COPD READMISSION AVOIDANCE PROJECT

Owen Sound Family Health Team

BACKGROUND

In Canada, COPD has the highest rate of hospital readmissions of all chronic diseases (Canadian Institute for Healthcare Information (CIHI), 2008). Hospital readmissions place a burden on patients, families, the healthcare system, and the quality of healthcare services (CIHI, 2012). The COPD Readmission Avoidance Project was established in June 2013. The goal of the project is to reduce hospital readmission rates and emergency department visits related to COPD through a collaborative relationship between the Owen Sound Family Health Team, the Community Care Access Centre, and Grey Bruce Health Services.

PERFORMANCE INDICATORS

- 95% of patients with COPD who are discharged will have an appointment with a healthcare provider within 1 week of discharge
- 75% of patients with COPD will be placed on the COPD order set and Pathway
- 100% of patients with COPD will receive COPD self-management education prior to discharge
- Readmission rates for COPD within 30 days, when initial RFV is COPD, will decrease by 10%
- ED visits related to COPD within 30 days of last hospital presentation will decrease by 10%

Source for indicators: COPD Readmission Avoidance Project, GBHS Improvement Project Charter

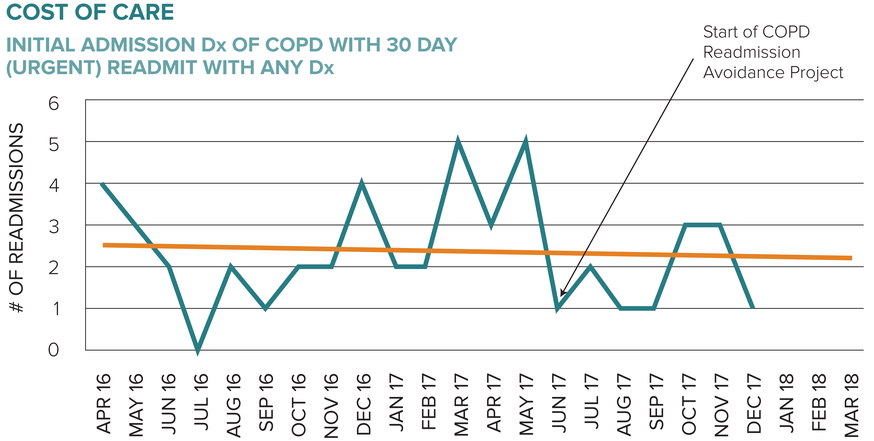
METHODS

- The Owen Sound Family Health Team is automatically notified of any FHT patient who is discharged from the hospital after admission for COPD.
- The OSFHT performs a follow-up phone call within 48 hours to all FHT patients post discharge
- The OSFHT schedules an appointment with their primary health care provider or with the respiratory therapist within 7 days of discharge.
- The RRT or physician provides home visits within 7 days post discharge for patients who are unable to come into the FHT.
- CCAC also provides a home visit from a rapid response nurse post discharge.
- The project utilizes pathways and order sets to standardize care, and performs discharge medication reconciliation prior to discharge from hospital.
- COPD project folders containing educational material and care plans are currently being distributed to the medicine and emergency units, with plans to expand distribution to surgery, monitored beds (step-down), and woman and child units.

RESULTS

COST OF CARE

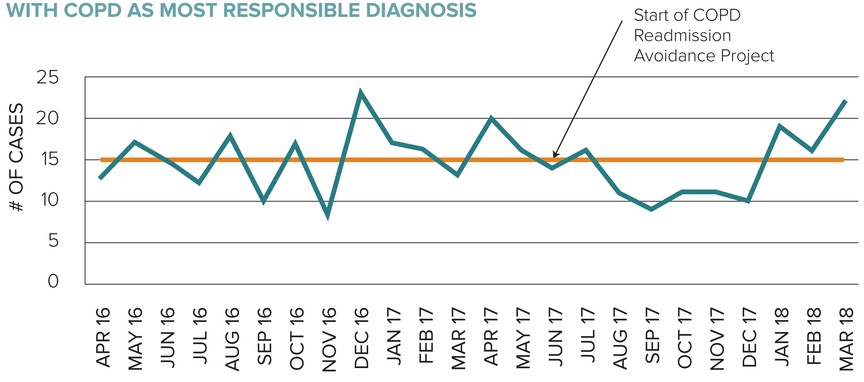
INITIAL ADMISSION Dx OF COPD WITH 30 DAY (URGENT) READMIT WITH ANY Dx



