COPD
Readmission
Reduction Program

Transition Program
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Pulmonary Services SMCS
Over View

• 3rd Leading Cause of Death in US (ALA, Aug. 2013)

• CMS and Chronic obstructive pulmonary disease (COPD) is a leading cause of mortality worldwide. (Lancet, Jan. 2014)

• 12 million people diagnosed and 12 million people have it and do not know (NIH, July 2013)

• In 2010 the U.S. spent $29.5 billion in direct health care expenditures, with additional costs not captured in claims due to under-diagnosis and misdiagnosis. (NBCH, Sept. 2012)

• AARC 2014
  ◦ 49.9 Billion spent of COPD exceeding heart failure
  ◦ Among all disease state-COPD patients have the high-test readmission rates in the nation
3rd Leading Cause of Death US

1. Heart Disease
2. Cancer
3. COPD
4. Strokes

Number of COPD Deaths in Women Increasing Sharply

The Problem

- Coronary heart disease: -59%
- Stroke: -64%
- Other CVD: -35%
- COPD: +163%
- All other causes: -7%
Summary

- CMS developed hospital outcome measures to assess 30-day mortality and readmission rates following admissions for acute exacerbation of chronic obstructive pulmonary disease (COPD). Between 1998 and 2008, the number of patients hospitalized annually for acute exacerbations of COPD increased by approximately 18 percent.

- CMS plans to publicly report these measures on Hospital Compare beginning in 2014 as part of the Hospital Inpatient Quality Reporting (IQR) program.

- Additionally, CMS plans to include the COPD readmission measure in the Fiscal Year 2015 Hospital Readmissions Reduction Program (HRRP).

- Mortality and readmission rates for patients with COPD vary widely by hospital, suggesting that opportunities exist for hospitals to improve the quality of care provided to COPD patients.
“A readmission is a failed transition.”

Community issues include failure of communication between hospital and community.

Above all, the planning process needs to encompass both the hospital and the community.

No quarterback, however skillful, can complete passes without downfield receivers with whom he has trained; and no receiver can catch a pass from a quarterback who does not know how and when to throw. Patients are not footballs, but teamwork is teamwork. “ (AARC, April 2014)
Avoiding Unnecessary 30 Day Readmissions

- Early identification of patients at risk for readmission
- Emergency Department Case Management
- Transition from inpatient to outpatient
- Continuum of Care Partnership with SNF, HH etc.
30 Day Readmission COPD

- SMCS COPD readmission rate is at 21.8% for 2013.

- The national average, in a dry run study completed in 2013 by CMS, was 21.1%

- Our target, is to decrease COPD readmissions to 11.7%
COPD CoMorbidities

- Cardiovascular Disease (CHF)
- Diabetes
- Depression
- Anemia
- Mal-nutrition
- Gastric Reflux
- Osteoporosis
- Cancer
- Pneumonia
- Pulmonary Embolus
Respiratory Care & SNF Partnership

**Skilled Nursing Facility**
- SNF HF Discharge Orders
- HH Liaisons - Post D/C
- SNF Forum

**Respiratory Care**
- IP Patient & Staff COPD Education
- SNF COPD Discharge Orders
- CM COPD Transition Note
- COPD Stop Light
- SNF Staff COPD Education
- SNF Forum
- Pulmonary Rehab - Post DC
Coordination Transition of Care

- My Story
- Non-pharmacological treatments
IP Education

- Following Global Initiative Chronic Lung Disease (GOLD)
- Disease Management (PNA/Trach)
- Medications/Devices- Assist Reconciliation
Risk for Readmission: □ High  □ Moderate

□ Patient has appointment with Physician (First and last name)__________________ date:______ time:______ ph:______

□ Follow up appointment to be arranged by SNF with Physician (first and last name)__________________ ph:______ within 7 days post SNF discharge

□ Patient has been referred to Advanced Illness Management (AIM) (916-707-7079) please notify of SNF discharge date

Respiratory:

□ Oxygen at__________ to keep SpO2__________

□ CPAP settings:__________________

□ BiPAP settings__________________

□ Use spacer with MDI

□ NRT and Smoking Cessation__________________

□ Trach Care BID

□ Trach humidification__________________

Other:

□ Oral Care BID

□ Promote Physical Activity BID

□ Notify physician for anxiety of depression for possible treatment if appropriate

Adjunct Therapies:

□ Depending on the clinical condition of the patient, an appropriate fluid balance with special attention to administration of diuretics, anticoagulants, treatment of comorbidities, and nutritional aspects should be considered. At all times, health care providers should strongly enforce stringent measures against active cigarette smoking. Patients hospitalized because of exacerbations of COPD are at increased risk of deep vein thrombosis and pulmonary embolism; thromboprophylactic measures should be enhanced. (GOLD, 2014)

Sighs/Symptoms to Monitor: Place COPD Stop Light at head of bed.

