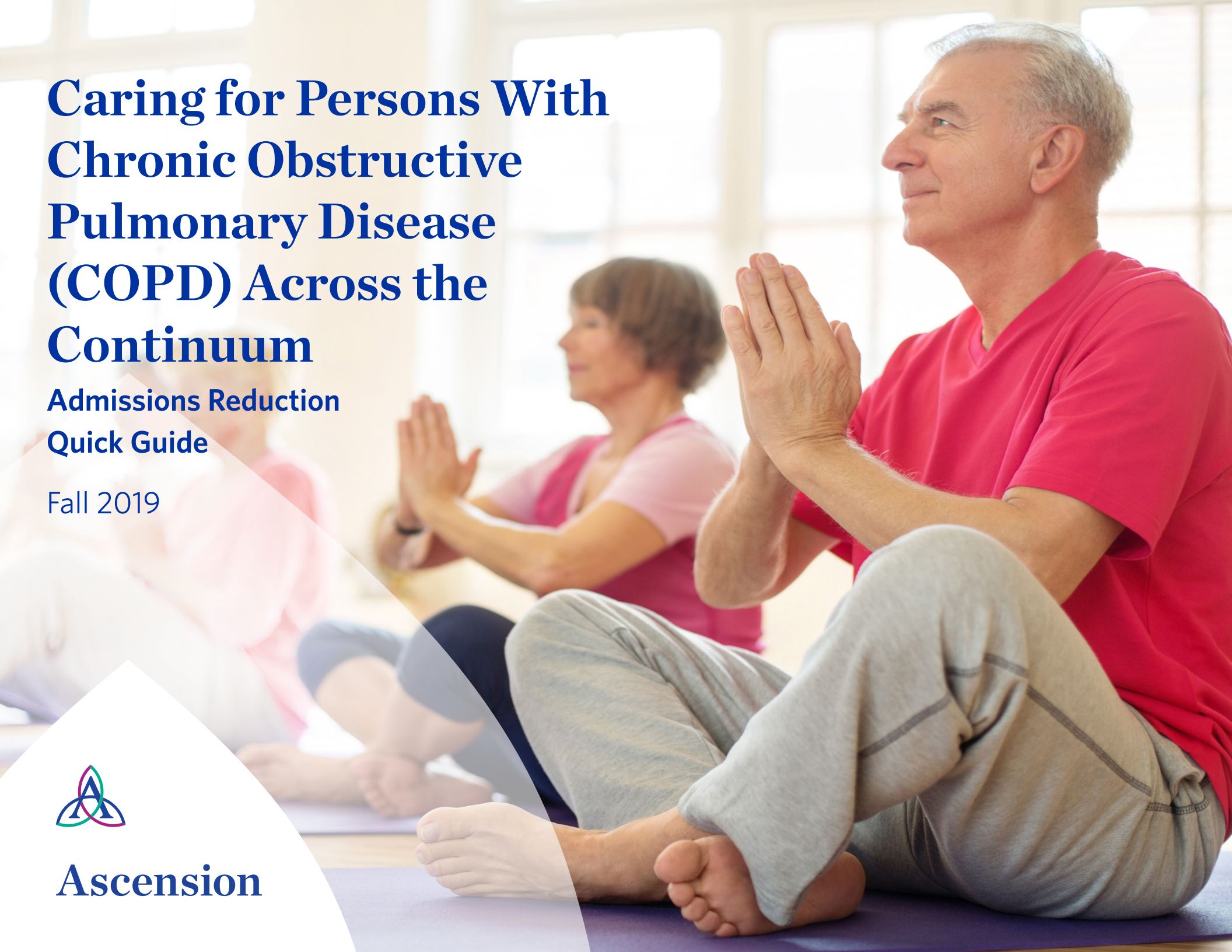
Caring for Persons With Chronic Obstructive Pulmonary Disease (COPD) Across the Continuum

Admissions Reduction Quick Guide

Fall 2019



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Disclaimer

This quick guide is intended to be a general guide for creating systems or processes to improve care for individual patients, not as an aid for specific care decisions. The resource materials and practices are for general information purposes only. This quick guide is complementary and is not inclusive of all recommendations and considerations. The information provided is not a substitute for sound clinical judgment from the healthcare professional. Because every patient encounter is unique, individual care decisions must always represent unique interactions between specific caregivers and the patient; no document should ever be used to substitute for that judgment. Similarly, since individual Ministry Markets and hospitals are each unique, the improvement of System quality approaches must reflect the local environment guidelines and regulatory requirements. It is for this reason that one of the important governance functions of all hospital and Ministry Market boards is the quality of care provided; local quality improvement efforts are all managed at the local level. This quick guide is not intended to supersede or replace guidelines, practice standards, policies or procedures issued by the hospital and Ministry Market boards. It is also not intended and should not be construed as legal or professional advice or opinion. While Ascension strives to ensure the accuracy of the information provided in this document, information may be subject to change, and it is the responsibility of the user of this document to ensure they have the most up-to-date and complete information from available resources.

Breathe in. Breathe out. Breathe easier.

