

PULMONARY DISEASE NAVIGATOR
P1 - INTRODUCTION

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Pulmonary Disease Navigator and Respiratory Care Educator

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OBJECTIVES

History and Foundations of Navigation

Rationale and Value-Based Care

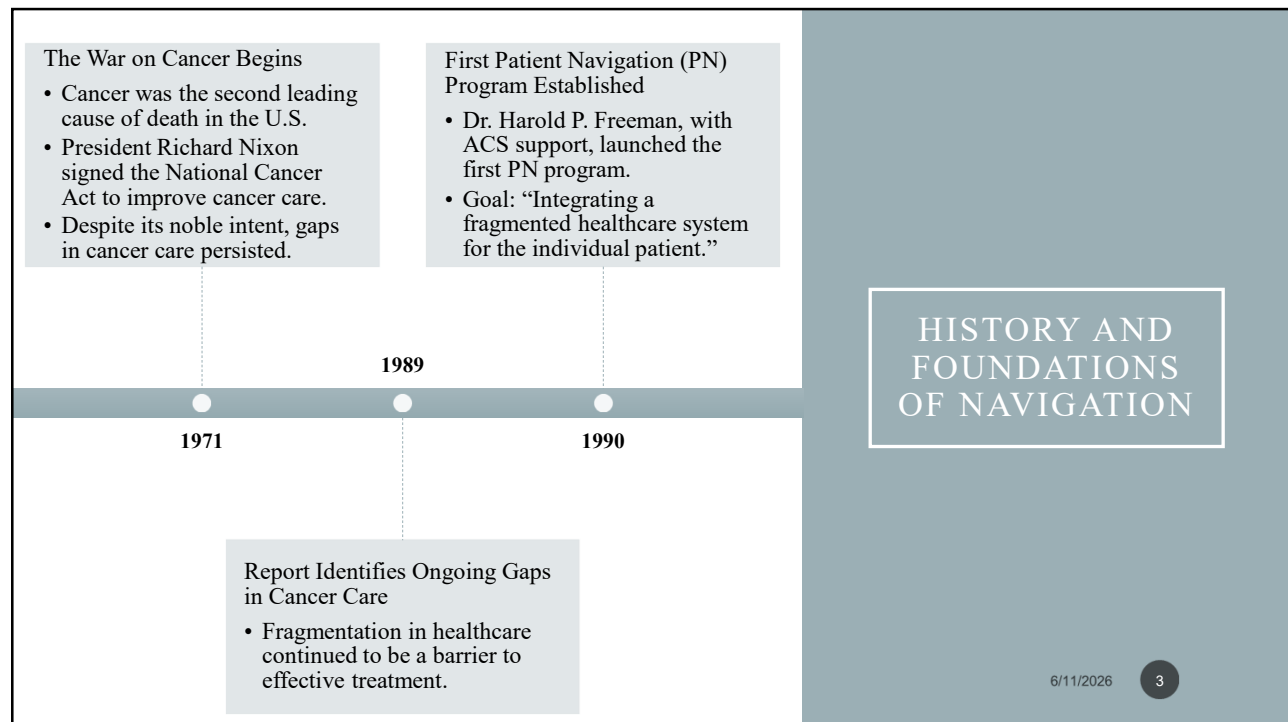
Pulmonary Disease *and* Navigation

Requirements and KSAs

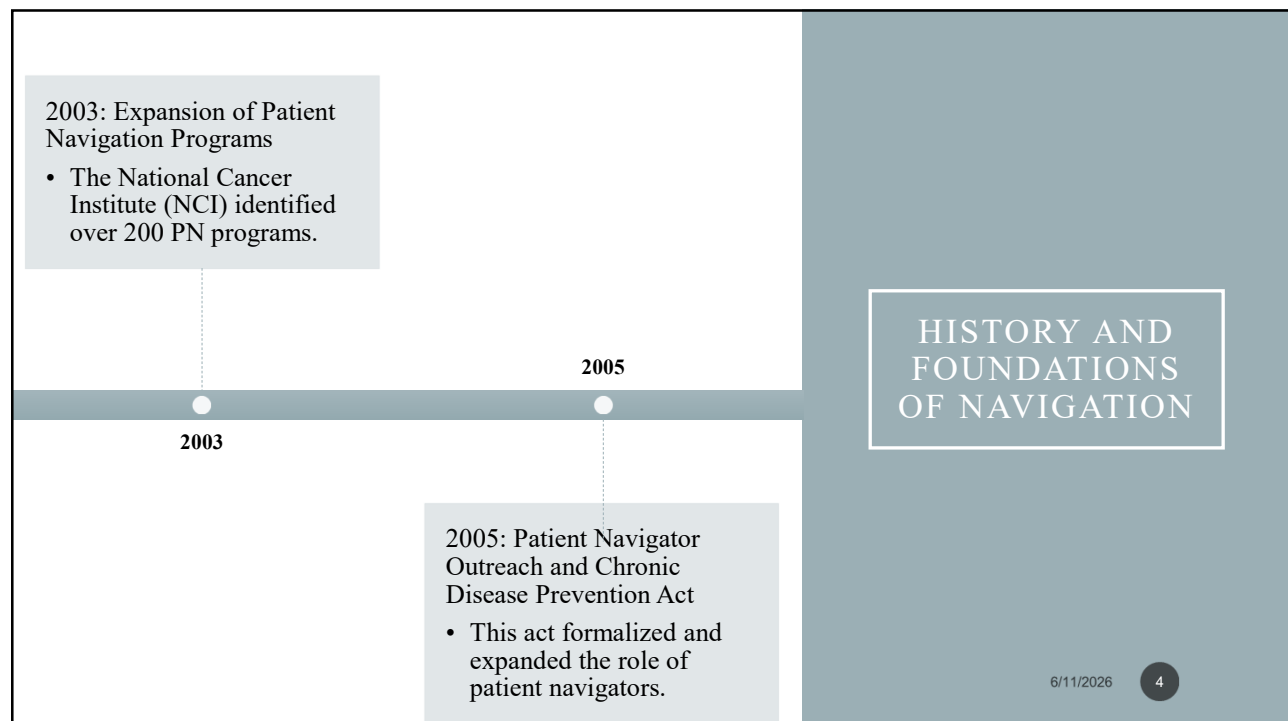
Navigating

Metrics for Success and the So-What

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CANCER → COPD → AND ONWARD

Cancer Mortality Trends (1971–Present)

- Remained the **2nd leading cause of death** worldwide since 1971.
- Continued national focus and funding for research and treatment improvements.

