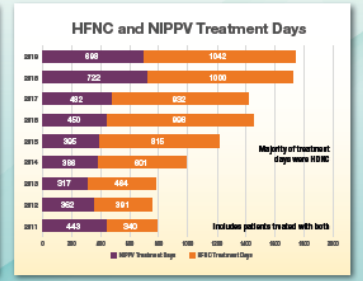


Results

From 2016-19 there were 1,517 patients admitted through the Emergency Department that were placed on HFNC. 564 patients were admitted directly to the medical floor on HFNC. 70 of these patients required a transfer to the ICU, where only 26 required NIPPV (26/564, 4.6%). 1,023 patients were admitted to the ICU and 568 were managed without NIPPV (56%). 188 patients were discharged to the floor from the ICU on HFNC, with none requiring rescue NIPPV. 129 HFNC ICU patients required NIPPV. 188 patients initially on NIPPV were transitioned to HFNC. 138 patients were on both during the day of admission to the ICU, not clear which was used first. HFNC patients treated on the medical floors were managed successfully without NIPPV 95.6% of the time. 494 ICU admissions were avoided, and many ICU days were decreased using HFNC. Over the 9-year period, there was a large increase in treatments with a shrinking percentage of NIPPV use. The average days on NIPPV was 1.65 and on HFNC was 2.96, many of these days on the floors. The average direct cost for patients treated with NIPPV, without HFNC, was $19,475. The average direct cost for HFNC, and no NIPPV was $10,194.







Conclusions

Patients requiring HFNC can be safely managed on the medical floor. This can free up ICU resources and decrease NIPPV use. Overall hospital costs were decreased. Decreased NIPPV use allows for increased available therapist time, as NIPPV is time and labor-intensive for RTs.

DISCLOSURES: Fascia, Pedley, & Acevedo: consultants for Fisher & Paykel. Acevedo: consultant for Monaghan Medical and Vapotherm.

CROUSE LUNG PARTNERS™
PRIMARY RESPIRATORY CARE

Recognition from CHEST

(American College of Chest Physicians)

FISH BOWL
AN INNOVATION COMPETITION

CHEST ANNUAL REPORT 2019

HOME | IMPACT | STORIES | CHEST FOUNDATION | FINANCIALS | JOIN US

[Education and Clinical Practice How I Do It]

