

**The Future of COPD in Minnesota: A strategic plan
Summary from the November 17, 2004 Minnesota COPD Summit
Updated October 2007**

The following is a summary of the recommendations, first steps, and potential partners to improve the health outcomes for individuals with COPD in Minnesota as recommended by participants of the November 17, 2004 Minnesota COPD Summit. This summary is aligned with the three core functions of public health: assessment, policy development, and assurances. Formative, process, and impact evaluation will be utilized to ensure high-quality COPD programming and the tracking of health outcomes for patients with COPD. The "Resources Needed in Addition to Staff Time" column is a resource estimate based on the experience of the American Lung Association of Minnesota and the Controlling Asthma in American Cities Project.

The recommendations from the November 17, 2004 Minnesota COPD summit are consistent with the U.S. Healthy People 2010 strategic objectives for people with COPD:

Objective 24-9: Reduce the portion of adults who activity is limited due chronic lung and breathing problems.

Target: 1.5 percent

Baseline: 2.2 percent of adults aged 45 years and older experienced activity limitations due to chronic lung and breathing problems in 1997.

Objective 24-10: Reduce deaths from COPD among adults.

Target: 60 deaths per 100,000 adults

Baseline: 119.4 deaths per 100,000 persons aged 45 years and older occurred in 1998.

ASSESSMENT OF COPD IN MINNESOTA

This recommendation is consistent with the in-development national American Lung Association key objective to advocate for a federal COPD data and surveillance plan.

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
1. Scope of COPD in Minnesota			
Mortality data	Request 2000, 2001, 2002, and 2003 vital stats from the Minnesota Department of Health. Data will include demographics, geographic region. No race/ethnicity.	1. Pathologists and pulmonologist input on potential diagnosis codes 2. Minnesota Dept of Health to provide raw data files 3. ALAMN staff to analyze data	Assistance from pathologists, pulmonologists, and Minnesota Department of Health
Morbidity data: hospitalization and emergency department	Request 2000, 2001, 2002, and 2003 (2004 when available) hospital claims data from the MN Hospital Association. Data will include hospitalizations, ED, demographics, length of stay, geographic region, and charges. No race/ethnicity data.	1. Minnesota Hospital Association 2. Data Intelligence, Inc to analyze data	<ul style="list-style-type: none"> • \$960 for data acquisition from Minnesota Hospital Association • \$2,500 for data analysis and reporting
Morbidity data: health care utilization	Request MN Medpar (Center for Medicare and Medicaid Services) data for 2002. Data would include health care utilization (out-patient, ED, and hospitalization payments). Demographics included. No race/ethnicity data. In the future,	1. Center for Medicare and Medicaid Services 2. Data Intelligence, Inc to analyze data	\$5,000 for data request \$9,000 for data analysis and reporting

	may include pharmacy benefits.		
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Morbidity data: health care utilization	Partner with one or two Minnesota-based health plans to analyze health care utilization data.	One or two Minnesota-based health plans	\$5,000 incentive per health plan to off-set programmer time (total \$10,000)
	National Committee on Quality Assurance (NCQA) is developing COPD standard in 2007.	NA	NA
	In 2005, the Minnesota Department of Health is including one COPD/emphysema/chronic bronchitis question on the Behavioral Risk Factor Surveillance Survey (BRFSS).	Minnesota Dept of Health	NA
Quality of Life data	<ol style="list-style-type: none"> 1. Conduct a quality of life questionnaire with patients with COPD in Minnesota. 2. Identify a validated quality of life assessment tool for patients with COPD. 3. Work with existing pulmonary rehab centers and support group coordinators in Minnesota to distribute the survey. 	<ol style="list-style-type: none"> 1. Developer of existing COPD-related quality of life tool 2. Pulmonary rehab centers and support group coordinators in Minnesota 3. Data Intelligence, Inc to analyze the data 	Estimated \$15,000 (based on the 2003 CAACP experience with asthma QOL survey)

PUBLIC POLICY DEVELOPMENT

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
Advocate for research funding regarding effective treatment for patients with COPD	Review literature related to treatment for patients with asthma.	Existing literature.	Literature acquisition = \$250
Advocate for research funding regarding effective equipment for patients with COPD	Review literature related to effective equipment for patients with asthma.	Existing literature.	Literature acquisition = \$250
Advocate for COPD-friendly, standardized oxygen travel (airline) policies	Support American Lung Association National Office and others' advocacy agendas.	American Lung Association National Office	NA