COPD Mortality Trends (1971–2023)

- **1971:** Ranked **10th** as a cause of death in the U.S.
- **2023:** Climbed to the **4th leading cause of death worldwide – 6th in the U.S.**
- Increasing death rates and declining quality of life for COPD patients.

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NO
BETTER
SOLUTION

Respiratory Therapists as Pulmonary Navigators

- **Need for Immediate Action**
 - COPD's rising mortality rate mirrors the urgency seen in the 1971 cancer crisis.
 - A structured, patient-centered approach is necessary to improve outcomes.
- **Respiratory Therapists (RTs) as the Solution**
 - RTs are trained to assess, implement, and deescalate cardiopulmonary care.
 - Positioned to integrate care, reduce hospital readmissions, and enhance quality of life.

Just as patient navigation redefined cancer care, pulmonary navigation can transform COPD management.

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FOUNDATIONS

Healthcare models define how care should be delivered to improve access, continuity, and patient outcomes.

Patient navigation aligns with patient-centric and biopsychosocial (BPS) models of care.

These frameworks ensure biological, psychological, and social factors influencing health are addressed.

A patient-centered approach builds trust, promotes education, autonomy, and accountability.

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FOUNDATIONS - PATIENT-CENTRIC CARE & THE BIOPSYCHOSOCIAL MODEL (BPSM)

- **Carl Rogers** (1950s) introduced *client-centered* care: emphasizing empathy, respect, and holistic understanding of patients while eliminating biases and emotional invalidation → **George Engel & John Romano (1970s)**: biopsychosocial model (BPSm), integrating biomedical, psychological, and social factors into care, highlighting the role of **lifestyle, social capital, and health literacy** in health outcomes.
- **Harvey Picker & Patient-Centered Care Expansion (1980s-1990s)**
 - Established the Picker Institute (1980s) to promote patient and family-centered care.
 - **Core principles**: respect for patient values, care coordination, effective communication, emotional support, family involvement, physical comfort, and smooth care transitions.

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FOUNDATIONS - PATIENT-CENTRIC CARE & THE BIOPSYCHOSOCIAL MODEL (BPSM)

- Navigators **combat SDoH-related disparities** by ensuring:
 - Correct diagnosis, treatment, medications, and specialist involvement.
 - A personalized, patient-centered care plan, rather than a disease-focused approach.
- **Integrated Care Model:**
 - Merges biomedical expertise, patient-centric care, and BPSm principles.
 - Meets the patient where they are, ensuring an individualized, effective navigation process.
 - Reinforces continuity, trust, and improved patient outcomes.

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- **Global and U.S. Prevalence:** **15.7 million Americans** diagnosed with COPD in 2018. - **392 million cases worldwide**, projected to reach **600 million by 2050**.
- **Disease Characteristics:** Heterogeneous lung disease with chronic respiratory symptoms and progressive airflow obstruction - Caused by airway and alveolar abnormalities.
- **Risk Factors: Smoking, occupational, and environmental hazards** - Genetic forms like alpha-1 antitrypsin deficiency remain underdiagnosed (~2 million cases).
- **Mortality Impact:** 6th (varies w C19 data) leading cause of death in the U.S. and 4th globally - 3.5+ million deaths worldwide in 2019. 130k in the US annually.
- **Healthcare Burden in the U.S.:** **+920,000 emergency visits** and **nearly 700,000 hospitalizations** annually - \$50 billion in annual healthcare costs, with 70% spent on exacerbation-related hospitalizations – **direct care costs projected to total \$1 trillion between 2019 and 2038**
- **Hospital Readmissions:** **3rd/4th leading cause of hospital readmissions in the U.S.** - 18–22% of patients readmitted within a month - \$15,200–\$20,000 per readmission, often due to **limited access to providers, nutrition, and medication.** – poor quality care

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ROOT CAUSE

- Step outside the financial, clinical, and administrative
 - Decrease QOL
 - Decreased mobility
 - Some are symptomatic all day - everyday.
- Let's not forget the root of healthcare



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GENERAL REQUIREMENTS - PDN

3 to 5 years as a clinical practitioner
 Bachelor's degree in Respiratory Care
 1 to 3 years of experience as an educator
 If applicable, obtain Pulmonary Disease
 Educator endorsement (NC)



There is NO formal training for PDN

Much of the training is on the job as there is not a standardized program

Knowledge, Skills, and Abilities (KSAs) for not only clinical but administrative duties, too.

Facility usually determines competencies such as determining pt. needs and barriers, and networking to close the gaps

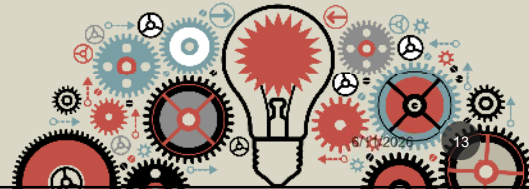
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KNOWLEDGE

- Respiratory Care
 - Clinical and operational
 - Clinical is generally standardized
 - Operation would be molded by facility workflow and other external influences
 - Policy, protocol, law
- Ethics
 - A means of running a business in healthcare
- Administrative
 - Other departmental duties and resources - Supply chain
 - In depth EMR knowledge and navigation
- Social
 - Pop. health statistics, demographics, etc.
- Professional



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SKILLS

- Perk of Pulmonary Disease Navigation lead by an RT
 - Specific knowledge
 - Specific skills
- The not-so-perk
 - Not many RTs practice administratively
 - Not many RTs have PFT experience
 - That's the beauty of it – its new – its developing – its building mentors



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ABILITIES

Abilities are not much more than the *capacity to express the skill*. Typically, abilities are the tasks* completed on the job.