It is an authentic expression of our Mission to **serve all persons,** with special attention to those who are poor and vulnerable.

By working together, across outpatient and inpatient spaces and across disciplines, we can create care that **truly connects with and empowers** the persons in our communities who suffer from chronic airway diseases.

Helping persons in our communities breathe easier: It's how we live our Mission.

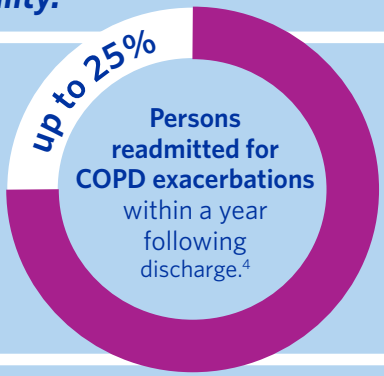
COPD Admissions Reduction Quick Guide

Chronic obstructive pulmonary disease (COPD) is a source of suffering for persons in the communities we serve.

Almost **16 million** people in the U.S. have been diagnosed with **COPD** and **millions more** have **low pulmonary function** but do not know they have **COPD.**[1]

COPD is the fourth leading cause of death in the United States[2] ***as well as a leading cause of disability.***[1]

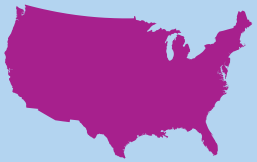
Acute exacerbations of COPD were responsible for approximately **1.5 million** emergency department visits and **700,000** hospitalizations in 2010.[3]



Lower socio-economic status is strongly linked to **poorer outcomes** for persons with **COPD.**[5,6]

Ascension Medical Group currently serves approximately **82,000 persons** with COPD.

Americans spent ***approximately*** **$50 billion** on direct and indirect costs of **COPD-related healthcare** in 2010.[7]



1. National Heart, Lung, and Blood Institute. COPD National Action Plan. Updated February 2018. Accessed June 28, 2019.
2. Heron M. Deaths: Leading causes for 2017. *Natl Vital Stat Rep.* 2019;68(6):1-76.
3. Ford ES, Croft JB, Mannino DM, Wheaton AG, Zhang X, Giles WH. COPD surveillance—United States, 1999–2011. *Chest.* 2013;144(1):284-305.
4. Halpin DMG, Miravitlles M, Metzdorf N, Celli B. Impact and prevention of severe exacerbations of COPD: a review of the evidence. *Int J Chron Obstruct Pulmon Dis.* 2017; 12: 2891-2908.
5. Eisner MD, Blanc PD, Omachi TA, et al. Socioeconomic status, race, and COPD health outcomes. *J Epidemiol Community Health.* 2011;65(1): 26–34.
6. Gershon AS, Dolmage TE, Stephenson A, Jackson B. Chronic obstructive pulmonary disease and socioeconomic status: a systematic review. *COPD.* 2012;9(3):216-26.
7. Guarascio AJ, Ray SM, Finch CK, Self TH. The clinical and economic burden of chronic obstructive pulmonary disease in the USA. *Clinicoecon Outcomes Res* 2013; 5:235-45.

What is the Ascension FY20 asthma and COPD priority goal?

Improve the care of persons with asthma and COPD:

Ascension will achieve a **6% reduction** in hospital admissions for Ascension Medical Group (AMG) patients with a diagnosis of asthma or COPD.

