Breathe Easier: Implementing Strategies for Reducing COPD Readmissions

September 12, 2024

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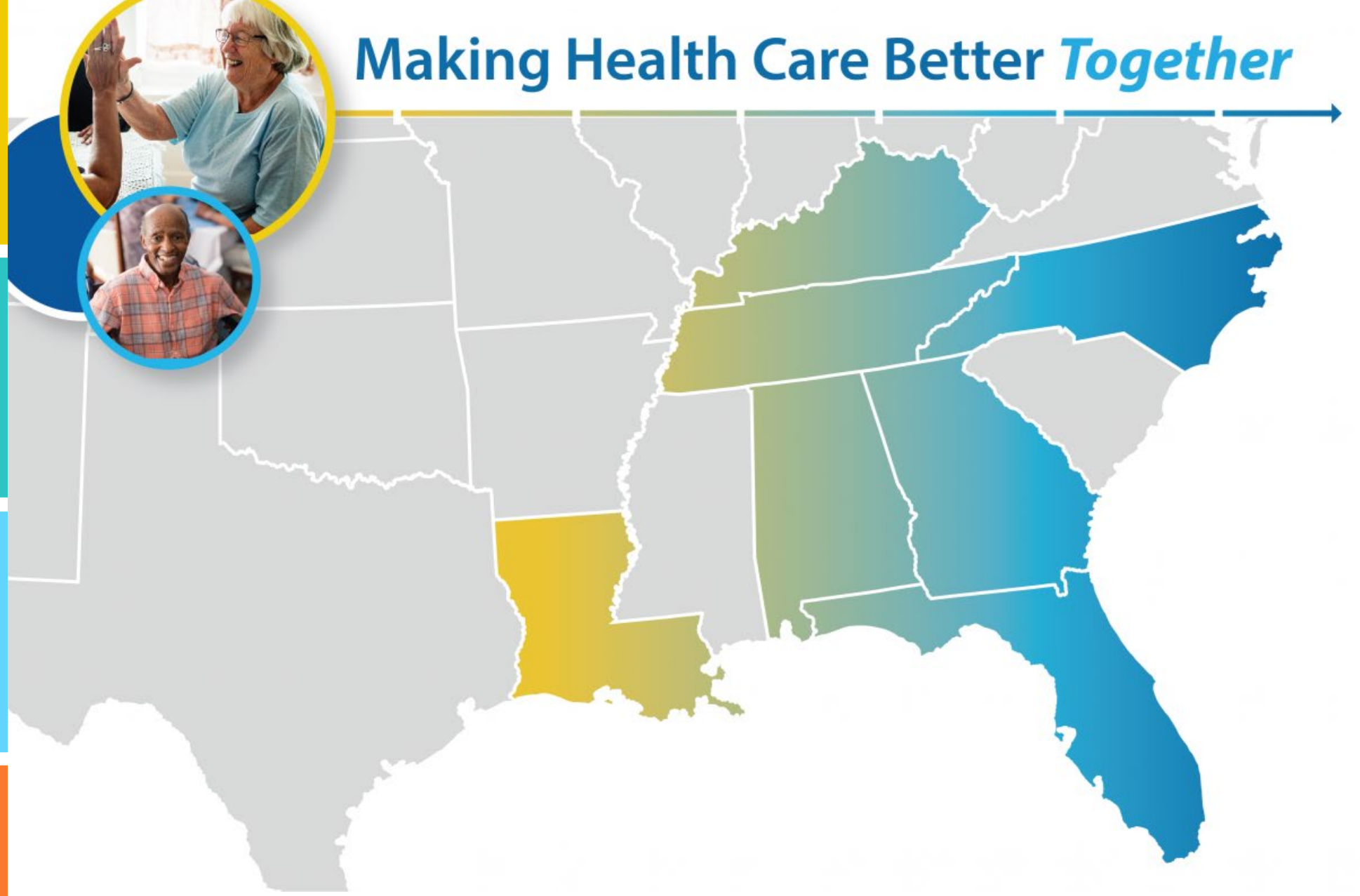
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP



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Learning Objectives

- Apply a QAPI framework and evidence-based strategies to prevent readmissions for individuals with COPD.
- Recognize the unique factors and multifaceted implications of reducing COPD readmissions.
- Understand the pathophysiology and management of COPD.

