18 Primary Care and Interaction with Specialty Care for the COPD Patient

Key Points
1. The Primary Care team will ultimately manage the care of the patient with COPD in close collaboration with Pulmonary Services.
2. Relationships between Primary Care and Pulmonary Specialists must be collaborative, fluid, and respectfully recognize each provider’s unique role in the care of the patient.
3. Traditional management of the COPD patient in the primary arena setting has changed and includes expanding roles and responsibilities of all team members.

18.1 Introduction: A Healthcare System in Crisis and New Models of Care

The U.S. Healthcare System continues to face a challenging environment including rising healthcare costs while achieving mediocre health outcomes for its population of 311 million people. The current healthcare system is saturated with inconsistent coordination and discontinuous care, poor access to both Primary Care and Specialty Services (Pulmonary; Cardiology) and increasing numbers of emergency room visits, hospitalizations and hospital readmissions (Ewing, 2013). In addition, the US spends approximately $3.6 trillion dollars per year on healthcare which is an average of over $8000.00 per citizen. In addition, the US population is living longer with an average life expectancy of 82.2 years for women and 77.4 years for men. With this aging population, the process of chronic disease management becomes critical in the Primary Care setting (Wat, 2014). The percentage of Americans struggling with a chronic disease such as cardiac disease, diabetes, hypertension, chronic obstructive pulmonary disease, obesity and cancer is staggering and affects at least 133 million adults which is nearly one in two adults. Seven percent of U.S. children also suffer from at least one chronic disease including diabetes, hypertension, and obesity. The consequences of these chronic disorders are sobering; 70% of all adult deaths are attributed to chronic diseases and more than 75% of the U.S. health care budget is spent on the management of chronic disease (Richmann, 2014). These results have stimulated the examination and testing of other models of providing and managing Primary Care to the U.S. population. One proposed solution is a redesign of the primary care outpatient setting called the Patient Centered Medical Home (Higgins, 2013).
The Patient Centered Family Medical Home Model is a patient driven, team based approach that delivers efficient, comprehensive, and continuous care through active communication and coordination of healthcare services (Daschle, 2013). It is based on a set of seven principles: 1) respect for the patient; 2) coordination and integration of care; 3) emphasis on communication and education between the patient and staff; 4) emphasis on physical comfort; 5) emotional support/alleviation of fear and anxiety; 6) involvement of family and friends and 7) attention to transition and continuity of care and improved access (Jackson, 2013). The Patient Centered Care Medical Home Model is also known by a variety of other names such as the Patient Aligned Care Team or PACT (Veterans Administration System). This team structure has the patient at the center of the process and dictates that the patient is no longer the passive recipient of healthcare but rather is viewed as an integral and active participant. In fact, the patient is recognized as the most important member of the healthcare team. Thus, the patient and provider are reconfigured into a shared decision making model where the patient ultimately will decide on the unique plan of his/her care. The matriarchal/patriarchal all-knowing physician is no longer viewed as the epitome of medical care. Surrounding that unique patient are the members of the Primary Care Team consisting of a Primary Care Provider (medical doctor, nurse practitioner or physician assistant), registered nurse, licensed practical nurse and medical support assistant. In addition, integrated into the Primary Care Team are allied health providers including nutrition, pharmacy, social work, and mental health (Yoon, 2013). (Figure 18.1).
To complicate improvement in primary care further, the U.S. continues to face a growing need for primary care physicians and will need an additional 52,000 doctors by 2025. The reasons for the primary care physician shortage are complex and include population growth, an aging population, the rising cost of medical school, more lucrative specialty care opportunities, and scope of practice laws. There is projected to be a substantial shortage of non-primary care specialists of 33,100 in specialties such as cardiology, oncology, and emergency medicine. Thus, other providers such as nurse practitioners and physician assistants are helping to fill the gap in care. In addition, other allied health providers such as nutritionists, pharmacists, mental health providers, and physical therapists are being relied upon more frequently to help in the management of chronic disease and lifestyle issues (Herman, 2014).

Specialty care is viewed as a secondary tier and to be consulted only when primary care has a question or problem with a complex patient. In this model, only the most complex and sickest patients are seen by specialty care. This practice redesign creates improved access for specialty care; however, it conversely increases the workload for the primary care team. It is expected that the primary care team will manage most of the care of the patient including specialty services. This assumes that the primary care team has additional skills, experience and professional development to feel comfortable in managing the complex specialty patient (Pagan, 2013).