*Notify SNF Physician or patient’s PCP for any of the following:

1. Marked increase in intensity of symptoms

2. Onset of new physical signs (change in color of mucus, fever)

3. Failure of an exacerbation to respond to initial medical management

4. More frequent exacerbations

5. Increased need to take more medications

□ SNF Physician may contact patient’s PCP__________________ ph:______

□ SNF Physician may contact patient’s pulmonologist__________________ ph:______

Date:______ Time:______

Physician Signature:__________________ Physican #:________

Sutter COPD Transfer/Summary
Orders to Skilled Nursing Facility

Patient Identification
CM COPD Transition Note
(PNA too)

COPD Care Transition Note

Referring MD: __________________________

Met with: □ Patient  □ Family/Caregiver

INTERVENTIONS/EDUCATION:

□ Warning signs and symptoms & who to call
□ Discussed patients understanding of medical condition
□ Medications and Devices
□ Management of an exacerbation (flare-up)
□ Prevention of exacerbation (flare-up)
□ Exercise/Physical Activity
□ Alcohol/drug/tobacco
□ Manage Fatigue
□ Manage Anxiety/Depression
□ Follow-up with doctors/health care providers

□ Other____________________________________________________

FOLLOW-UP:

□ Core Measure Alert in chart
□ Referred-HH/AIM/Hospice
□ Pt has MD appt within 7 days
□ Stop Light
□ Refer to Pulmonary Rehab if candidate
□ Pt has f/u for ICD/CRT-D???
□ SNF Orders Initiated
□ Name/cell number provided
□ Other________________________

CareTransition Coordinator (CTC)

__________________________________________ Time Spent: __________________________
COPD Stop Light (PNA too)

Controlling COPD at home
How do I feel today?

<table>
<thead>
<tr>
<th>How is my cough?</th>
<th>Cough is normal</th>
<th>Cough is worse than normal</th>
<th>Chest pain that does not go away</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Change in mucus: More than normal</td>
<td>Looks yellow, green or gray</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is my medicine working?</th>
<th>Normal dose is working</th>
<th>Need to use my medicine more often than normal</th>
<th>Medicine is not working</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How is my breathing?</th>
<th>Breathing is normal</th>
<th>More trouble breathing while: Walking</th>
<th>Feel tired or restless</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>More trouble breathing at rest</td>
<td>Feel confused or sleepy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lips or nails turning gray or blue</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other:</th>
<th>Fever</th>
</tr>
</thead>
</table>

Preventing pneumonia at home
How do I feel today?

<table>
<thead>
<tr>
<th>Do I have a cough?</th>
<th>No cough or cough is normal.</th>
<th>My cough is worse than normal.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If I cough up mucus, it looks white.</td>
<td>I am coughing up mucus that looks: Yellow, Green, Streaked with blood</td>
</tr>
<tr>
<td></td>
<td>My cough is lasting longer than a normal cold.</td>
<td>Pain in my chest that does not go away.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do I have a fever?</th>
<th>No fever.</th>
<th>Fever of 100 – 101.5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fever over 101.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How is my energy level?</th>
<th>My energy level is normal.</th>
<th>I am too tired to do most of my normal activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I am so tired that I can hardly do any of my normal activities.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Am I short of breath?</th>
<th>My breathing is normal.</th>
<th>I am short of breath.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I am short of breath at rest.</td>
<td>I do not feel alert.</td>
</tr>
</tbody>
</table>
SNF Staff Education

• Disease management
• Improving the Quality of Care a Team Approach to Transition of Care
• Increase patient ability to self-manage symptom and their care
• Tools of the trade: Oxygen Therapy-Medications-Challenges with Devices, Manage and Prevent Exacerbations
• Improve the health and well being, and patient satisfaction
Pulmonary Rehab and Activity

- GOLD 2014 “All COPD patients with breathlessness when walking at their own pace on level ground appear to benefit from rehabilitation and maintenance of physical activity
- Physical Therapy at SNF
- Maintenance/Activity SNF
- Refer to Pulmonary Rehab upon discharge if candidate
Next Steps

- Finish Order Sets and Care Transition Notes
- Staff Education (IP and SNF)
- Quarterly Forum
- CM and Transition Teams
- Pulmonary Rehab
- PCP follow up appointment when DC SNF
Questions

The Sutter Health Promise

We Plus You Partnership in Action

What would we ever do without partners? At Sutter Health, we partner with you toward a single goal: providing high-value, quality health care that’s more personalized and human. It’s how we make health care better. Most of all, it’s how we get better, together. See how we’re putting partnership into action today.
References:


CMS Medicare Hospital Quality Chartbook, Performance Report on Outcome 2013, Prepared by


Magnus P Ekström , The rise and fall of COPD mortality, The Lancet Respiratory Medicine - 1 January 2014 ( Vol. 2, Issue 1, Pages 4-6 ) DOI: 10.1016/S2213-2600(13)70257-1


NBCH (National Business Coalition on Healthcare and Drive for COPD, September 2012, Retrieved from website www.nbch.org/nbch/files/ccLibraryFiles/Filename/000000002422/NBCH_AB_COPD_F.PDF