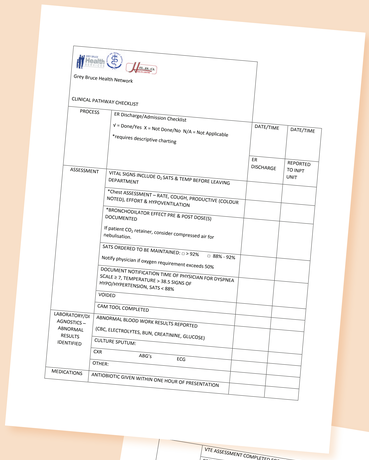
Source: Grey Bruce Health Services

POPULATION HEALTH

VOLUME OF ADMITTED CASES TO INPATIENTS WITH COPD AS MOST RESPONSIBLE DIAGNOSIS



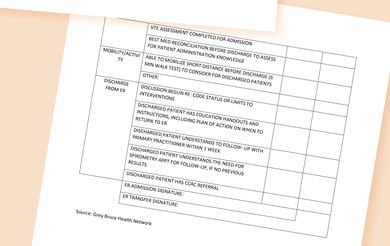
Source: Grey Bruce Health Services



Grey Bruce Health Network

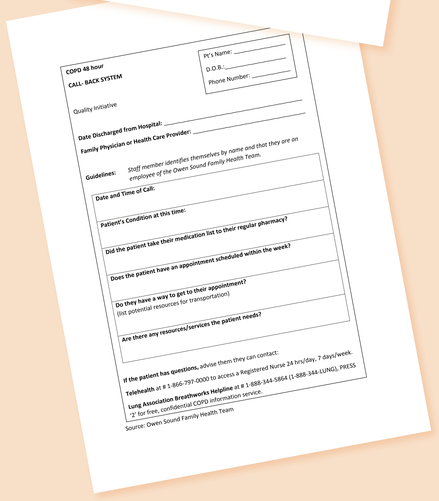
CLINICAL PATHWAY CHECKLIST

		DATE/TIME	DATE/TIME
PROCESS	ER Discharge/Admission Checklist Y = Done/Yes X = Not Done/No N/A = Not Applicable *requires descriptive charting	ER DISCHARGE	REPORTED TO INPT UNIT
ASSESSMENT	VITAL SIGNS INCLUDE O2 SATS & TEMP BEFORE LEAVING DEPARTMENT		
	*Chest ASSESSMENT – #x/TE, COUGH, PRODUCTIVE (COLOUR NOTED), EFFORT & HYPOVENTILATION		
	*BRONCHODILATOR EFFECT PRE & POST DOSE(S) DOCUMENTED		
	If patient CO_2 retainer, consider compressed air for nebulization		
	SATS ORDERED TO BE MAINTAINED @ > 92% @ 88% - 92%		
	Notify physician if oxygen requirement exceeds 50%		
	DOCUMENT NOTIFICATION TIME OF PHYSICIAN FOR DYSPNEA SCALE ≥ 7, TEMPERATURE > 38.5 SIGNS OF #/HQ/INFERTENSION, SATS < 88%		
	VOIDED		
	CAM TOOL COMPLETED		
LABORATORY/DIAGNOSTICS – ABNORMAL RESULTS IDENTIFIED	ABNORMAL BLOOD WORK RESULTS REPORTED (CBC, ELECTROLYTES, BUN, CREATININE, GLUCOSE)		
	CULTURE SPUTUM:		
	CXR ABG's ECG		
	OTHER:		
MEDICATIONS	ANTIBIOTIC GIVEN WITHIN ONE HOUR OF PRESENTATION		