18.3 How Does the PACT Team Differ from Traditional Roles/Responsibilities?

The Family Medical Home or Patient Aligned Care Team must have an organizational foundation of patient centeredness, continuous improvement, and adequate resources. The very structure of the team is built on patient access, care management, and coordination and practice redesign. Patient access to the team is a cornerstone of practice; however, the traditional face-to-face provider patient visit is rapidly being reconstructed to include non-traditional visits such as scheduled telephone visits when a physical exam is not needed, secure messaging (email), and group medical appointments for chronic disease management. The patient is typically seen on an annual basis for a wellness exam and certainly for ill visits when a physical exam is imperative. Thus, the non-traditional visits allow improved access via alternative pathways for patients to interact with their family medical home. In addition, other allied professionals including nutrition, social work, mental health, pharmacy and, in some settings, substance abuse, chronic disease case management (COPD/Diabetes), and physical therapy are relied upon for their expertise. These professionals are integrated directly into the teams. In this way, patients are able to access a variety of professionals at point of care in the primary care setting as a formalized appointment or as a “warm handoff” (Roseland, 2013).
How Does the PACT Team Differ from Traditional Roles/Responsibilities?

Patient care management and coordination are key to the family medical home. In particular, the team identifies those patients who are at higher risk for emergency room visits and inpatient hospitalizations due to their complex medical and psychological histories. Chronically ill patients (COPD, diabetes, coronary artery disease) are followed more closely utilizing non-traditional visits with the team nurses and allied health professionals. Team care is focused on prevention, management of chronic disease, and coordinating transitions of care. In particular, continuity of care can be challenging when patients are seen by specialty care, in the emergency room and/or admitted and discharged from inpatient hospital stays. The problems most commonly encountered include discrepancies in medication management, failure to understand medications, and overall lack of understanding in the plan of care. This is true not only for the patient but often for the primary care team and creates tension often between services. Primary care often feels as if they are responsible for coordinating the care for a patient with limited communication from specialty care (Plaisance, 2010; Kilo, 2010; Gardner, 2014).

Finally practice redesign has been instrumental in the reconfiguration of how primary care is provided to the patient. The family medical home has expanded the roles, responsibilities, and tasks of each member of the team. Each team member is encouraged to practice at the top of their educational level (Swartwout, 2014). This team approach enables its members to value each member’s skills and expertise, thereby promoting communication and teamwork. Frequently teams have designated weekly meetings to discuss high risk patients and management strategies. During these team meetings, workload dealing with both patient visits and non-visit work such as paperwork for family medical leave is discussed and distributed as dictated by time, skill level, educational competencies, and training. In this way, all visit and non-visit work is distributed amongst the team members, freeing up the provider to focus on patient management (Coulmont, 2013). (Figure 18.2)
18.4 General Roles of the PACT Team

The patient centered primary care team includes the patient, clerical associate, clinical associate, nurse care manager and the provider. Each team member is responsible for a specific function within the PACT. The patient is central to the entire team and has the responsibility to schedule appointments as needed, participate in face to face visits, prepare for primary care visits, and participate in all care. The clerical associate specializes in customer service, team work, and clerical office support. Direct patient care, secure messaging, care management, teamwork, patient education and clinical support are the duties of a PACT clinical associate. The nurse care manager anchors the team with a multitude of duties including: direct patient care, group visits, patient/family education, disease management, daily huddles, team meetings, health education, and patient coaching. Finally, the provider focuses on the management of complex patients through direct patient care, group visits, telephone visits, and secure messaging (Maeng, 2013; Hoff, 2013; Baxter, 2013).

18.5 Care Management of the COPD Patient PACT Roles and Responsibilities

Comprehensive care management of the total patient is the cornerstone of PACT team practice. Importantly, the patient is at the center of the structure of his/her management. For a patient with COPD, this structure becomes even more critical to optimize pulmonary health and prevent further disease progression. Surrounding that structure are the tools necessary to help the patient maintain optimal health including: personalized health care planning, labs/imaging studies, medication reconciliation, preventive services, protocols, consults, referrals, and local community resources (Comlossy, 2012).

18.5.1 The Patient

First and foremost, the patient is involved at the very beginning of his/her primary care visit and plan of specialty care. This model dictates that the patient is responsible for scheduling appointments, preparing for appointments, and participating in his/her unique plan of care. The personalized health plan (PHP) is a tool used to individualize the care provided by the team for that patient. It is patient driven, holistic in approach, and offers the patient a choice of what area of their health care they would like to improve. There are a variety of models but they all center around the broader questions of why health is important to the patient and the patient’s selection of the primary health focus. The tools present areas of health assessment and prevention such as: be tobacco free, eat wisely, be physically active, limit alcohol, feel spiritu-
ally connected, manage stress, and be involved in one’s healthcare. Thus, the patient chooses their area of focus and the team becomes more of a coach to help that patient achieve their self-determined goal. This approach is a fundamental change in how healthcare is now being delivered in the United States. Historically, it was the provider (almost always a physician) who dictated to the patient the plan of care. There was almost always no negotiation, limited discussion, and minimal education given to the patient. Now the patient has become the central player in the delivery of his/her own healthcare and as such the process has become more equalized and a more shared decision making process (Jarousse, 2013; Berryman, 2013). For the patient with COPD, the PHP can focus on tobacco cessation, medication review, proper use of inhalers and participation in pulmonary rehabilitation. The plan may also focus on a mental health issues common to COPD patients such as depression or anxiety.

