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.

OUTCOMES AND KEY SUCCESSES
• 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.

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.
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REFERENCES:
• 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.

RECOMMENDATIONS

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