- Innate to the individual
- CAN, CANT, and COULD



- Cognitive/Emotional
 - I can empathize
 - I catch on to ethical situations
 - I can understand the subject and I can build on my knowledge-base.
 - I can think fast
 - I can plan and organize
 - I am reliable and tenacious
- Physical
 - I can manually do these things
 - I have balance and stamina
- Ability is lifting a 50lbs box
- Skill is doing it efficiently

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WHAT'S THE JOB LIKE

- Patient interview and assessment
 - Provider or self/algorithmic consult
 - Collect and review pertinent subjective and objective data - interview
- Needs and resources
 - Identify provider gaps
 - Introduce resources
 - Compile clinical recommendations
- Wrap up and follow through
 - Line up resources to close gaps in care and follow up with the patient 48hrs after discharge*

- Outcome metrics are generally set by the facility
- Flexibility
- Autonomy and communication with leaders
- Professional growth and exposure



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DIFFERENCE IN PN AND CM

- Case management helps patients follow established clinical protocols, and promotes patient safety, quality of care, and cost-effective outcomes.
- Navigation employs this with focused expertise.
 - Provide a holistic approach that includes the medical and the social.
 - Make care realistic and humanistic

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NOTE - STEPWISE

PULMONARY DISEASE NAVIGATOR ASSESSMENT – FULL NOTE

Navigator: Chandler Jones, MSHA, RRT, RRT-ACCS, RRT-NPS, CPFT, PDE
 Reason for Admission: *** - Utility Risk: ***, CORE+ COPD Readmission Risk Score: ***.

Initial consult for SDOH needs and summary of recommendations per NH Pulmonary Disease Navigator Algorithm and/or 2025 GOLD Guidelines: (***) PFT *possibly* shows **GOLD Grade *****, *** **COPD** with pre-FEV1 ***% and pre-FEV1/FVC ***%. In the last twelve months ≥ 1 hospitalization as a result of pulmonary decline - CAT ≥ 10 , mMRC ≥ 2 , STOPBANG ≥ 3 , placing the patient as a **Group *** COPD**. Patient presented to facility due to ***.

•**SDOH:** Patient is/**IS NOT***** established with Novant/**non-Novant***** PCP. Patient is/**IS NOT***** followed by Salem Chest Specialists*** for pulmonary needs. Patient lives with *** in a *** **WITH**/***/without*** triggers. Patient states they can/**CAN NOT***** mobilize adequately at home and at baseline. Patient feels safe/**UNSAFE***** in home/neighborhood. Pt does/**DOES NOT***** have insurance. Patient can/**CAN NOT***** afford and obtain/sustain their medications and living arrangements. Patient does/**DOES NOT***** have primary and secondary transportation. Patient **DOES**/***/does not have food/necessity insecurities. Patient social support consists of ***. Patient is/***/**IS NOT** up to date on vaccines. There **WERE**/***/were no discernable educational/cognitive barriers and the patient was able to recall disease specific knowledge when prompted and/or information was provided. An individualized action plan was discussed. Patient expected to be discharged: ***.

o**Plan:** Meds-Beds, Nutrition, Case Management, Community Health Worker, Care Connections: ***, and patient education/action plan.

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• **Pertinent Medication:** ***.

○ **Recommended Changes:** Consider discharging with (pending any contraindications/coverage) ***. Consider alternative therapy such as addition of vitamin D, daliresp, ohtuvayre, or dupixent, daily steroids/abx, symptom management medications.

○ **Peak Inspiratory Flow Rate Assessment Details:**

Peak Inspiratory Flow

*** L/min for pMDI/HFA

*** L/min for Med-Low (Ellipta)

Interpretation:

- **Effort:** ***. Based on the PIFR values above, the patient's inspiratory flow rate is: Adequate/**NOT ADEQUATE***** and does/**DOES NOT***** currently meet *optimal* inspiratory flow for current home inhaled medication therapy.

Notes: Coached and educated on proper use and inhalation technique. **Avoid DPI until PIFR is ≥ 60 L/min***.**

• **Smoking, Cessation, Exposures, and Allergies:** *** ppd for *** years. Quit: ***. Patient **DOES**/does not*** meet criteria for lung cancer screening. Patient **IS/IS NOT***** ready to quit and endorses understanding of the impact of smoking cessation***. Patient advised to quit smoking***. Pt prophylactically cautioned against smoking with or around oxygen.

○ **Fagerstrom Score:** ≥ 4 , or low to moderate nicotine dependence. **Recommendation:** Patches: 14mg/24hr patch, Inhaler: 6 –12 cartridges/day, Lozenge/Gum: 2mg; or Patches: 14mg/24hrs and Lozenge/Gum: 2mg ***.

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• **PAP Therapy:** ***

• **Bronchial Hygiene:** OPEP/IS/OLE/Vest***

• **Oxygen Therapy:** Uses: RA*** ***L/min. 6MWT if not on home oxygen or to assess new oxygen requirements.

• **Early Mobility while IP and OP Pulmonary Rehabilitation** - ***

• **Palliative Care:** GOC and/or OP Palliative Care

- ROM ≥ 80 and/or FEV1 ≤ 60 or EF ≤ 40

- PCO2 ≥ 52 mmHg

- BMI ≤ 22 or ≥ 30

- Home O2/NIV

- LT Steroids/LT Abx

- ≥ 2 ED visits in 12mo

• **Other Recommendations/Considerations:** Respiratory Care Assess and Treat. Alpha-1 Antitrypsin Deficiency Screening. Follow up PIFR Measurement. Updated Vaccines. Drug/Alcohol Rehabilitation/Counseling***. OP Psychiatric/Behavioral Therapy - ACT/CBT for chronic disease. MDI Spacer. COPD Bridge Program (Rotech)***. Meets criteria for Zephyr Valve***.

• **CHF:** (***). LVEF - ***. Patient does does not have a scale. Patient does does not weigh every day. Patient does does not have a blood pressure cuff. Patient abides by low sodium and/or fluid restricted diet - Yes No . CHF education was provided, reviewed, and understood requires follow up . Subject matter discussed includes disease process, daily weight, sodium restriction/intake, fluid restriction/intake, signs and symptoms, medications involved with CHF treatment, and cardiac rehabilitation. A CHF action plan was included and was discussed with the patient. Pt is aware of signs and symptoms of exacerbation .

• **Follow Up:** Patient will need follow up with PCP/Cardiology in 4-7 days, OP Pulmonary in 2-4wks.

Per NH Clinical Documentation Improvement Pulmonary Reference Guide, ICD Codes J41.X, J43.X, J98.3, J44.X, J45.XXX, J47.X, J96.1 require a *resulted* PFT. Please take caution when adding ICD dx code w/o clinical documentation. 2025 GOLD guidelines state that spirometry which demonstrates the presence of a *post-bronchodilator* FEV1/FVC < 0.7 (70%) is *mandatory* to establish the diagnosis of COPD. Please include appropriate diagnosis in the chart.