ORGANIZATIONAL/HEALTH PLAN POLICY

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
Address appropriate, legal reimbursement for medications, treatment, equipment, and education	<ol style="list-style-type: none"> 1. Assess existing health plan pharmacy-related benefits and services related to COPD that are covered (including payment of oxygen, pulm rehab, smoking cessation) 2. Identify barriers to quality COPD care based on the above mentioned benefits assessment 	<ol style="list-style-type: none"> 1. Minnesota-based health plans 2. Data Intelligence, Inc or PharmD student to conduct telephone surveys with health plans. 	Estimated \$12,000 for contract or staff time to conduct multiple telephone interviews with health plans (based on 2003 CAACP experience surveying health plans regarding pharmacy-related benefits and services related to asthma).
Gain professional organizational policy/resolution support for guidelines around COPD	<ol style="list-style-type: none"> 1. Identify professional organizations who's members serve patients with COPD 2. Determine organizational process to gain formal support 	ICSI (Institute for Clinical Systems Improvement)	TBD

ASSURANCES (PROGRAMMING): For the health care professional

This recommendation is consistent with the in-development national American Lung Association key objective to increase provider compliance with COPD guidelines.

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
Develop a multi-disciplinary, primary care systems change approach to ensure early detection, appropriate diagnosis, use of spirometry, assessment of patient flow, patient education, referral for COPD, and coding.	Train providers on evidence-based: <ul style="list-style-type: none"> • Implementation and interpretation of spirometry • Implementation of pulse ox • COPD guidelines • Early diagnosis • Co-morbid conditions • Medication options • Treatment options • When/how/who to refer • Legal and appropriate coding and reimbursement • Smoking cessation resources • Patient education(including time effective methods, stages of change; patient motivation, end of life issues) • How to do the above in a timely manner • How to improve regimen adherence 	ALAMN Other smoking cessation resources	Funds to develop and pilot test and COPD seminar, based on the PACE (Provider Asthma Care Education) Funds to develop and pilot test a COPD educator course, based on the Asthma Educator Certificate Course
	Develop a systems-change model/project around COPD	Systems change mentors ICSI (Institute for Clinical Systems Improvement)	Resources to pilot test this model with clinics.
	Develop a COPD "education" template for health care providers to follow.	TBD	TBD

ASSURANCES (PROGRAMMING): For the patient with COPD

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
Increase early detection – <ul style="list-style-type: none"> • How and when to ask for screening 			
Improve education at time of diagnosis – <ul style="list-style-type: none"> • What does this mean? • What is the disease progression? • How can I find more information? • Acceptance/guilt issues • Resources available 			

<p>Improve understanding of treatment issues -</p> <ul style="list-style-type: none"> • Equipment available • Oxygen systems (type, power, weight) • How to use meds/delivery devices • How to manage complex treatment plan • What is pulmonary rehab, what should I expect, and where can I get it? • What are exacerbations? • Triggers? 			
<p>Provide education around support issues -</p> <ul style="list-style-type: none"> • Daily living aids • Coping skills (relaxation and stress management) • Behavior change techniques • Physical activity • Nutrition • Weight management • Transportation (parking, handicap access, etc.) • Travel options • Overcoming isolation • Financial issues • Commitment to rehab while still employed • Support groups 			
<p>Address end of life issues –</p> <ul style="list-style-type: none"> • Hospice • Patient wishes • Living wills 			
<p>Determine family/friends issues –</p> <ul style="list-style-type: none"> • What does this disease mean? • What can I expect? • How can I help? 			

ASSURANCES (PROGRAMMING): For the general public

This recommendation is consistent with the in-development national American Lung Association key objective to increase the awareness of COPD among the general public.

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
<p>Increase awareness for three reasons:</p> <ol style="list-style-type: none"> 1. Support those with COPD 2. Motivate for early screening 3. Encourage smoking cessation 	TBD	<p>Employer groups, especially human resources around missed work, health care premiums) Note: there is no HEDIS measure for COPD.</p>	TBD

Consider the following formats: <ul style="list-style-type: none"> • Health fairs • Public relations • COPD clearinghouse • Ribbons as symbol of support • Repeat, repeat, repeat 			
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ASSURANCES (PROGRAMMING): For industry

Recommendation	First Steps	Potential Partners	Resources needed in addition to staff time
Provide patient input on product development	TBD	TBD	TBD
Advocate for standardization of products	TBD	TBD	TBD
Ensure reimbursement for COPD-related products	TBD	TBD	TBD
Conduct and disseminate research on patient outcomes, best treatment options, and efficacy	TBD	TBD	TBD