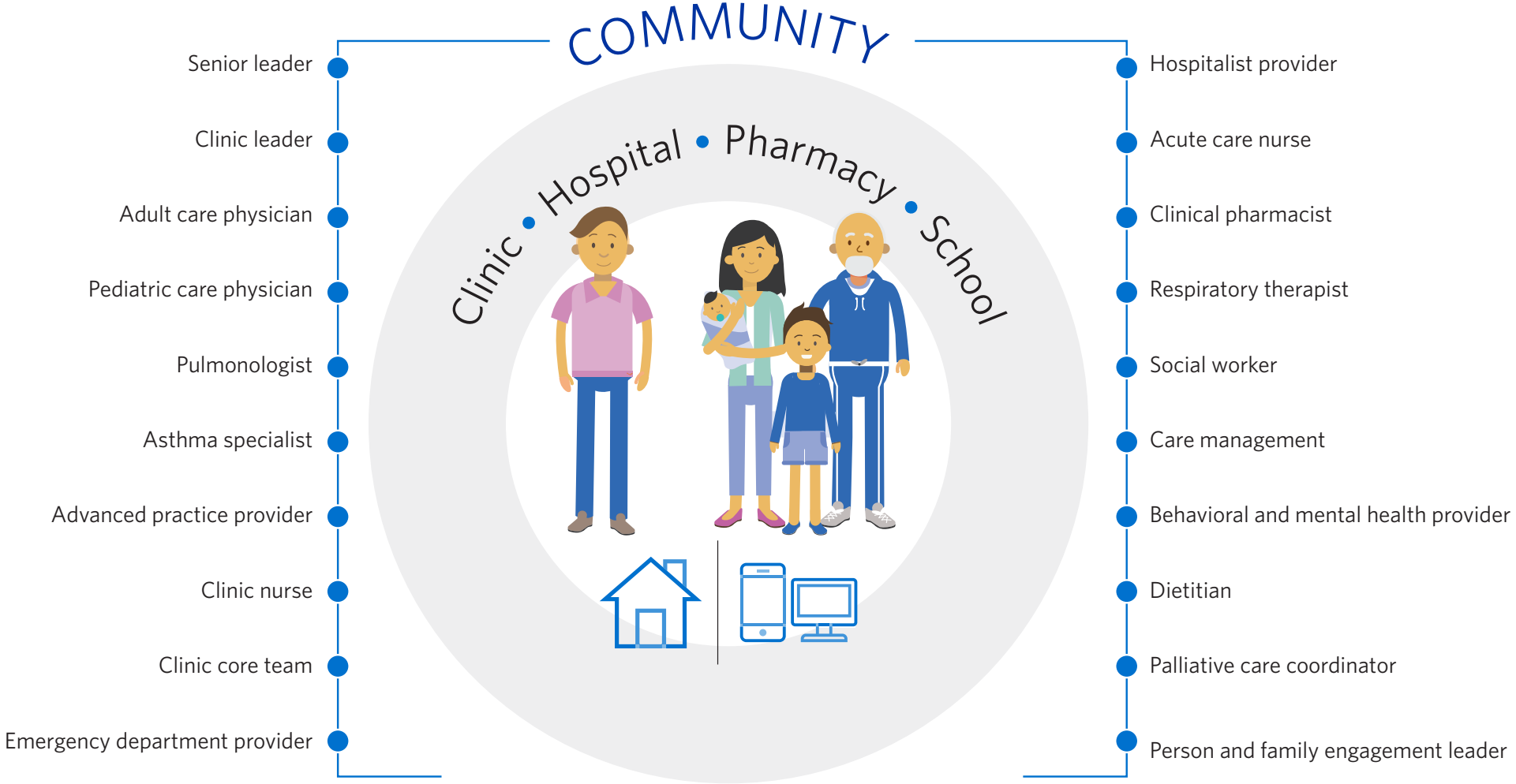
Denominator criteria
Patients 18 years of age or greater with a diagnosis of asthma or COPD during an ambulatory or acute care inpatient/ outpatient encounter. Patients 2-17 years of age must only have an asthma diagnosis.
Numerator criteria
Discharge from an acute inpatient encounter with an asthma or COPD diagnosis.
Exclusion criteria
• Deceased any time prior to the measurement end date. • Evidence of hospice care exists during the measurement period. • Patients with end-stage renal disease (ESRD).
Evaluation period
• Eligibility period: patient encounters during FY2019. • Follow-up period: asthma and COPD admissions rate in FY2020 for patient encounters in the eligibility period.

Getting started

To get started, we recommend that leaders:

1. Form a market-level team with members from the **ambulatory and acute care settings** focused on attaining goals related to the care of persons with chronic airway disease across the continuum of care.
   - Develop clear roles and expectations for members of the healthcare team and document these roles and expectations in the developed protocols and policy.
   - Develop protocols and integrate standard practices into the electronic health record (EHR) and include documentation requirements.
   - Monitor adherence to evidence-based guidelines, facilitating therapeutic management and effective person/patient monitoring.
   - Use high-reliability and AIM4Excellence® processes and resources to develop action plans and improve collaboration.
2. Review the Caring for Persons With Asthma and COPD Toolkit to identify opportunities for improving the reliability and effectiveness of processes.
3. Review the Ascension-created educational materials and offer education to the healthcare professionals who are involved in caring for persons with chronic airway disease about the significance of appropriate diagnosis, treatment, education and monitoring.
4. Prioritize quality metrics related to the work.
   - Implement a process to provide continuous performance feedback to healthcare professionals involved in the care of persons with chronic airway disease.
   - Track progress at regular intervals to monitor improvement.
5. Use leader rounding and huddles to identify opportunities for improvement in real time and engage teams in collaborative problem-solving.

