Empowering nurses to engage in self-care activities both inside and outside the workplace contribute to nursing satisfaction and cohesiveness. When nurses use innovative tools, patients and staff both benefit with better outcomes and nursing expands to reach the outer scope of its practice.

THE COPD JOURNEY: CARE MANAGEMENT ACROSS THE CONTINUUM

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BACKGROUND

Chronic Obstructive Pulmonary Disease (COPD) is one of the leading causes of death in the United States. The severity of the illness is primarily associated with progressive deterioration in lung function and frequency of exacerbations. According to the Center for Medicare and Medicaid, key components to minimizing the impact of the exacerbation episode includes providing clients with discharge support and care management across a continuum. This aids in the prevention of future relapses and reduces unnecessary readmissions in the hospital setting. It was recognized among the pulmonary care team that readmission rates were increasing for the COPD patient population up to 27.22%. These metrics caused staff to identify the need for a care management program in the acute care and outpatient setting as a target for quality improvement.

PURPOSE

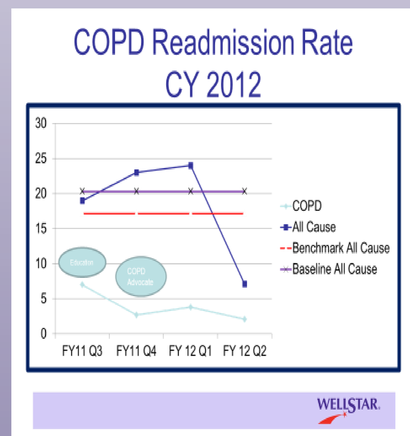
The purpose of the care management program is to provide patients and family members with a safe and smooth transition from the acute care environment to the outpatient setting, concentrating on preventing unnecessary hospital readmissions and promoting continuity of care for COPD clients. The main goals include, "BREATHING EASIER" education to empower patients to take control of their disease process, smoking cessation, and referral to appropriate outpatient programs.

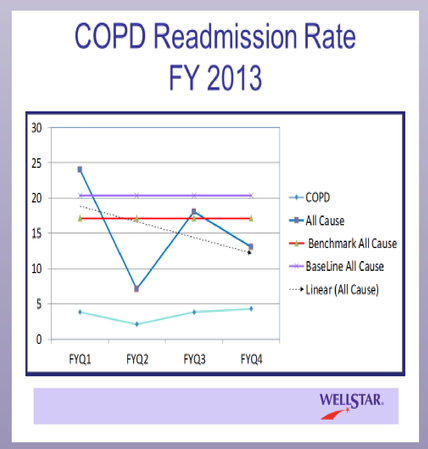
METHODS

Once COPD patients are admitted to the hospital they are assessed for their current stage in the disease process and discharge planning is initiated. Patients with a diagnosis of COPD are provided "BREATHING EASIER" education, utilizing the teach back method and referred to the appropriate outpatient program. If COPD is suspected and the patient does not have a FEV1 on record, the patient is referred to a pulmonologist for outpatient Pulmonary Function Testing (PFT). 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 outpatient case manager for ongoing follow up, enhancing interdisciplinary collaboration across the continuum of care.

TEAM

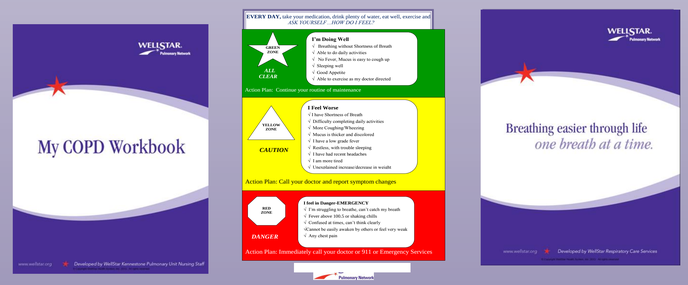
Patient centeredness is an ongoing active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive, and chronic care through all life stages. The interdisciplinary team consists of the medical group, clinical nursing staff, respiratory therapist, pulmonary rehabilitation, care coordination, and the transition care team. The team utilizes evidence-based medicine and clinical support tools to guide decision making and ensure that patients have education and tools to actively participate in their care. Daily interdisciplinary rounds help to identify the risk for readmission and ascertain discharge needs pertinent for the COPD patient population. Community partnering with various sub acute and long term care facilities, outpatient pulmonary rehabs, hospice, and the use of the patient centered medical home help promote continuity of care for the client.





TIME LINE

EDUCATIONAL MATERIALS



RESULTS

- **Prior to implementation of the care management program COPD readmission rates were 27.22%.**
- **After program implementation the readmission rate decreased to 19.8%, resulting in a 7.42% reduction.**
- **All cause readmissions also declined from 20.31% to 14% for FY 2014.**
- **Latest data for all-cause readmission for Kennestone Hospital is currently below the national average of 22.6%.**
- **The average cost per COPD case with a five day length of stay amounts to approximately $40,403.**
- **This equates to a total saving of $2,020,150.**

CONCLUSION

The care management program has increased continuity of care for the COPD population, fostering a smooth transition at time of discharge. This is evidenced by a decrease in readmission rates captured from FY 2012-FY2014. Utilizing evidence based practice has contributed to an improvement in patient outcomes and quality of care for those diagnosed with this chronic condition. In addition, preventative strategies and earlier detection have led to improved patient flow through the health system. Post discharge calls resulted in positive patient feedback and allowed for trouble shooting to avoid readmission. Continuing to use the COPD care management program will serve to enhance future outcomes.

CONTACT

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