Title:
The COPD Journey: Care Management Across the Continuum

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Session Title:
Frontline Clinical Leadership Posters
Slot (superslotted):
FL CL PST: Friday, September 26, 2014: 10:00 AM-10:30 AM
Slot (superslotted):
FL CL PST: Friday, September 26, 2014: 11:45 AM-1:00 PM
Slot (superslotted):
FL CL PST: Friday, September 26, 2014: 3:00 PM-3:30 PM

Keywords:
COPD, continuum and medical home

Learning Activity:

<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
<th>TIME ALLOTTED</th>
<th>FACULTY/SPEAKER</th>
<th>TEACHING/LEARNING METHOD</th>
<th>EVALUATION/FEEDBACK</th>
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<td>Critique selected definition of the term, &quot;curriculum&quot;</td>
<td>Definitiions of &quot;curriculum&quot;</td>
<td>20 minutes</td>
<td>Name, Credentials</td>
<td>Lecture PowerPoint presentation</td>
<td>Group discussion: What does cultural training mean to you?</td>
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Abstract Text:

**Purpose:** The purpose of the care management program is to provide patients and family members with a safe and smooth transition from the acute care environment to the outpatient setting. The significance of the care management program is to improve a patient's quality of life while living with chronic obstructive pulmonary disease (COPD). The goals include, "BREATHING EASIER" education to empower patients to take control of their disease process, referral to appropriate outpatient programs, and reducing hospital readmissions.

**Methods:** The program was implemented due to excessive repeated COPD readmissions in an attempt to reduce frequency of readmits. Once COPD patients are admitted to the hospital they are assessed for current stage in the disease process and discharge planning is initiated. Patients with a definitive diagnosis of COPD are provided BREATHING EASIER education and referred to the appropriate outpatient program. If COPD is suspected and the patient does not have a FEV1 on record, upon discharge patient is referred to pulmonologist for outpatient pulmonary function testing. The COPD ADVOCATE coordinates transition of care to the outpatient setting, arranges high tech respiratory equipment (bi-pap, non-invasive vent) for the home, and conducts post discharge calls to those with the
highest risk for readmission, ensuring a smooth transition of care. Referral is also made to the embedded outpatient case manager for ongoing follow up.

**Results:** Implementing the care management program has led to a reduction in COPD readmissions and increased overall patient satisfaction scores. Prior to implementation of the program, COPD all cause readmission rate was 22%. Since program implementation COPD all cause readmission rate has decreased to 16%.

**Conclusion:** Evidence based practice and collaboration across the continuum enhances quality care, patient safety, and patient satisfaction. This has been achieved thru the use of electronic medical record and the establishment of the medical home practices. Collaboration between the inpatient acute care setting and the outpatient setting has aided in the transition of care for this patient population.