1 Form a market-level team with members from the ambulatory and acute care settings

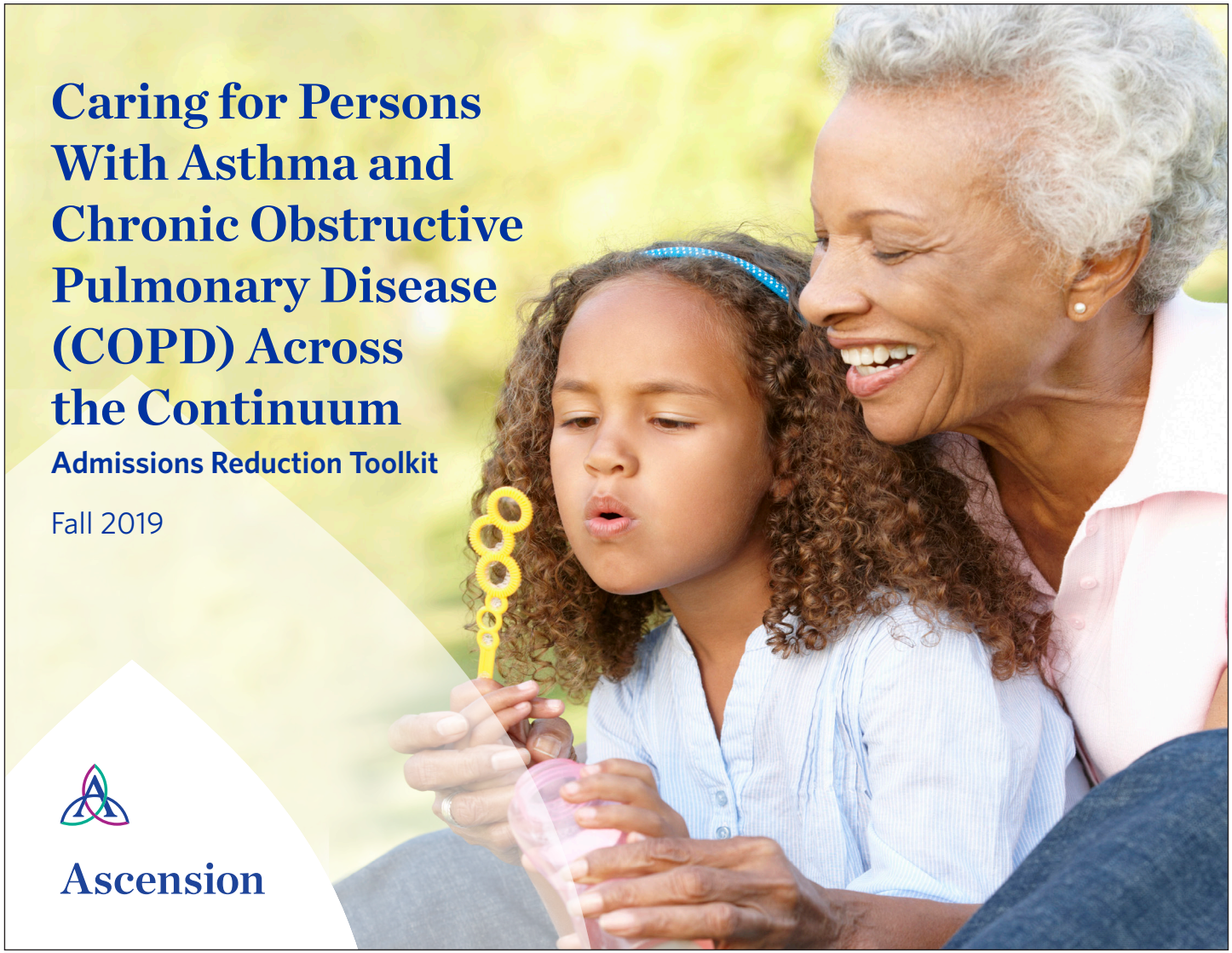


2 Review the Caring for Persons With Asthma and COPD Toolkit to identify opportunities

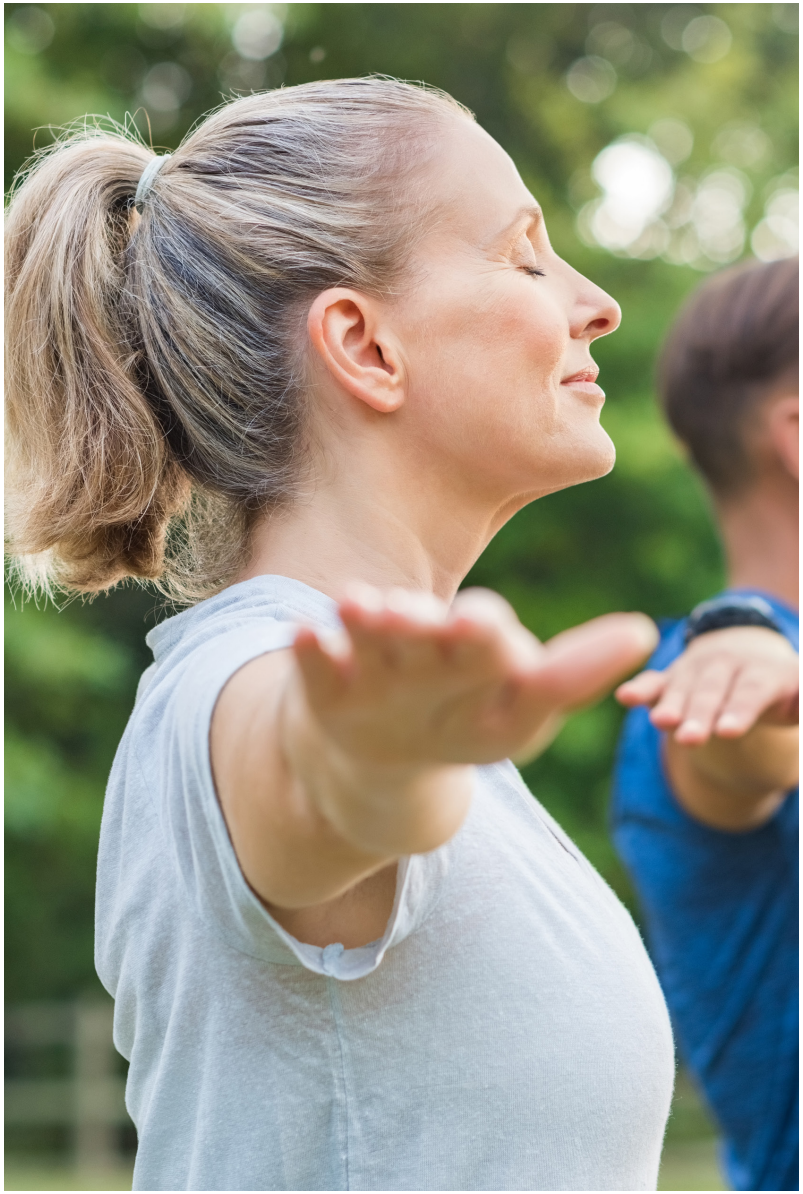
Working together on a systematic approach to asthma and COPD care that focuses on two domains:

