



COPD Transitions of Care to Reduce Readmissions

AnMed Health Medical Center, Anderson South Carolina

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PROJECT SELECTION

Identify Problem

- COPD was the 3rd leading cause of death in the US in 2011
- COPD noted to be one of AnMed Health's top 5 DRG with readmission reduction opportunity

Planning – Methods - Strategies

- Multidisciplinary Team formed to develop readmission reduction plan

1. Brainstorming

- Analyze current situation:
 - Timeframe of most readmissions – by day 5 post discharge
 - Largest population of readmissions come from the home setting
 - Common reasons for readmission
 - Medication management, polypharmacy
 - Issues with equipment
 - Understanding and managing disease symptoms
- Potential solutions:
 - Improved patient education process
 - Post-discharge contact with patient – in-home, phone

2. Review Best Practices

- Literature reviews
 - Patient education materials and methods
 - Treatment pathways
- Consult with other organizations to review their initiatives

3. Finalize Project Tools

- Patient identification and readmit risk evaluation tool
- Personalized COPD Action Plan
- Post-discharge home visit and phone call schedule
- Clinical Health Coach Team identified (RN, RT, or Paramedic)
- Standardized in-home and telephone evaluation tools
- COPD Help Line
- Emergency Department alert system for readmits
- Midas database for patient data collection and analysis

4. Implementation Strategies

- Clinical Health Coach education and training
- Communication strategies: memos, presentations, posters, email
- Internal Stakeholders
 - Attending physicians (hospitalists, residents, pulmonologists)
 - Emergency Department Physicians
 - Nursing, Care Coordination, Respiratory Therapy, Pharmacy
- External Stakeholders
 - Primary Care Physicians
 - Home Health Providers

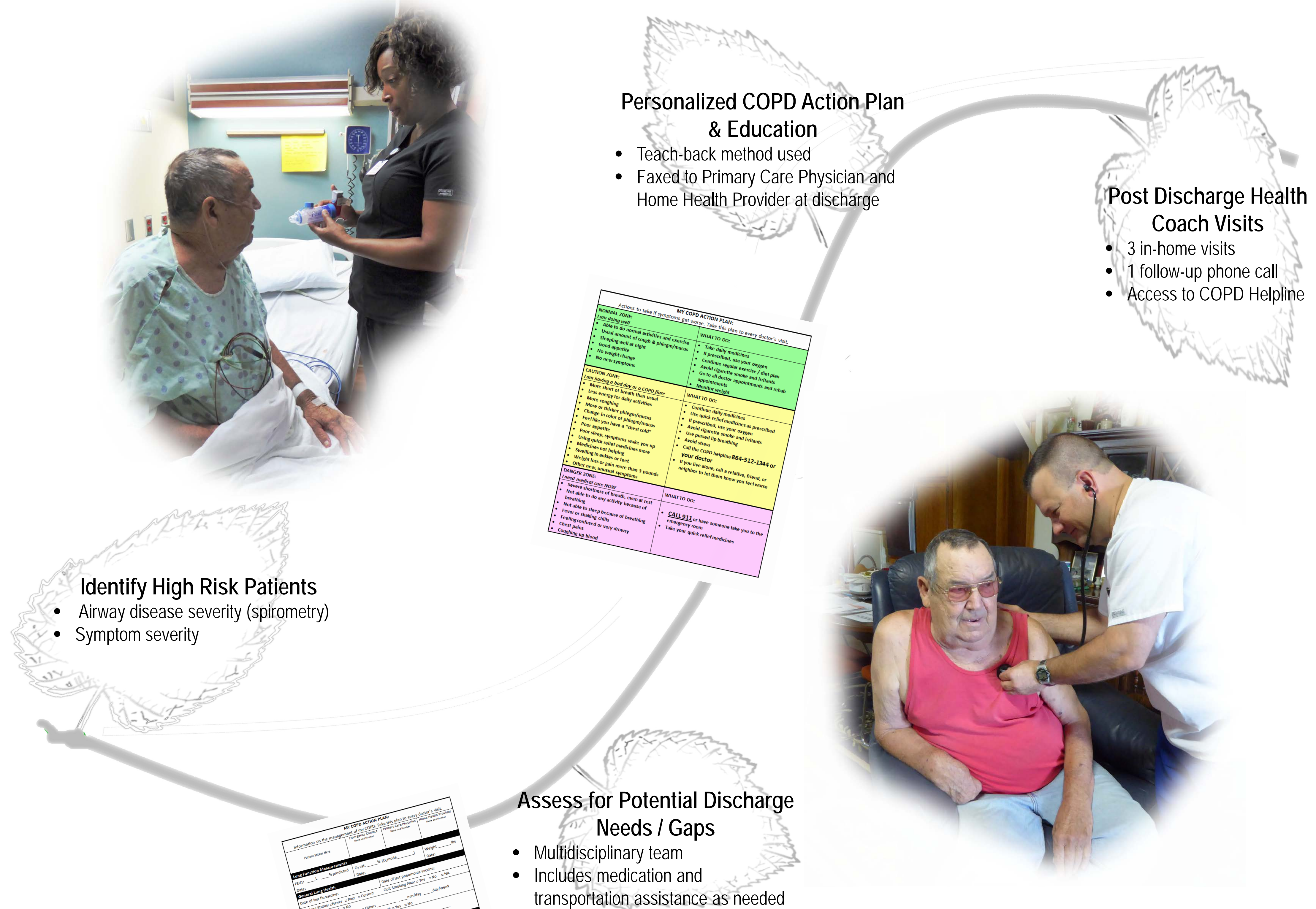
5. Review and Refine

- Review MS-DRGs of patients in database to evaluate accuracy of identification and evaluation tool
- Inclusion of patients discharging to AnMed Health Rehabilitation Hospital
- Root Cause Analysis for program patients readmitted within 30 days

