COPD GOLD
Quality Initiative to Prevent Readmissions

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Triad HealthCare Network
Physicians Partnering with CONE HEALTH

CONE HEALTH
The Network for Exceptional Care

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Cone Health Magnet Facilities
Annie Penn Hospital
Behavioral Health Hospital
Moses Cone Hospital
Wesley Long Hospital
Women's Hospital

PROBLEM AND EVIDENCE

- Chronic Obstructive Pulmonary Disease (COPD) attributes to 80% of deaths in the United States.
- Over the next five years, a projected cost burden of greater than $200 billion for the health care industry is associated with COPD.
- 2012: Evidence based research found Cone Health had 23% of total claims attributed from COPD admissions.
- 2015: CMS began the Readmission Reduction Program, includes 30-day COPD readmission penalties.

IMPLEMENTATION OF STUDY

- COPD GOLD (Global initiative for chronic Obstructive Lung Disease) Quality Initiative began in 2012.
- Patients were referred to as 'gold' due to the best practice guidelines.
- **Target group included:**
  - Patients with a history of COPD
  - 3 or more hospitalizations in 6 months
  - Those needing education and how to prevent or respond to acute exacerbations
- Triad HealthCare Network (THN) Care Management Program participated in study with inpatient RN staff.
- 8 hours of educational sessions on COPD were completed by all staff.

INPATIENT MONITORING

- EMR was flagged to designate a COPD GOLD patient.
- Patients were assessed by RNs, THN RN Hospital Liaisons or THN program manager- consents to participate in the program were obtained. THN pharmacist completed medication reconciliation.
- Pulmonary consults and standard order sets with clinical pathways were followed. COPD flowsheets were used.
- Patients received a 'gold' card, identified them as a program participant. Education on all aspects of the disease process was given.
- Outpatient appointments were made within seven days of discharge.
- A flu and pneumonia vaccine campaign was also initiated.

POST DISCHARGE

- Interactive voice response (IVR) telephone calls were made to patients. If a positive trigger response was noted, THN Care Management completed a more thorough phone assessment and intervened as needed.
- Many patients were discovered to have financial constraints, anxiety and/or depression and a knowledge deficit of the disease process.
- THN Care Management intervened with care coordination
  - Coordinated appointments with the pulmonologist
  - Facilitated ordering of DME
  - Arranged transportation to appointments
- Disease management continued with education on the COPD disease process and medications.
- Patients were followed by a RN, pharmacist or Licensed Clinical Social Worker.

RECOMMENDATIONS

- Due to the success of the pilot program, it was recommended that the COPD GOLD program be implemented system wide.
- The program has been implemented on four of the main Cone Health system campuses.

REFERENCES:

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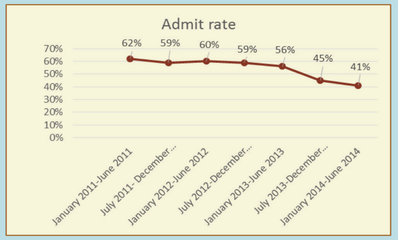
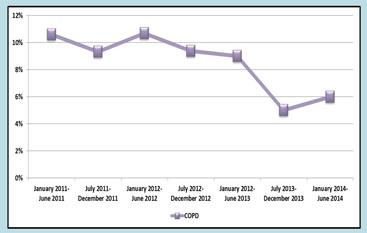
OUTCOMES AND KEY SUCCESSES

COPD Admission Rates at Cone Health



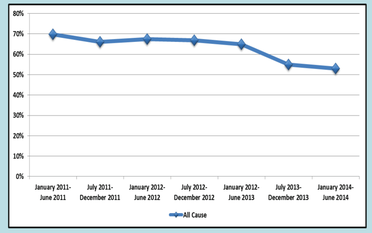
Decreased by 66%

Admissions from the ED for COPD with PNA



Decreased to 5%

Admissions from the ED for COPD-all cause



Decreased by 53%