Reducing symptoms (relieve symptoms, improve exercise tolerance, improve health status).

Reducing risk (prevent disease progression, prevent and treat exacerbations, reduce mortality).



Evidence-based approaches to improving care



Refer to **Chapter 3** of the Caring for Persons with Asthma and COPD Toolkit for more detailed approaches to achieving and maintaining COPD control.

Evidence-based approaches to providing quality COPD care
Identify persons at high risk
• Anyone who has chronic cough or sputum production, shortness of breath and/or a history of smoking could have COPD.
Confirm the diagnosis
• Perform spirometry testing and identify stage of disease.
Develop the treatment plan
• Select therapy based on symptom assessment and exacerbation risk. • Assess patient response to treatment and adjustments to treatment.
Implement strategies to prevent deterioration
• Use a written, person-centric COPD action plan. • Reduce risk factors: smoking cessation, vaccines up-to date, exercise and healthy lifestyle, other risk factors. • Integrate care with pulmonary rehabilitation. • Offer supportive, palliative and end-of-life care, as appropriate.
Manage exacerbations
• Educate persons, families and caregivers on actions to take with worsening symptoms and when to contact healthcare provider. • Optimize ED and inpatient stays; ensure appropriate transitions of care and follow-up.

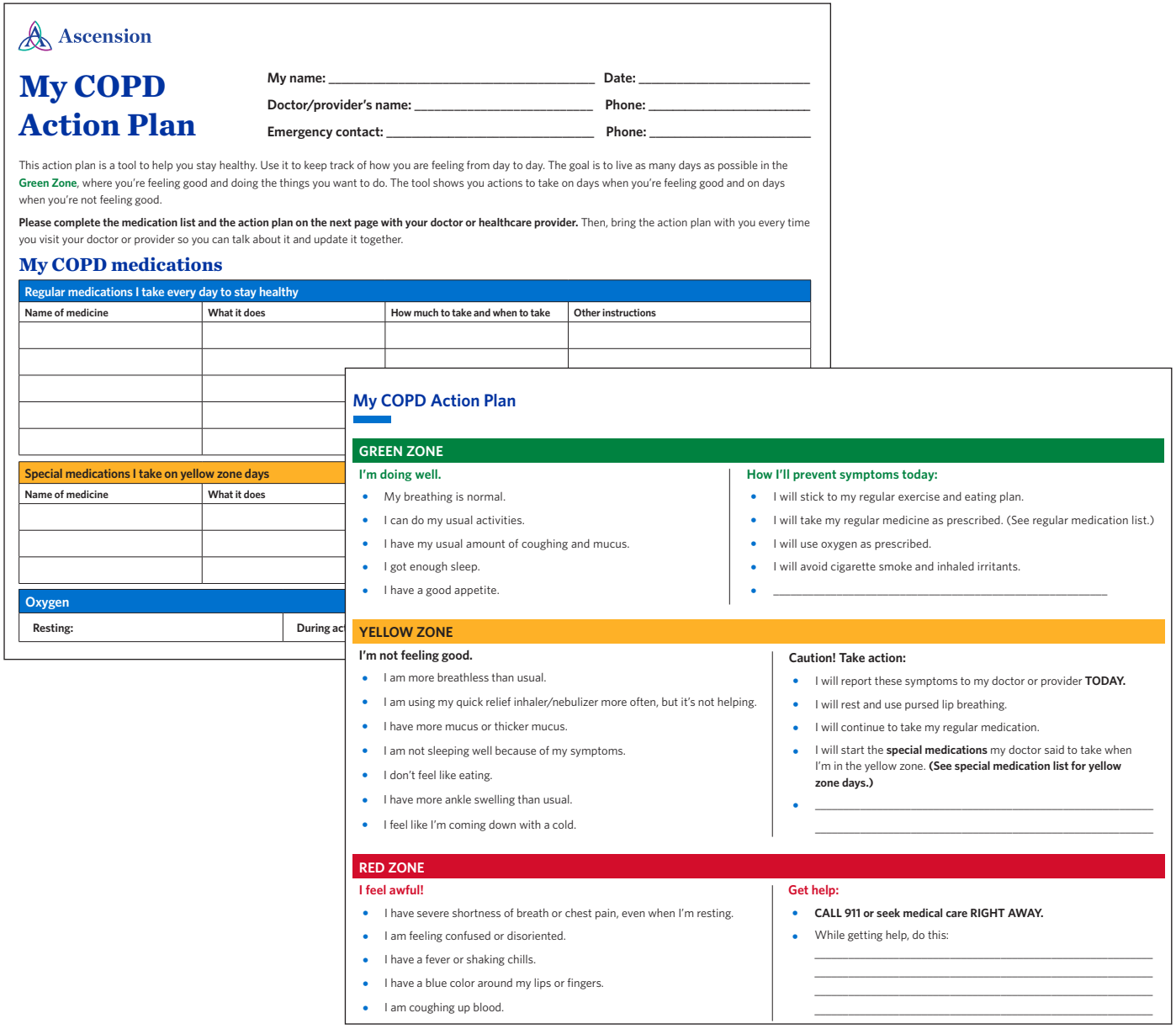
Providing compassionate, personalized care for all