GOAL

Decrease the 30-Day COPD Readmission Rate by 20%.
(From 18.8% to 15%)

IMPLEMENTATION



Identify High Risk Patients

- Airway disease severity (spirometry)
- Symptom severity

Personalized COPD Action Plan & Education

- Teach-back method used
- Faxed to Primary Care Physician and Home Health Provider at discharge

Post Discharge Health Coach Visits

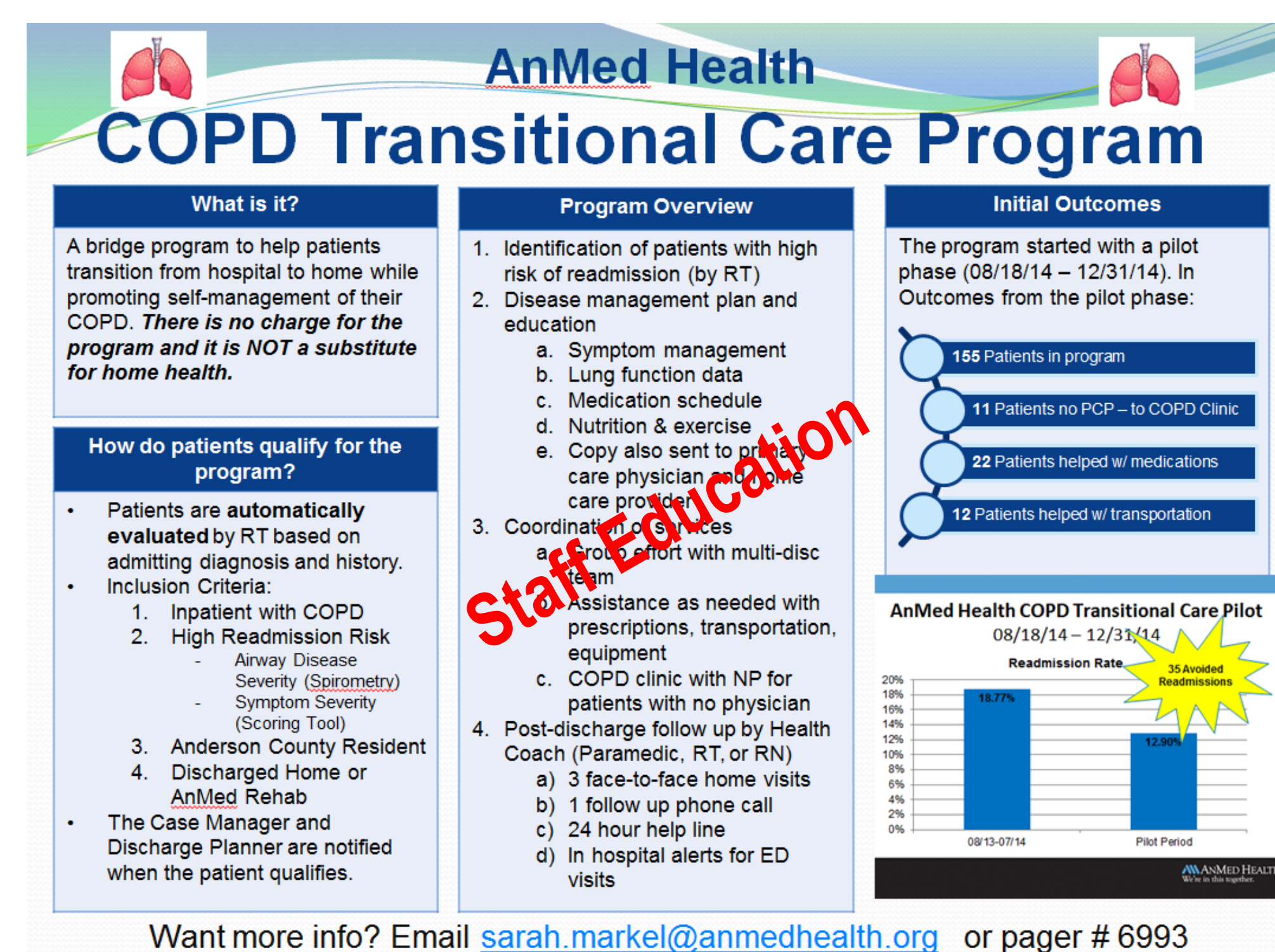
- 3 in-home visits
- 1 follow-up phone call
- Access to COPD Helpline