*These recommendations have been sent to *** or have been placed via protocol*

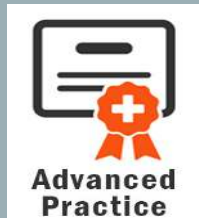
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IT HINTS AT APRT

- Medication recommendation
- Referral for diagnostic testing
- PFT interpretation and disease staging
- Inter/multi disciplinary team interaction
- Building the scope
- Tons of autonomy
- RT driven protocols



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PATIENT IMPACT



- How does this type of role impact our most valued and impacted stakeholders – the patient?
 - Patients are educated and this allows for a more robust and informed plan of care
 - LOS decrease (Kwan, 2014; PIH, 2023)
 - Costs (and penalties) decrease (Worland et al., 2022)
 - Patient's needs are addressed (Natale-Pereira et al., 2014)
 - THERE IS TRUE CONTINUUM OF CARE

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SO WHAT? FUTURE NEED

- Pulmonary Navigation is a niche field that is growing - its growing from need
- Furthers our goals of advanced degrees
- Historically low provider rates
- Volume-base vs value-base
- Can be molded to fit any initiative
- Can be used other than COPD

- The big problem is marketability, function, and scope.
- Were in a position now where we can show the benefits of a PDN program
- There needs to be a systematic approach to creating PDN specific programs



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THANK YOU


Chandler Jones, MSHA, RRT, RRT-ACCS, RRT-NPS, CPFT, PDE
 Pulmonary Disease Navigator and Adjunct
 Professor for Respiratory Care | #atthetopofyourl...



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PULMONARY DISEASE NAVIGATOR P2 - IMPLEMENTATION & OUTCOMES

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OBJECTIVES



Recap - Introduction



Metrics for Success



Literature Review



Current Program and Challenges



Selling it to C-Suite/Implementation



The So What

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- Discussed the history, foundation, and purpose of navigation
 - Dr. Harold Freeman
 - Biopsychosocial models, patient-centered care, integrated care
 - To alleviate the stressors encountered while utilizing healthcare services by multiple means
- Looked at COPD as a major cause of death globally, as a financial siphon, and a chronic burden to quality of life
- Pulmonary navigation from my window, requirements, KSA and more
- Patient impact and future needs

RECAP

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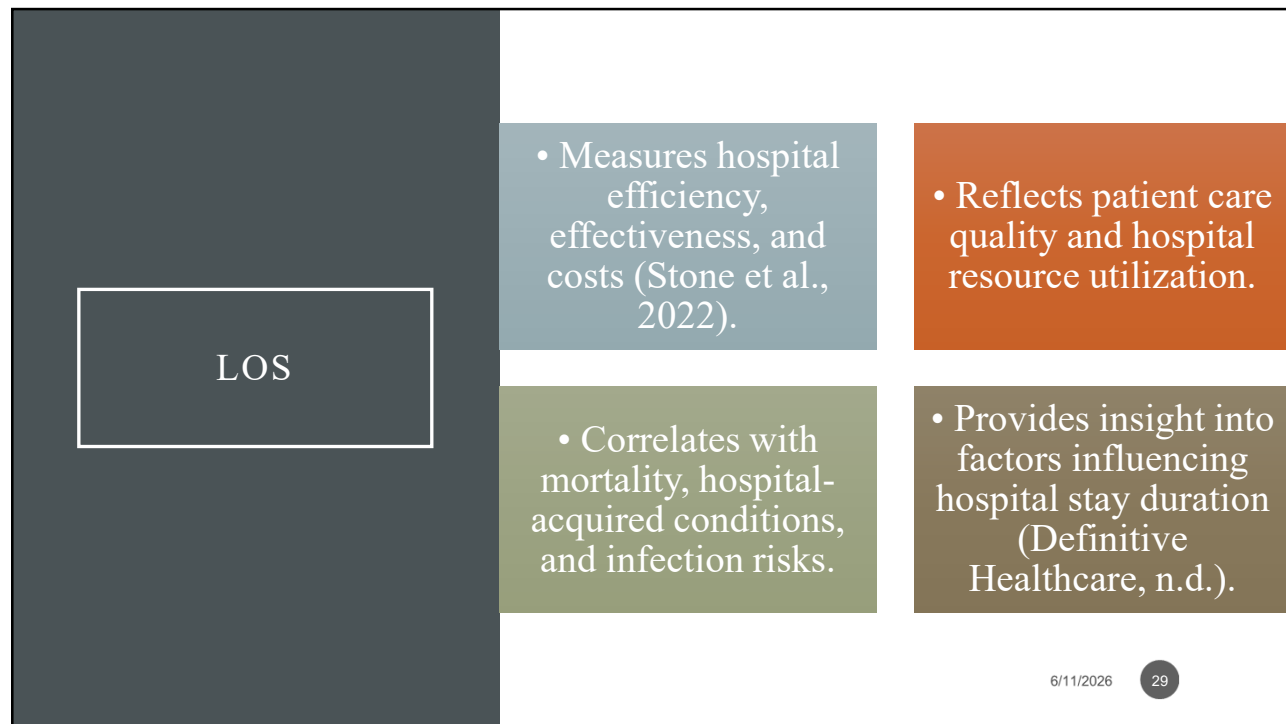
METRICS FOR SUCCESS

- Patient navigation aligns with current quality driven metrics by nature
- Identify high-value, high-impact, evidence-based measures that promote better patient outcomes
- Provide useful information for improvement, decision-making and payment.
- Align measures across public and private payers to achieve congruence in the measures being used for quality improvement, transparency, and payment purposes.