An approach to care that empowers persons, families and caregivers includes the following components:

Partnership in developing treatment goals.

Self-management education at multiple points of care.

Tools to support self-management.



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My COPD Action Plan

My name: _____ Date: _____

Doctor/provider's name: _____ Phone: _____

Emergency contact: _____ Phone: _____

This action plan is a tool to help you stay healthy. Use it to keep track of how you are feeling from day to day. The goal is to live as many days as possible in the Green Zone, where you're feeling good and doing the things you want to do. The tool shows you actions to take on days when you're feeling good and on days when you're not feeling good.

Please complete the medication list and the action plan on the next page with your doctor or healthcare provider. Then, bring the action plan with you every time you visit your doctor or provider so you can talk about it and update it together.

My COPD medications

Regular medications I take every day to stay healthy

Name of medicine	What it does	How much to take and when to take	Other instructions

Special medications I take on yellow zone days

Name of medicine	What it does

Oxygen

Resting:	During ac

My COPD Action Plan

GREEN ZONE

I'm doing well.

- My breathing is normal.
- I can do my usual activities.
- I have my usual amount of coughing and mucus.
- I got enough sleep.
- I have a good appetite.

How I'll prevent symptoms today:

- I will stick to my regular exercise and eating plan.
- I will take my regular medicine as prescribed. (See regular medication list.)
- I will use oxygen as prescribed.
- I will avoid cigarette smoke and inhaled irritants.
- _____

YELLOW ZONE

I'm not feeling good.

- I am more breathless than usual.
- I am using my quick relief inhaler/nebulizer more often, but it's not helping.
- I have more mucus or thicker mucus.
- I am not sleeping well because of my symptoms.
- I don't feel like eating.
- I have more ankle swelling than usual.
- I feel like I'm coming down with a cold.

Caution! Take action:

- I will report these symptoms to my doctor or provider **TODAY.**
- I will rest and use pursed lip breathing.
- I will continue to take my regular medication.
- I will start the **special medications** my doctor said to take when I'm in the yellow zone. **(See special medication list for yellow zone days.)**
- _____

RED ZONE

I feel awful!

- I have severe shortness of breath or chest pain, even when I'm resting.
- I am feeling confused or disoriented.
- I have a fever or shaking chills.
- I have a blue color around my lips or fingers.
- I am coughing up blood.

Get help:

- **CALL 911 or seek medical care RIGHT AWAY.**
- While getting help, do this:

Barriers and solutions for self-management

Medication-based barriers

Examples: adherence, device technique, side effects, affordability, lack of insurance, person's forgetfulness/fear/beliefs

Solutions:

- Assess adherence to treatment, inhaler technique and medication side effects at each visit.
- Select inhaler device based on the person's needs, such as the person's ability to appropriately use the inhaler.
- Develop a process with local pharmacy leaders to support the person's access to care, including assisting the person with navigating medication access barriers, recommending copay assistance programs, and helping persons enroll in patient assistance programs, where applicable.
- Engage clinical pharmacists for medication counseling, education and support.

Lifestyle barriers

Examples: smoking, physical inactivity, diet/nutrition, environmental control, overweight, mental health (depression, anxiety, stress)

Solutions:

- Assess symptoms and risk of exacerbation at each healthcare visit.
- Offer self-management education and support.
- Partner with persons and families to create a written action plan.
- Advise persons not to smoke tobacco and to avoid secondhand smoke.
- Refer to behavioral and mental health providers as needed.
- Refer for nutrition education/counseling.