Laboratory and imaging studies are important diagnostic tools used to diagnose and treat illness. In this model, the patient is able to obtain his/her results by accessing a secure website which includes all the components of the patients’ electronic medical chart or EMC. In this way, the patient again has access to critical data in the individualized plan of care (Jampel, 2013; Mancuso, 2013).

18.5.2 Clerical Associate (CA)

This member of the team is the first line of contact with the patient and the very face of the PACT Team. As such, all initial communication relating to patient visits and concerns are triaged through this team member including such things as scheduling, reminder calls, managing sick and informational calls to the team, obtaining outside records, faxing information back to outside facilities, and issues with customer service. Clerical associates are experts in day to day mechanics of running an outpatient office. For the COPD patient, the clerical associate will need a basic understanding of the disease so that when a patient calls, the clerical associate can assist in triaging the severity of the patient’s symptoms and can schedule an emergent ill visit with a provider or other appropriate healthcare visit. Integral to the management of a specialty patient, any recent change in care such as an inpatient stay or change in medication will need to be verified though acquisition of records (McNellis, 2013).

18.5.3 The Clinical Associate

The clinical associate is the first clinical person to assess the patient after they are checked into the PACT Team. As such, the associate performs the initial assessment of the patient including collection of data related to the visit, vital signs, prevention screening, and administration of immunizations, medications, and treatments. This team member is the initial responder to triaged messages (secure messaging) as well
as telephone messages related to clinical concerns. It is often this team member who reminds the provider that the patient with COPD requires immunizations such as influenza and pneumonia vaccinations. The clinical associate is also trained to do point of care screening with spirometry for the patient suspected of having a pulmonary disorder. This clinical member is often the educator and instructs the patient on the use of his/her inhalers and the use of a spacer. The personalized health care plan for the COPD patient is often started by the clinical associate. Often this clinical member is the first to initiate treatment or other medications promptly (True, 2013).

18.5.4 Nurse Case Manager

This professional registered nurse anchors the team and provides direct patient care, triaging and clinically responding to secure messaging, phone calls and walk-in ill visits. The nurse is responsible for assisting with chronic disease management, coordinating transitions of care, and daily team work.

This team member is an expert in medication reconciliation which is especially important for the patient with COPD. Medication reconciliation continues to be one of the most important tasks for both the team and patient and it may be extremely time consuming to perform medication reconciliation correctly. Often medications are changed during a specialty visit or inpatient hospital stay and poorly communicated to both the patient and the PACT. The nurse case manager is an expert educator and reviews each medication with the patient including its purpose and how and when it is to be administered. The nurse is able to assess clinically a specialty patient and determine the needs of that patient in consultation with the primary care provider. This team member has a huge role in both family and patient education, coordination of transitions of care referrals such as pulmonary rehabilitation, home care, palliative care and hospice. The care manager also has a vast knowledge of outside community resources which may be of use for a COPD patient including meals on wheels, the Council On Aging and the American Cancer Society (Worth, 2012; Lewis, 2012).

18.5.5 The Provider

The provider in a PACT is an expert in direct patient care. Direct patient care as redesigned in PACT includes not only traditional face-to-face visits (well and ill visits) but also non-traditional visits such as telephone visits, secure messaging, and group medical appointments. The use of alternative visits theoretically improves patients’ access to their provider and teams. Telephone visits are used when a physical exam is not necessary and the patient issue can be resolved on the telephone. Telephone visits are frequently used for a follow up from a previous visit, medication titration, discussion related to labs and imaging and plan of care. Secure messaging (by email)
is an easy way for a provider to answer a question, renew a medication, or assess a patient issue in writing. Group visits are used to educate and manage chronically ill patients with the same diagnosis. The provider’s main role is to provide care for patients through disease management of both complex and stable/chronic patients, preventative care, record review, view alerts, review of diagnostic results, referrals to specialty care, final medication reconciliation, initiation of the personalized health care plan, narcotic contracts, and referrals to additional community resources and services (Hoff, 2012; VA Teamlet training 2013).