CHEST

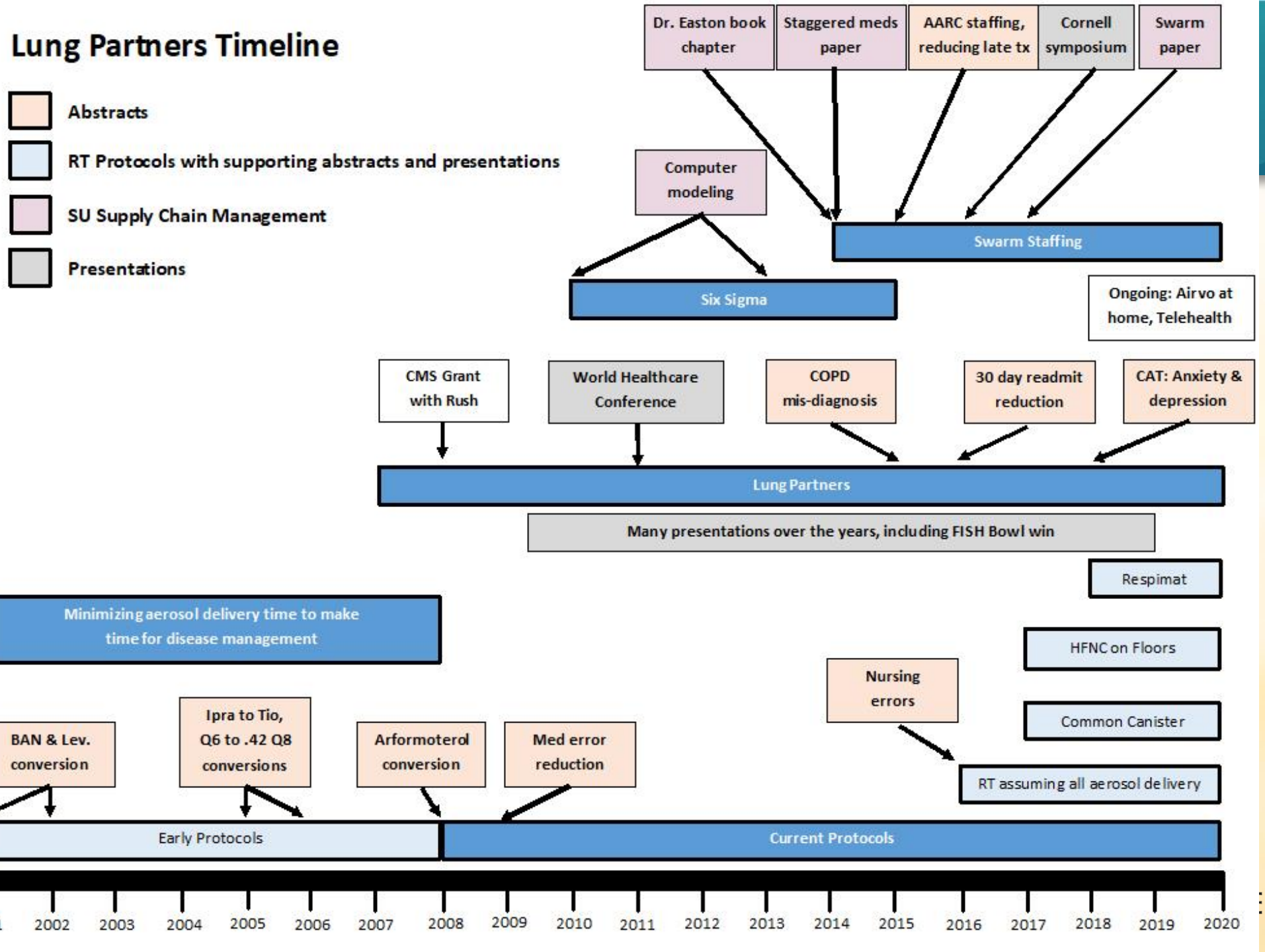
How to Create a Primary Respiratory Care Model

Check for updates

Russell A. Acevedo, MD; Wendy Fascia, MSRT; Jennifer Pedley, BS-RRT; Robert Pikarsky, BS-RRT; and Viren Kaul, MD

CROUSE HEALTH

Lung Partners Timeline



What We Have Learned

- Placing a Respiratory Therapist in a primary care role can be done and improve outcomes
- Fractionation of care can be reduced
- The only constant is change!
- We need to have RTs function at the fullest extent of their licensure to make best use of this valuable underutilized resource

Transition From Task Oriented to Patient Focused Primary Respiratory Care Department