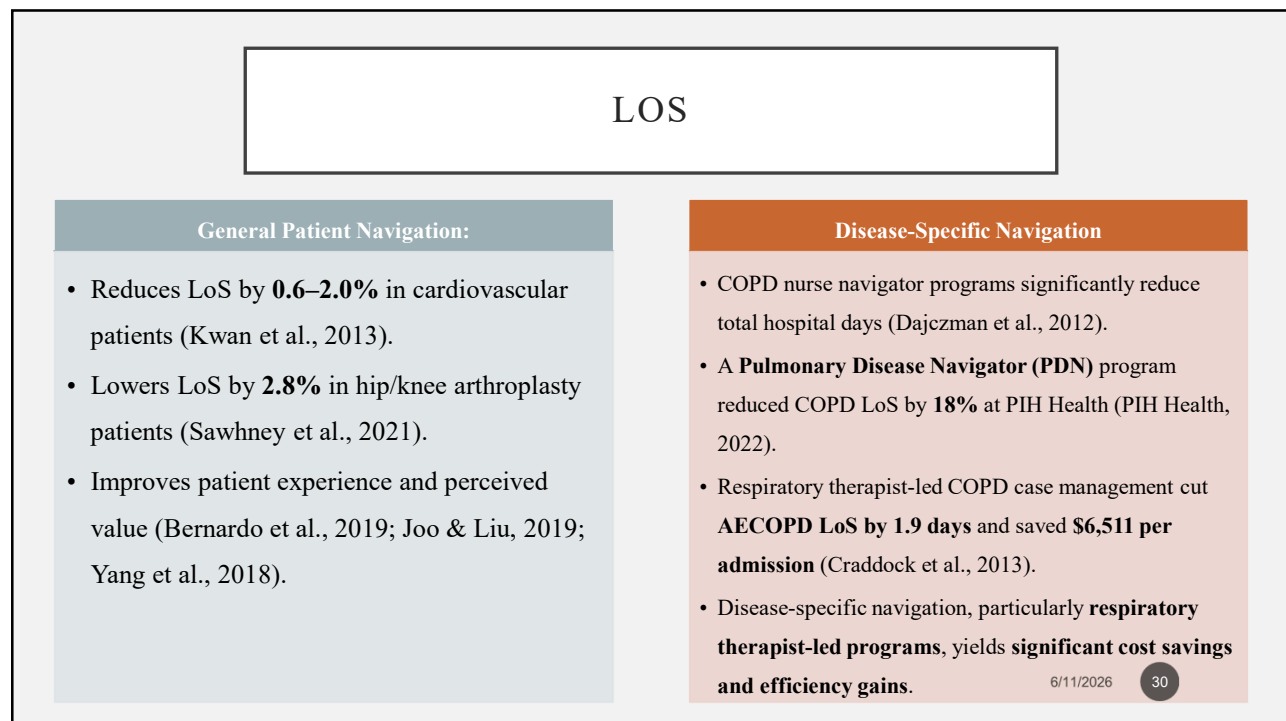
- Major
 - Mortality
 - Readmissions
 - Efficiency
 - Effectiveness
 - Safety and Patient Centeredness
- Minor
 - Appts
 - Facility referrals
 - Physician referrals
 - Medication recommendations

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LOS

Three healthcare workers die and arrive at the Pearly Gates. St. Peter calls the first one up and asks why they should be let into paradise.

The Nurse: "I worked my entire life in a hospital, tending to the sick and comforting the dying." St. Peter checks his book and says, "Welcome, you may come in."The

Physician: "I healed the sick and helped people through their suffering." St. Peter nods. "Yes, you may come in."

The Hospital Administrator: St. Peter asks why they should be let in. The administrator says, "I was in charge of managing hospital length of stays, reducing costs, and streamlining discharges."

St. Peter checks his book and says, "Yes, you may come in... but you can only stay for *three* days."

Early Patient Identification and Planning

- Identifies high-risk pulmonary patients early and initiates discharge planning from admission.

Reduction of Discharge Delays

- Coordinates oxygen, medications, equipment, follow-up appointments, and other resources needed for discharge.

Care Coordination

- Facilitates communication among the multidisciplinary care team to improve efficiency and reduce barriers.

Improved Discharge Readiness

- Provides education and transitional care support to ensure patients are prepared for a safe and timely discharge.

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Mortality Rates and Readmissions in COPD

MORTALITY



Quality of care deficiencies and high readmission rates contribute to increased mortality.



In-hospital mortality: 6.2% among 65,945 COPD patients (Waeijen-Smit et al., 2024).

Post-discharge mortality:

2.0% at 30 days

6.4% at 90 days

12.2% at 365 days



• Readmission rates:

19.8% at 30 days

26.5% at 90 days

38.2% at 365 days

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MORE MORTALITY

Long-term mortality risk

- **50%** of patients die within **5 years** after a COPD-related hospitalization (Agustí et al., 2023).
- **34.5% of patients die within 30 days of an exacerbation*** (Whittaker et al., 2022).
- **Untreated COPD** can reduce life expectancy by **5–14 years** (Temple Health, n.d.).
- **Severe COPD** results in **8–9 years of life lost** (Chen et al., 2020).

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MORTALITY

The Navigator's Role in Mortality

- Navigation extends quality life by ensuring coordinated care, access to treatment, and medication adherence – secondarily, symptoms.
- Recognizing when curative care is no longer effective, navigators facilitate:
 - **Advanced care planning**
 - **Goals-of-care discussions**
 - **Palliative care referrals**

- Navigation supports EOL care, ensuring patients receive compassionate and humanistic support.
- **Hauser et al. (2011)**: Navigation enhances EOL care optimization through early care planning.
- **Fisher (2024); The Partnership Between Navigation and Palliative Care (2019)**: Early navigator involvement improves EOL decision-making.



- COPD exacerbations are physically and mentally exhausting, placing patients in constant distress.
- Navigators with established patient rapport are well-positioned to guide patients and families through EOL care decisions.

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EFFICIENCY AND EFFECTIVENESS



Mortality, readmissions, and length of stay are directly influenced by EBP and guideline-directed medical therapy (GDMT).



• **Patient navigation improves adherence** to screening, diagnostics, and follow-up recommendations (County Health Rankings, 2016).



• Gaps exist between following recommendations and making them, transitioning from lay navigation to clinical navigation.



• Navigation is itself an EBP, but medical EBP requires navigators to be well-versed in pharmacology, disease management, and research-based strategies.

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E/E

- Navigator-Led GDMT and Medication Adherence
 - Nurse navigator-led GDMT improves heart failure medication adherence (Desai et al., 2020).
 - A 3-month nurse navigator-led GDMT program resulted in:
 - Increased utilization and dosing of all GDMT categories
 - Lower rates of adverse events (Kirkner, 2019).
 - A pharmacist-led diabetes program integrating navigation improved medication adherence and education (Blood et al., 2024).



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E/E

- **Respiratory Therapy and Pulmonary Disease Navigation**
- Respiratory therapists (RTs) are experts in optimizing cardiopulmonary therapy.
- **GOLD guidelines** provide a structured approach to COPD management, aligning with RT expertise.
- **No direct literature links PDNs with pulmonary guideline adherence**, but related disease successes suggest similar outcomes.