18.6 COPD and PACT

The recognition and diagnosis of COPD are the initial steps in the provision of COPD care management. All patients with a history of tobacco use and/or environmental exposure and respiratory symptoms should be evaluated with spirometry to determine the presence of airflow limitation. Spirometry and pulmonary function tests are interpreted by specialty care; however, the interpretation and results still need to be reviewed and understood by the provider. In many cases, patients are assigned a diagnosis of COPD without adequate diagnostic testing. This leads to incorrect diagnosis and treatment. After diagnosis, the provider will need to determine what medications should be ordered for the patient based on the physical assessment and patient evaluation. The provider should be familiar with the different classes of respiratory medications such as short and long acting β adrenergic agonists and anti-cholinergics commonly used for the treatment of COPD. A basic understanding of aerosol inhalers, the use of spacers, and the ability to instruct patients how to use their inhalers correctly is critical. Other basics needed to properly assess the COPD patient are baseline studies such as chest x-rays, electrocardiogram, and annual labs. Preventative immunizations (influenza and pneumococcal vaccines) are essential. Tobacco cessation should always be discussed and assessed as stopping smoking is the single most important life change a COPD patient can make. An emergency plan is critical when exacerbations are expected and should include a treatment plan (antibiotics and steroids) and the patient must be instructed on how and when to use the emergency plan. Pulmonary rehabilitation should always be discussed with patients and they should be referred when appropriate. Medication reconciliation is imperative for both the provider and the COPD patient. Finally, it is the provider who should finish the personalized health care plan and negotiate goal setting and subsequent primary care appointments with the patient (Panos, 2013).

In conclusion, care management for the COPD patient is complex and requires a team approach to meet the patient’s needs. Several areas of management can be initiated by all clinical team members including direct patient care, medication reconciliation, required referrals, and initiation of the PHP. (Figure 18.3).
The Primary Care Provider and PACT team are the patients’ first line of entry into the health care system. The team needs to be familiar with the recognition and early diagnosis of COPD to properly manage these complex patients.

It is important to note that primary care PACTs may need extra training and education to feel comfortable when managing complex chronically ill pulmonary patients. Providers who attended a six week mini-COPD residency at the Cincinnati VA Medical center found that they were more comfortable with the COPD patient. This education provided the PACTs and the specialists time to get to know one another and to learn each other’s role in keeping the COPD patient healthy. The residency was a series of six lectures on the basics of COPD, early recognition and diagnosis, spirometry and interpretation of pulmonary function tests, medications specific to COPD and proper use of inhalers and spacers, smoking cessation, Motivational Interviewing and multiple case studies for review (Panos, 2013).

A team approach with not only the PACT but integrating the pharmacist and the social worker into the team is instrumental. In a 2013 qualitative study, COPD patients were unclear of their medications, had multiple social and mental health issues and needed extra nursing education to better manage their chronic disease (Mulhall, 2013).

Specialty care is an important piece of the COPD patient’s overall plan of care. Pulmonologists should be utilized for those complex respiratory patients who are difficult to manage. They should be used a resource service and provide expert guidance on the management of the COPD patient. A COPD nurse educator or manager of pulmonary rehabilitation may also be used by the PACT as a resource for patient education, clinical questions, and may act as a bridge to connect the inpatient and outpatient services ensuring continuity of care.
Finally, the COPD patient will typically have exacerbations and remissions of their chronic disease state and may require hospitalizations to stabilize their pulmonary status. Thus, hospitalists will be managing the patient while they are inpatients and may request input from specialty care. Again, communication is at the forefront of transitions of care and the individualized plan of care needs to be communicated back to that primary care provider and PACT (Panos, 2013). A transition of care discharge summary note to help to direct care at patient discharge should be written by the hospitalist/pulmonologist and flagged to the team. This communication ensures continuity of care and helps the team manage the COPD patient in the outpatient setting.

COPD patients are not only complex medically but often need additional support from other specialists including mental health and tobacco cessation counselors. These additional professionals can help in the management of tobacco use/abuse and mental health issues such as anxiety and depression (Bao, 2013).

In conclusion, a partnership needs to exist between the patient, the primary care PACT, the pulmonary specialist and allied health providers. Through this partnership (Figure 18.4), the patient should obtain the best care for a long, active, and meaningful life (Pourat, 2013).

18.7 Summary Points

1. The US health care delivery system is evolving toward a Patient Centered Family Medical Home Model.
2. Comprehensive care management focuses all team members including administrative/clerical, nursing, and provider staff on the patient and everyone functions at their maximal level.

3. Management of patients with COPD involves a cadre of primary care team members and specialists whose collaboration, integration, and communication is essential for optimal care.

References


Department of Veterans Affairs. (2014). VA Teamlet Training.


Plaisance, N.H. (2012). Care coordination a fundamental pillar to PCMH, but some find it easier than others to implement. *MGMA Connexion, 12*(1), 42–43.