Assess for Potential Discharge Needs / Gaps

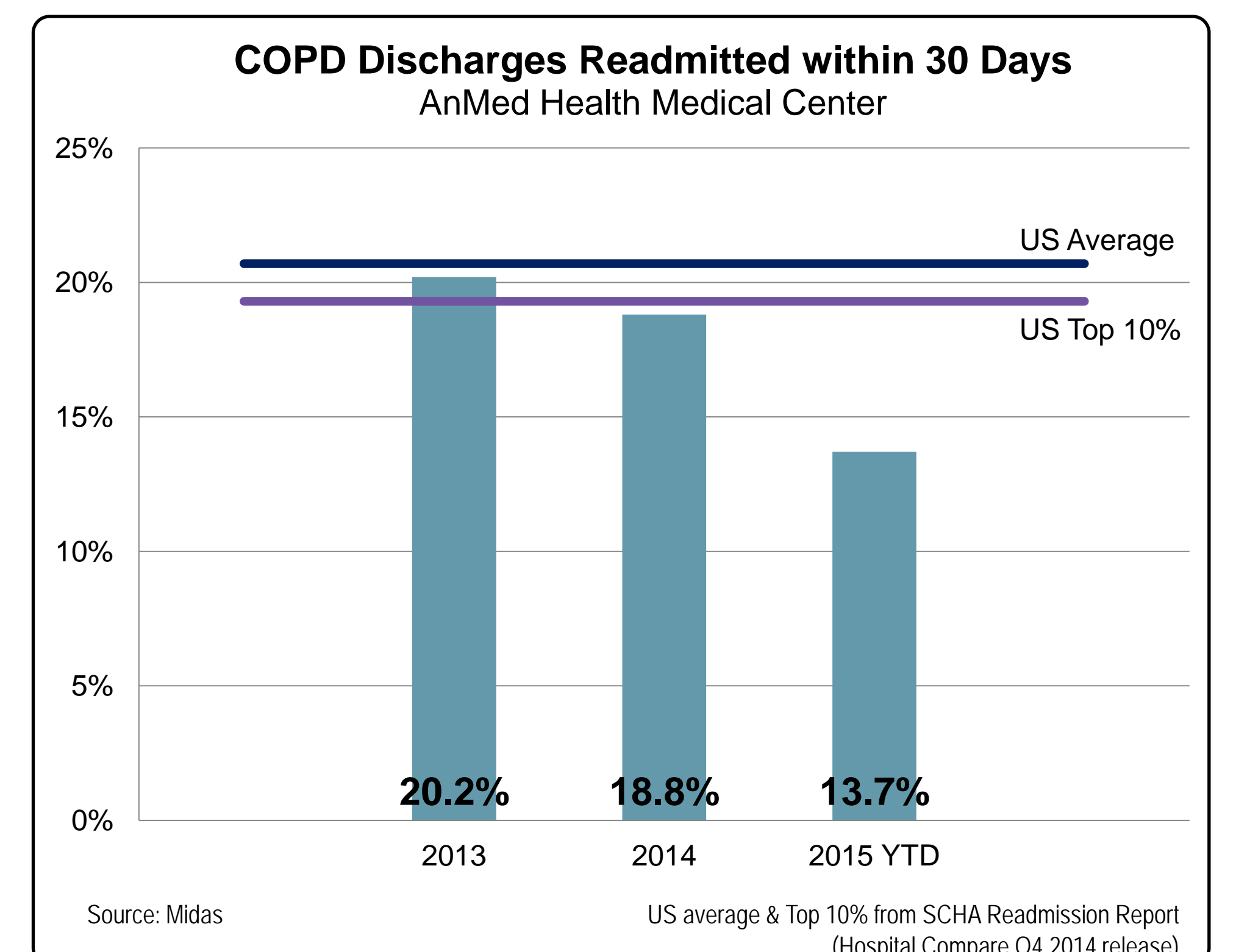
- Multidisciplinary team
- Includes medication and transportation assistance as needed

Common Issues Identified During Home Visits:

- Medication Organization (pill organizers and set-up provided by Health Coach)
- Problems setting up or using equipment (spacers, oxygen, BiPAP, glucometers)
- Environmental triggers (dander, dust, secondhand smoke)
- Transportation to follow-up appointments
- Social issues
- Difficulty "navigating the healthcare system"



OUTCOMES



Additional Results

08/08/14 – 06/13/15

- 396 Patients in the Program
- 1089 Home Visits Completed
- 301 Phone Calls Completed
- Operational Costs: \$43,678
- 77 Readmissions Avoided (Estimated)
- Cost Savings: **\$603,122**

RESOURCES

COPD Foundation. *COPD Foundation Pocket Consultant Guide*. 2014 edition.

Global Initiative for Chronic Obstructive Lung Disease. *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease*. Updated 2014.

Rennard, et al. Improving the COPD Foundation Guide for Diagnosis and Management of COPD, Recommendations of the COPD Foundation. *Journal of Obstructive Pulmonary Disease*. 10:378-389, 2013.

FOR MORE INFORMATION

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