Today's Agenda

- Ice breaker
- Data review and QAPI framework
- Team talk
- Cause and effect brainstorm using the "Fishbone" diagram
- Use tomorrow

Ice Breaker: Three Polls

1. During 2007-2010, around 8.5 million adults were diagnosed with COPD, but this may be an underdiagnosis, as more than 18 million had evidence of impaired lung function consistent with COPD. https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-prevalence

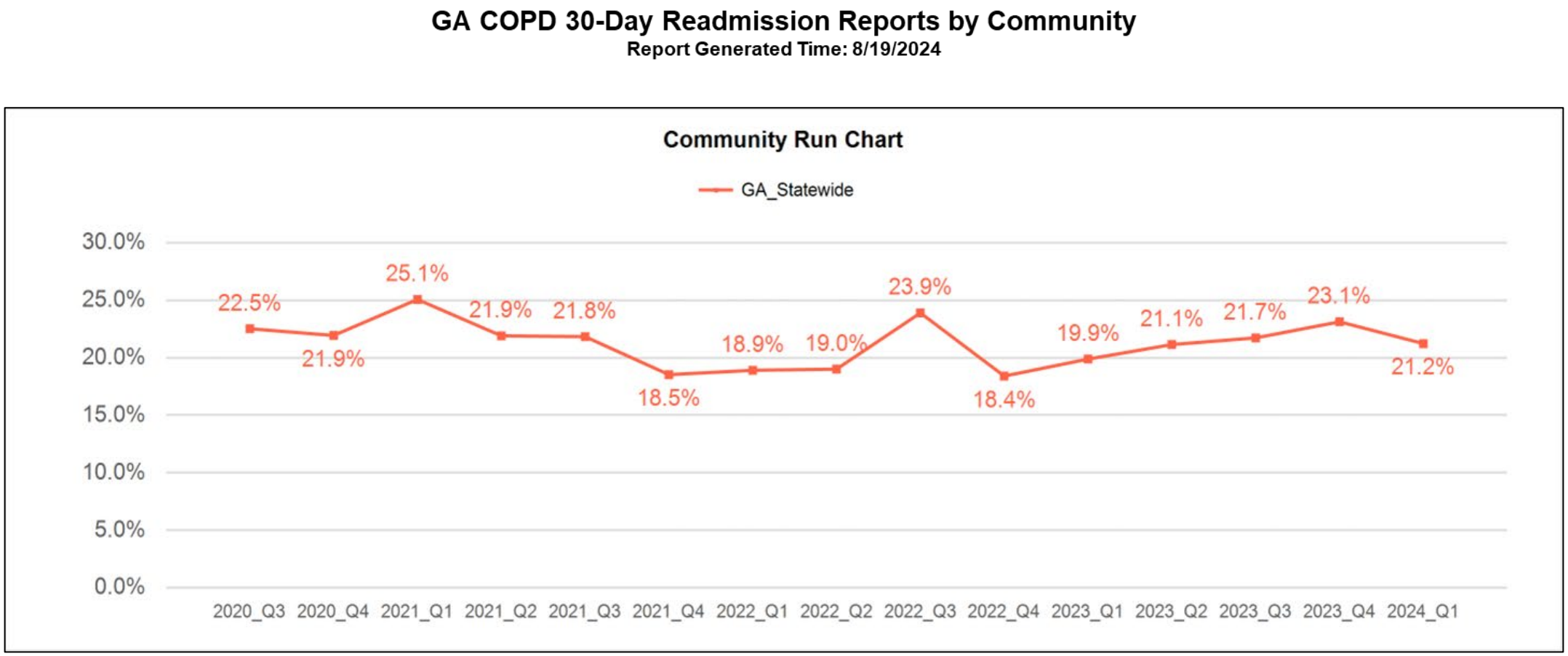
- True or False

2. Of those patients hospitalized for an exacerbation of COPD, one in five will require rehospitalization within 30 days. Preventing COPD Readmissions Under the Hospital Readmissions Reduction Program (nih.gov)