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COST EFFECTIVENESS

- **Nurse Navigator Compensation (2025 Estimates):** Average pay: \$32–\$42/hour (ZipRecruiter, Glassdoor, Salary.com).
 - High end: Up to \$55/hour.
 - Estimated annual salary range: \$65k–\$85k.
- **Perceived Cost Barrier:**
 - C-suite executives may view this compensation as expensive.
 - Important to present ROI and cost savings to justify implementation.

- **Pilot Program with Two Full-Time Navigators:**
 - Reduced radiation therapy no-show rates, allowing for salary recovery within 3 months.
 - High-risk hospital admissions decreased by 50%. Readmissions and ER visits reduced by one-third.
 - **ROI Achieved: 5:1.**
- **Intermountain Southwest Cancer Center (2014):**
 - Annual Savings: \$277,953.
 - Increased Efficiency: Oncologists saved 24 minutes per visit by delegating educational sessions to navigators.
 - Enabled oncologists to see one additional patient per day.
 - Potential Annual Revenue Generation: **\$485,312**, well over the cost of two full-time navigators.
- **Henrico Doctors' Hospital:**
 - Reduced breast cancer patient outmigration from 240 to 28.
 - Generated an additional \$350,000 in revenue from billable services.
 - Enhanced patient trust and engagement, increasing contribution margin by \$3,000 per patient.

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COPD Case Management by Respiratory Therapists (Craddock et al., 2013): Estimated Savings Per Admission: \$6,500.

Total Cost Savings During Study (around 11 months): \$481,814.

Mechanisms of Savings:

Reduction in hospital readmissions.

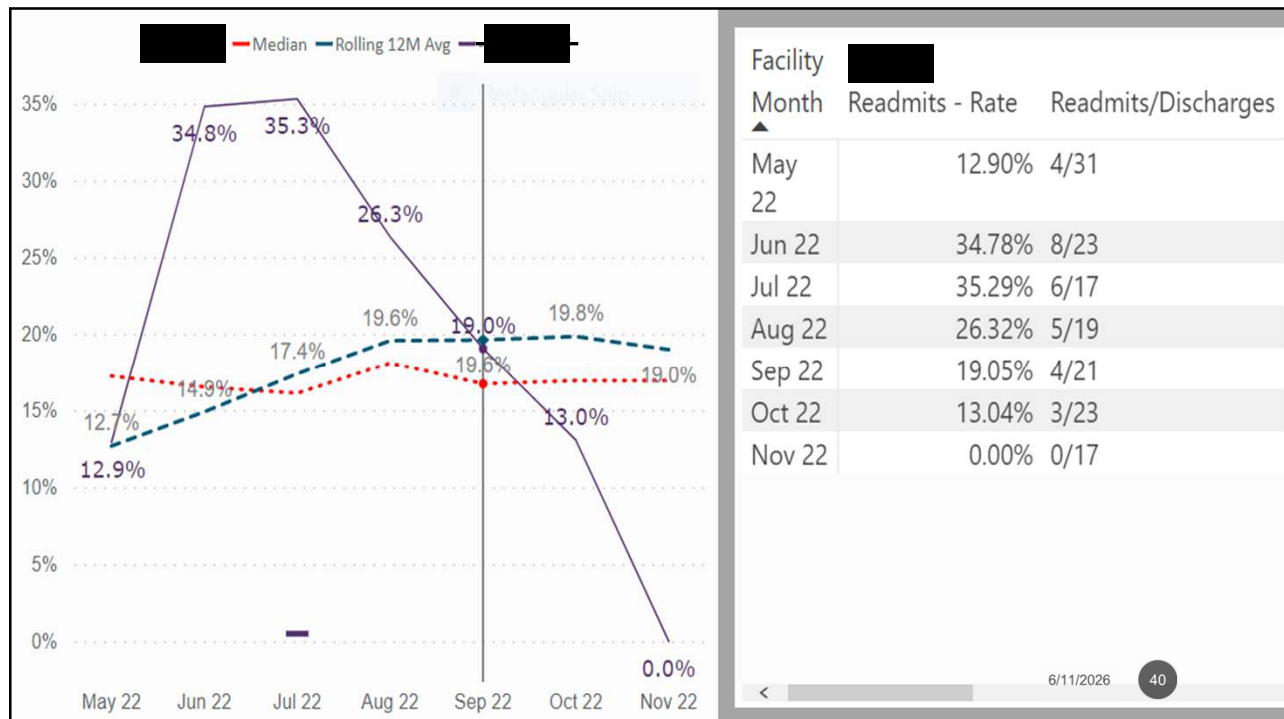
Improved patient education and follow-up.

Enhanced chronic disease management.

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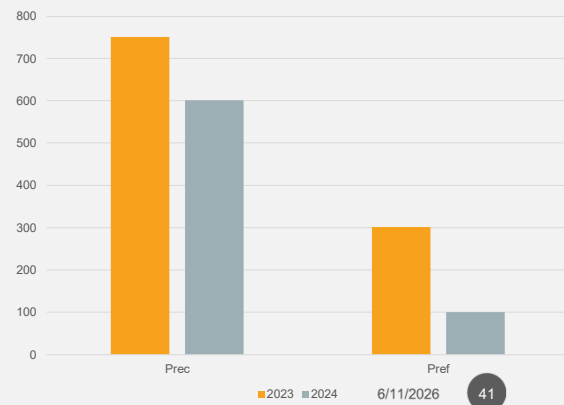
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MORTALITY AND EFFICIENCY

- Mortality – unexpected deaths
- 2023 – ~1004pts
 - ~751 had mention/recommendation for palliative/hospice care
 - ~301 had referrals
- 2024 – ~912pts
 - ~601
 - ~100 NEW referrals
- July-Nov – Recommendations to CBT
 - ~75 w ~30 referrals

- Efficiency – LOS
- Average for COPD dx code – 4.08d
- LOS for all those w PDN – 3.99d
- LOS excluding outliers (≥ 10 days) w PDN – 3.92d