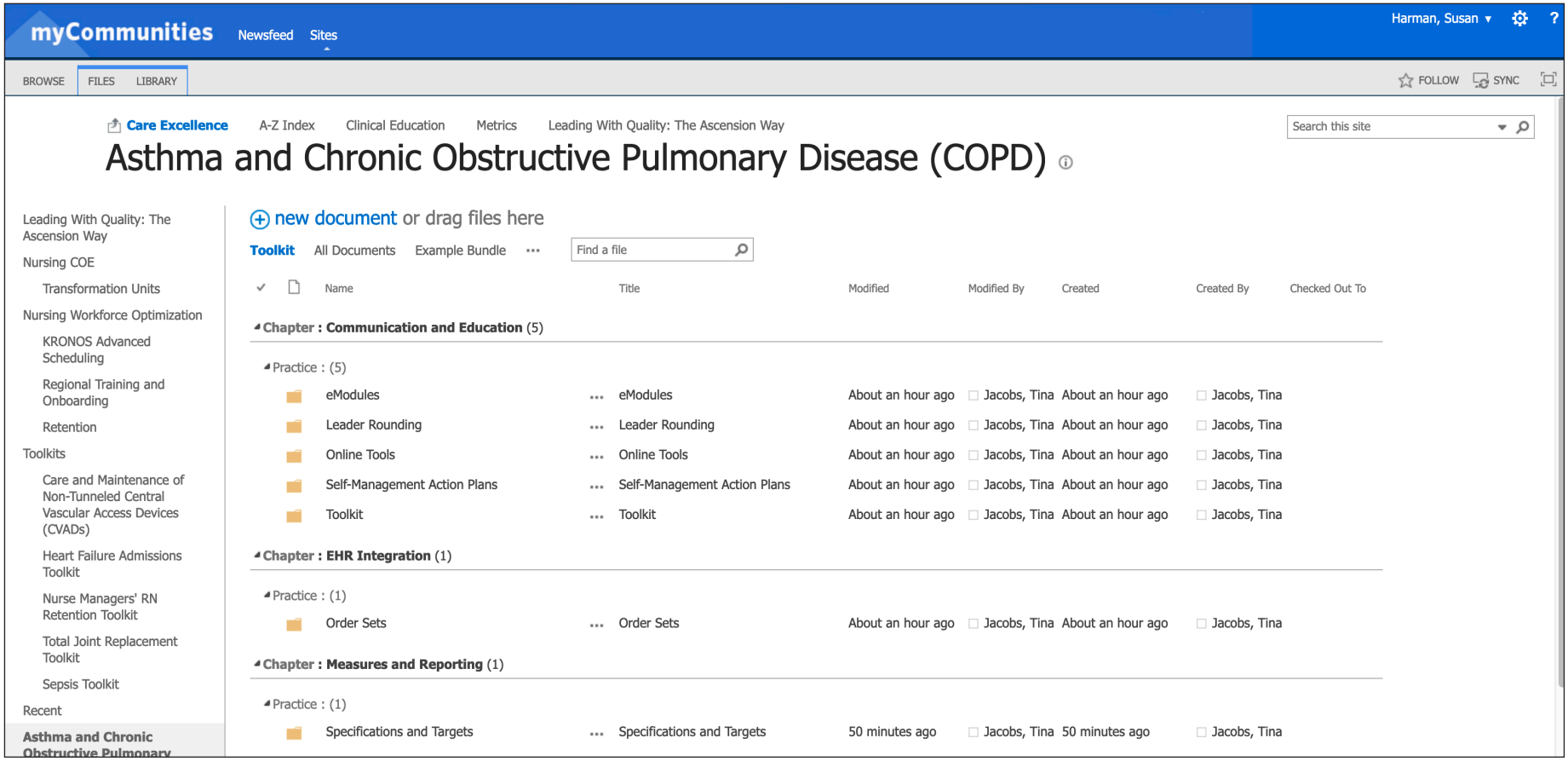
Social barriers

Examples: food insecurity, housing instability, transportation access, language, beliefs, health literacy, health numeracy

Solutions:

- Screen for social determinants of health and identify health determinant barriers to self-management.
- Create a library/list of community resources and community-based organizations.
- Establish an appropriate process for referral and feedback for local resources.
- Consider the person's needs and preferences for additional navigation support.
- Identify a team member (social worker, navigator, community health worker, etc.) to work with the person to define barriers and link to community resources and self-management support.

3 Review the Ascension-created tools and educational materials and offer education to healthcare professionals



Click here for Ascension-created tools and educational materials.