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

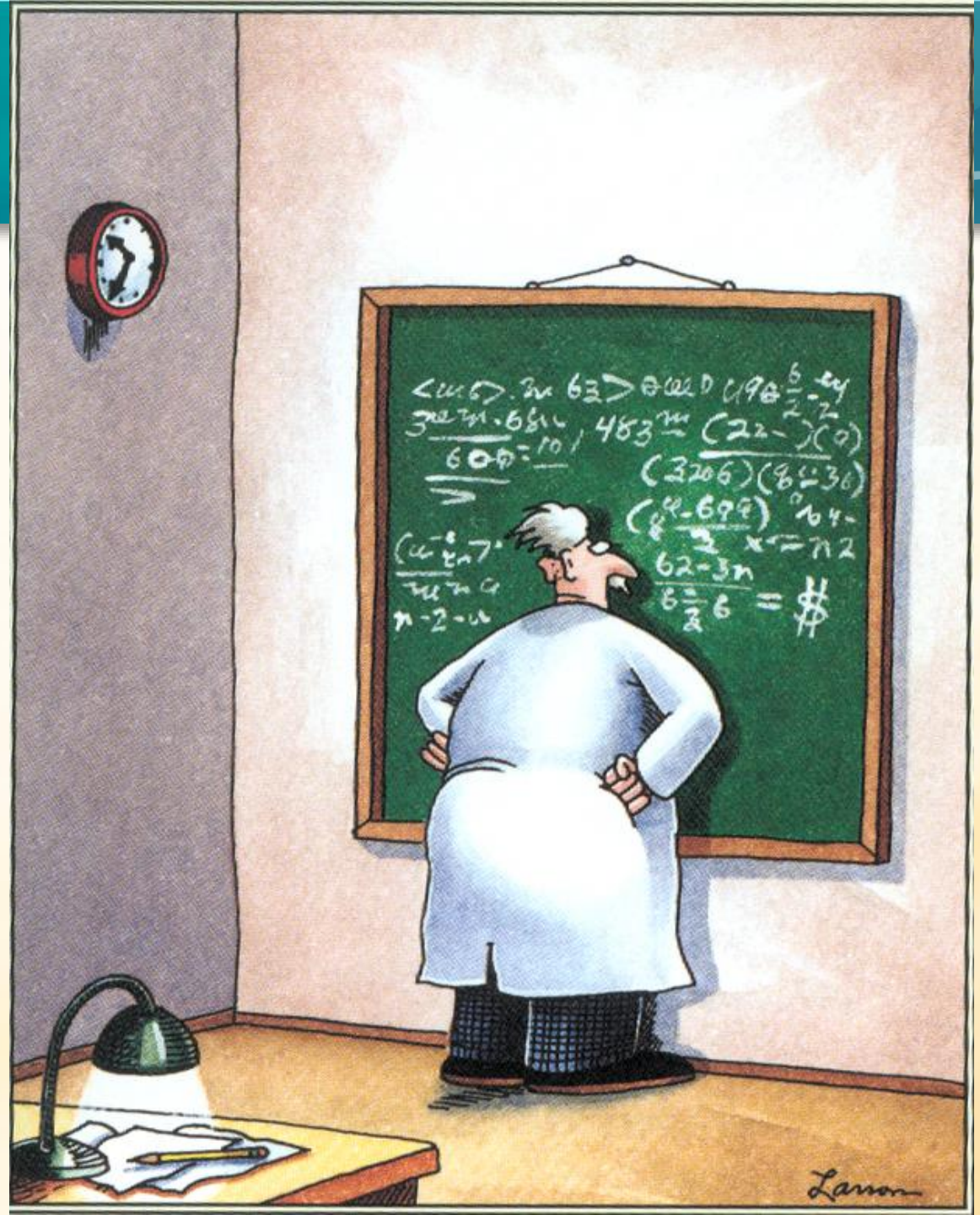
CROUSE HEALTH

Don’t Let the Widgets Get You Down!!

CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

CROUSE HEALTH

Einstein discovers that time is actually money!



CROUSE LUNG PARTNERS
PRIMARY RESPIRATORY CARE

Upcoming sessions

Tuesday, June 17| 11 a.m. – noon

Breast Cancer with Nuvance Health

Susan Boolbol, MD FACS – System Chief, Breast Surgical Oncology and Breast Program

Alecia Brophy, RN, BSN, BHCN – Navigator

Amanda Miller, LMSW – Social Worker, Division of Breast Surgery

Remaining sessions in this series:

- June 24 | Mental health and substance use disorders
- July 1| Building Community Partnerships

Care Connections

Questions?

Russell Acevedo, MD, FAARC, FCCP, FCCM
Crouse Health
russacevedomd@crouse.org

Morgan Black
Director, Care Connections
mblack@hanys.org

HANYS
Always There for Healthcare
SINCE 1925