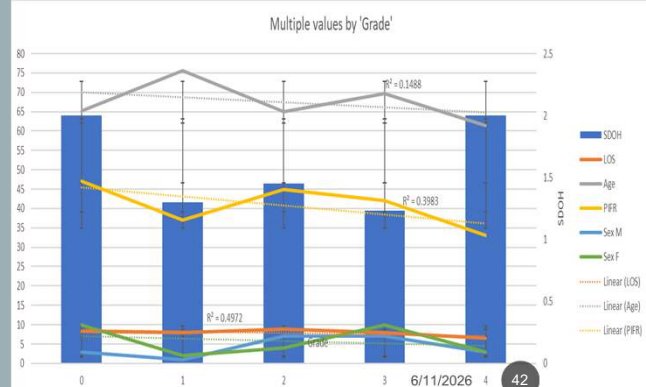


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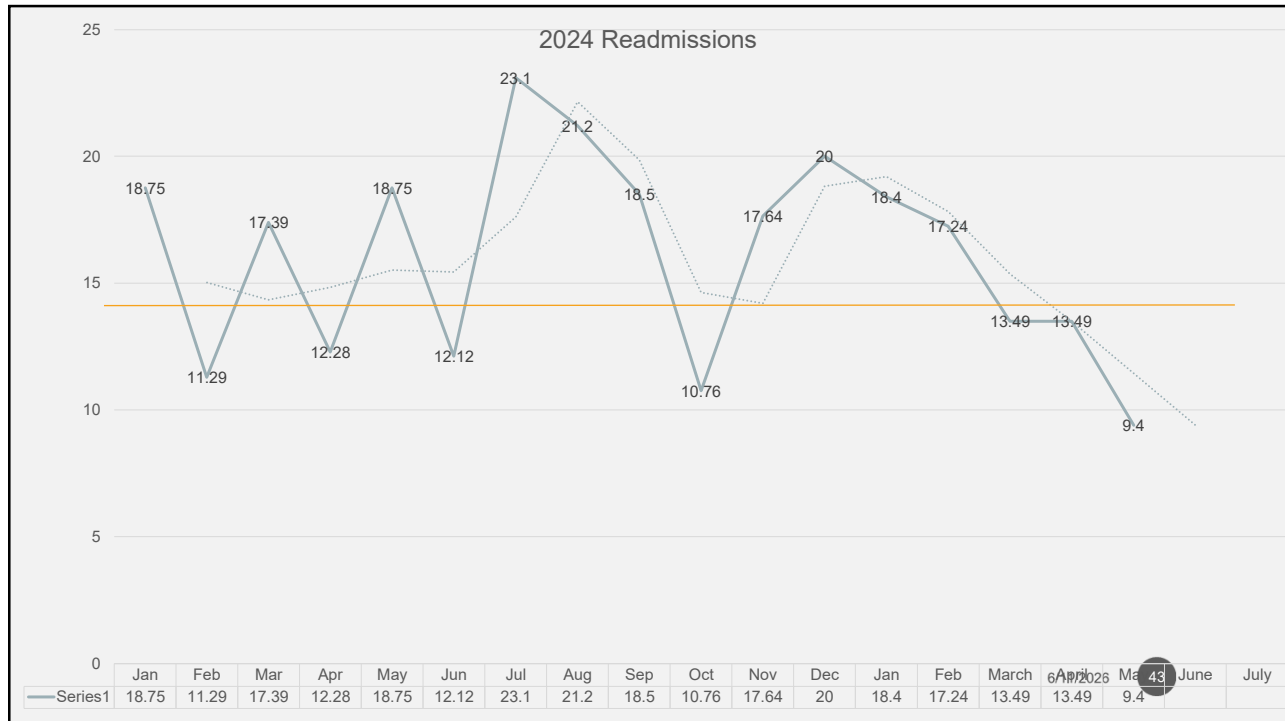
EFFECTIVENESS

- Effectiveness – GDMT/GOLD
- Tyto – Digital health initiative
- Documented GDMT or why not
- PIFR – Pilot study organized to guide inhaler selection and proper use. Up to 20% medication changes.
- COPD/CHF Team – SBAR format with pulmonary NICS director, pulmonologist, palliative care APP and navigator, pharmacy.
- Digital Inhalers/Spiro - upcoming
- Med “T” - live

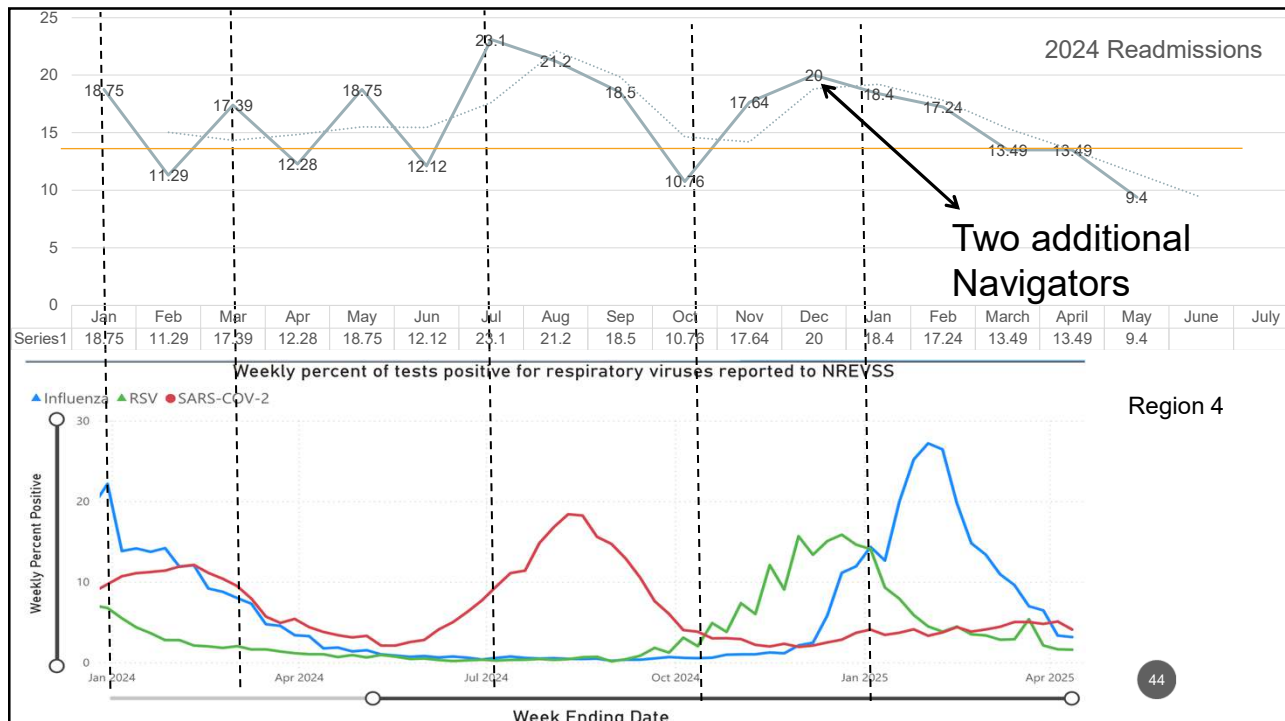
- A total of 73.68% were found to fall **below optimal** flow regarding their current inhaled medication therapy. 26.32% were on appropriate inhaled medical therapy.