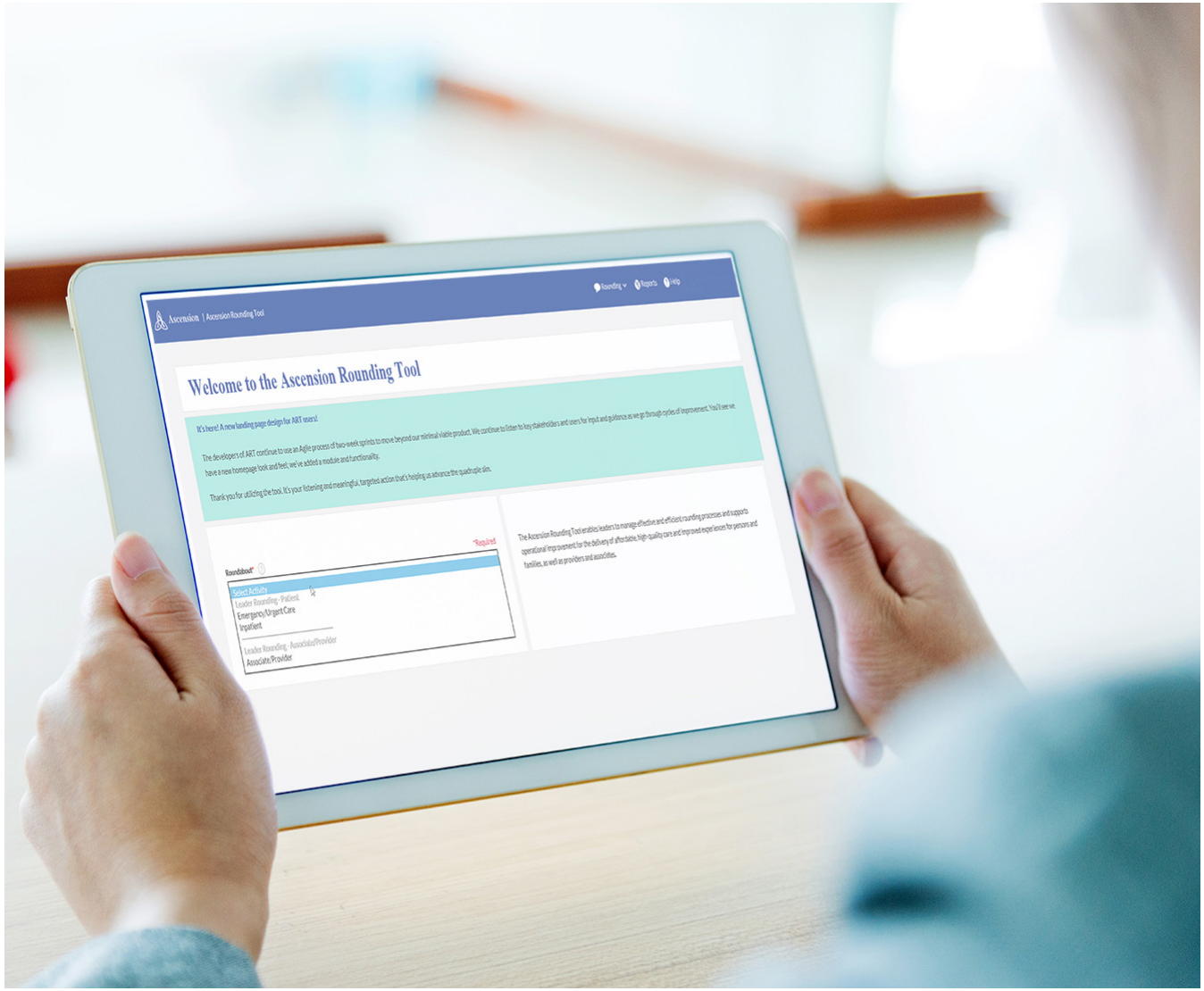
4 Prioritize quality metrics related to the work

A process should be identified at the local level to review performance regularly. Metrics should be tracked and discussed at regular intervals to identify and address any potential barriers to optimizing the care of persons living with chronic airway disease.

Metrics to consider evaluating

Disease	Intervention	Example metrics
COPD	Use of spirometry testing in the assessment and diagnosis of COPD	New diagnosis of or newly active COPD with spirometry testing to confirm diagnosis
	Use of COPD self-assessment questionnaire to measure the impact of COPD	COPD self-assessment questionnaire completed at each clinic visit
	Pharmacotherapy management of COPD exacerbation	• Diagnosis of COPD and appropriate medication dispensed that patient remained on during the treatment period • Patients discharged from an acute inpatient admission or an ED encounter with a primary diagnosis of COPD who were dispensed both a systemic corticosteroid and a bronchodilator
	Written, person-centric COPD action plan completed and reviewed at each visit	Written action plan provided at each clinical visit
	Medical assistance with smoking cessation for current smokers or tobacco users	• Advised smoker or tobacco user to quit during the measurement period • Discussed or recommended cessation medications during the measurement period • Discussed or provided cessation methods or strategies during the measurement period
	Influenza vaccination	Received an influenza vaccination after July 1
	Pneumococcal vaccination for adults age 65 and older	Have ever received one or more pneumococcal vaccinations

5 Make caring for persons with chronic airway disease part of leader rounding



We are encouraging leaders at all levels to talk with providers and associates about their role in improving care during rounds.

Leaders can then take meaningful action based on what they learn by listening, including taking what they learn to huddles to engage teams in improvement efforts.

Suggested language for rounding: *"We have launched a coordinated effort across Ascension to ensure that each person receives the optimal care for chronic airway disease. How would you describe your role in improving care for these patients?"*

Communications and education campaign

Below you'll find several online tools for persons with asthma and COPD that our Ascension experts and clinicians use in their clinics and hospitals to provide self-management education and assessment:

COPD Assessment Test (CAT).

Free training videos in multiple languages for inhalers: http://use-inhalers.com.

COPD360music: Harmonicas for Health

Additional tools and resources will be available on the initiative microsite as they are developed or adopted.

Your national team is here to support you

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