MOBILITY/ACTIVITY	VTE ASSESSMENT COMPLETED FOR ADMISSION		
	BEST MED RECONCILIATION BEFORE DISCHARGE TO ASSESS FOR PATIENT ADMINISTRATION KNOWLEDGE		
	ABLE TO MOBILIZE SHORT DISTANCE BEFORE DISCHARGE (6 MIN WALK TEST) TO CONSIDER FOR DISCHARGED PATIENTS		
	OTHER:		
DISCHARGE FROM ER	DISCUSSION BEGUN RE: CODE STATUS OR LIMITS TO INTERVENTIONS		
	DISCHARGED PATIENT HAS EDUCATION HANDOUTS AND INSTRUCTIONS, INCLUDING PLAN OF ACTION ON WHEN TO RETURN TO ER		
	DISCHARGED PATIENT UNDERSTANDS TO FOLLOW- UP WITH PRIMARY PRACTITIONER WITHIN 1 WEEK		
	DISCHARGED PATIENT UNDERSTANDS THE NEED FOR SPIROMETRY APPT FOR FOLLOW-UP, IF NO PREVIOUS RESULTS		
	DISCHARGED PATIENT HAS CCAC REFERRAL		
	ER ADMISSION SIGNATURE:		
	ER TRANSFER SIGNATURE:		

Source: Grey Bruce Health Network



COPD 48 hour CALL- BACK SYSTEM

Quality Initiative

PC's Name: _____
D.O.B: _____
Phone Number: _____

Date Discharged from Hospital: _____

Family Physician or Health Care Provider: _____

Guidelines: *Staff member identifies themselves by name and that they are an employee of the Owen Sound Family Health Team.*

Date and Time of Call:

Patient's Condition at this time:

Did the patient take their medication list to their regular pharmacy?

Does the patient have an appointment scheduled within the week?

Do they have a way to get to their appointment?
(list potential resources for transportation)

Are there any resources/services the patient needs?

If the patient has questions, advise them they can contact:

Telehealth at # 1-866-797-0000 to access a Registered Nurse 24 hrs/day, 7 days/week.

Lung Association Breathworks Helpline at # 1-888-344-5864 (1-888-344-LUNG), PRESS "3" for free, confidential COPD information service.

Source: Owen Sound Family Health Team

CONCLUSIONS

The COPD Readmission Avoidance Project quality improvement initiative is a joint effort of the Owen Sound Family Health Team, Grey Bruce Health Services, and Community Care Access Centre. A hospital admission for COPD triggers processes from all three collaborative partners that aim to reduce the rate of hospital re-admissions. The Owen Sound Family Health Team has been successful in providing follow-up phone calls and clinic appointments or home visits to approximately 90% of the Family Health Team patients with COPD discharged from hospital.

NEXT STEPS

- Leverage new knowledge and improved processes gained from participation in the Canadian Foundation for Healthcare Improvement INSPIRED Approaches to COPD: Improving Care and Creating Value quality improvement collaborative.
- Increase collaboration with Grey Bruce Health Services and CCAC to improve range of COPD services offered within the community and to avoid duplication of services.
- Engage physicians and allied health outside of the OSFHT to participate in a similar call-back and home visit process to improve COPD care post hospital discharge and help prevent hospital re-admissions.

REFERENCES

Canadian Institute for Health Information (CIHI). (2008). Health indicators 2008. Ottawa, ON: CIHI.

Canadian Institute for Health Information (CIHI). (2012). All-Cause Readmission to Acute Care and Return to the Emergency Department. Ottawa, ON: CIHI.

ACKNOWLEDGEMENTS

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GREY BRUCE Health SERVICES