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A CASE OF CAREGIVER FATIGUE

- **Patient Background:** 58-year-old woman with pneumonia, presumed COPD (no PFTs), 27-year history of tobacco/marijuana use.
 - No PCP or pulmonologist, uninsured, food insecure, financially strained due to caregiving.
- **Navigator Intervention:** Coordinated insurance enrollment, primary care, pulmonology referrals, and smoking cessation.
 - Connected patient with food resources and financial aid.
 - Documented intervention via EMR.
- **Diagnosis & Treatment:** *Spirometry* suggested mild restrictive lung disease; lung CT revealed Grade 2 NSCLC.
 - Early detection enabled immediate oncology referral and treatment, now in remission.
- **Quality of Life Improvements:** Improved lung function, reduced respiratory symptoms, enhanced daily living conditions.
 - Reduced stress through access to resources and smoking cessation.
- **Cost-Efficiency:** Early lung cancer treatment: \$20,000–\$30,000 vs. \$100,000+ for late-stage treatment.
 - Avoided COPD (even if restrictive am I right?) readmission savings: \$6,000–\$15,000 per event.
 - Estimated savings from this intervention: \$13,000 or more.
- **Broader Implications:** One successful intervention potentially covered ¼ of the PDN's salary.
 - Effective navigation can significantly reduce healthcare costs and improve patient outcomes.

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IMPLEMENT IT ALREADY

- Unlike revenue-generating departments that rely on **direct arbitrage** (e.g., charging more for a service than it costs to deliver), the Pulmonary Disease Navigator (PDN) role operates within a **coordination-of-care framework** that delivers **value through cost avoidance and improved efficiency** across the continuum of care.
- PDN is an investment in care optimization that yields a return by:
 - **Reducing potentially preventable readmissions** (especially 30-day COPD and pneumonia, which are tied to CMS penalties)
 - **Improving length-of-stay efficiency** by minimizing discharge delays
 - **Enhancing transitional care**, leading to fewer ED revisits and readmissions
 - **Preventing medication errors and increasing discharge medication adherence**, especially for high-cost inhalers and specialty drugs
 - **Avoiding downstream costs** by identifying and mitigating social determinants of health (SDOH) that drive acute utilization.
- This is akin to “back-end ROI”: the financial gain is realized not through billing, but through cost containment, penalty avoidance, and value-based care performance metrics.

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	IMPLEMENTATION P1 6/11/2026	• Phase 1: Planning and Preparation • Conduct a Gap Analysis: Assess current care gaps, such as delays in diagnosis or high missed appointment rates. • Define Scope and Model: Determine if the navigator is a respiratory therapist (clinical) or layperson (peer) and define their role in the continuum of care (screening, treatment). • Secure Leadership Support: Gain executive buy-in to ensure resources for staff and IT systems. 47
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	IMPLEMENTATION P2 6/11/2026	• Phase el numero two • Define Patient Eligibility Criteria • Clearly define which patients enter the program. • Develop Workflow Integration • Navigator programs should be embedded into existing clinical workflows rather than operate independently → PCP, Pulm clinics, ED, Acute care, etc. • Referral order set • Navigator tracking registry • Automated patient alerts • Documentation templates • Create Standardized Care Pathways • Navigator programs are most effective when tied to evidence-based clinical pathways: GOLD, ATS, GINA, etc. 48
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IMPLEMENTATION P3

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Phase 3: What is to be tracked?

- patient referral source
- diagnosis and risk category
- completed diagnostic tests
- appointment adherence
- hospitalization and readmission rates*

Develop Navigator Training and Competency Standards

- Clinical assessment
- Chronic disease management
- Motivational interviewing
- Care coordination
- Health system navigation

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C-SUITE

- **CFO Perspective:** The PDN's impact is measurable through lower Medicare spend per beneficiary, improved risk-adjusted outcomes, and avoidance of CMS penalties—critical in value-based reimbursement models.
- **COO Perspective:** The role facilitates smoother throughput, reduces length of stay, and improves interdepartmental workflows (nursing, case management, pharmacy).
- **CMO/CNO Perspective:** The PDN ensures clinical quality, guideline adherence, and patient satisfaction, directly impacting HCAHPS scores and safety metrics.
- **Population Health/Strategy Leaders:** PDNs proactively manage high-utilizers, enabling health systems to improve performance in ACO, MSSP, and bundled payment models.

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FUNDING OF THE PROGRAM AND BACK-END SAVINGS

- Like coordination-type roles, PDN accounts for costs on the back rather than direct arbitrage
- Readmission costs around 15k
- Misuse
- Waste
- Trial and error
- Evidence-based driven approaches to care

- Grants
- Further segmentation of specific disease population for even greater savings.



- Step-wise growth with proven efficacy

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- Pulmonary Disease Navigation is not merely an emerging field—it is a **necessary response** to a pressing healthcare crisis. COPD mortality is rising, and fragmented care remains a critical vulnerability. The PDN model fills these gaps by:
 - Focusing on individualized, evidence-driven interventions.
 - Bridging acute, post-acute, and outpatient care.
 - Achieving measurable outcomes in quality, safety, efficiency, and equity.
- As the healthcare system shifts toward value-based care, **PDNs represent a strategic advantage**: improving outcomes while reducing unnecessary costs and care fragmentation. The model is **scalable**, adaptable beyond COPD, and can be expanded to other complex diseases where navigation and continuity are lacking.
- The PDN role, particularly when led by respiratory therapists, is a cost-effective, evidence-informed solution to the COPD epidemic. It honors the philosophical roots of patient-centered care while demonstrating measurable, data-supported improvements in clinical outcomes. Institutions that adopt and refine the PDN model position themselves at the forefront of compassionate, accountable, and forward-thinking healthcare delivery.

SO WHAT?

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THANK YOU

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