- True or False

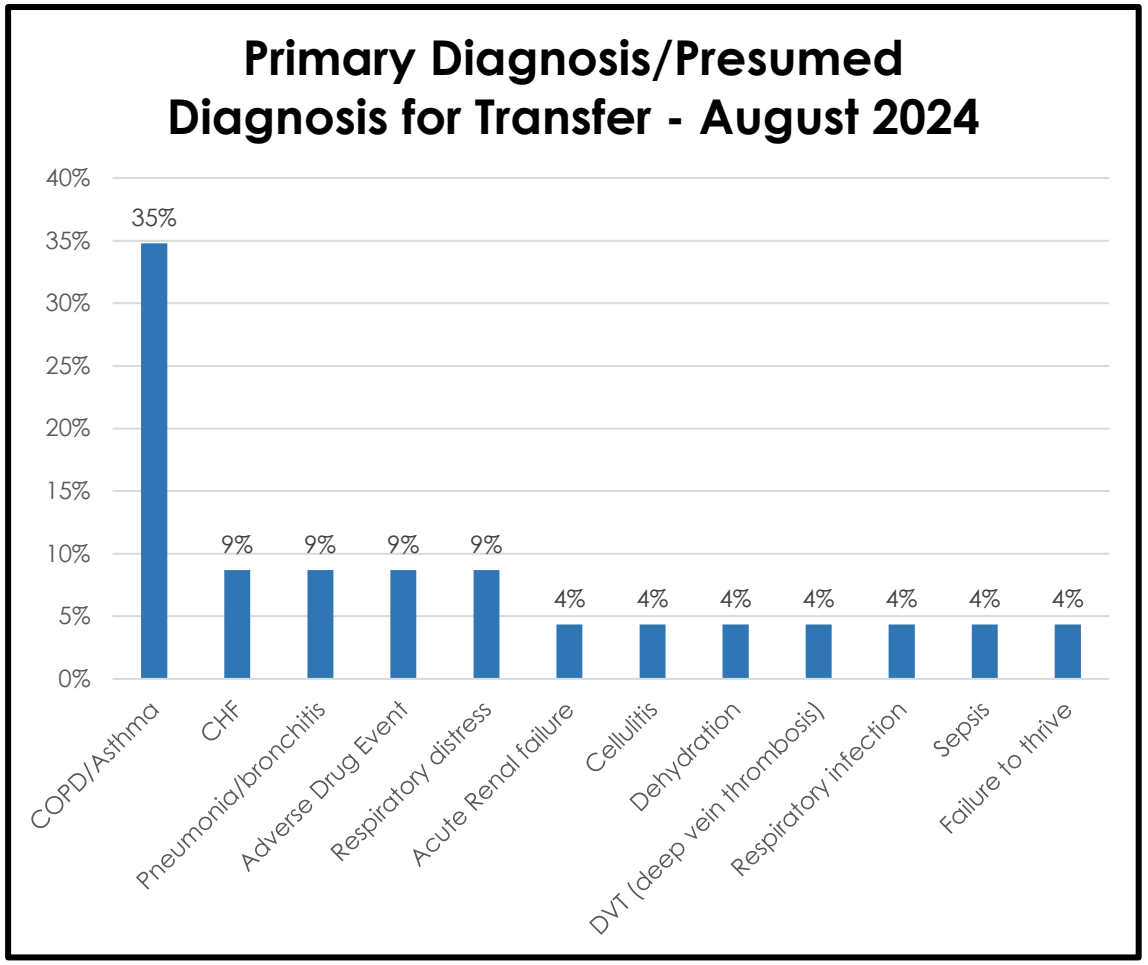
3. Annual costs of treating COPD are estimated to be $50 billion, with ____ of this expense attributed to treating exacerbations requiring hospitalization.
   a. 70%
   b. 45%
   c. 56%
   d. 32%

AHS Q1 2024 COPD 30-Day Readmission Reports by Community

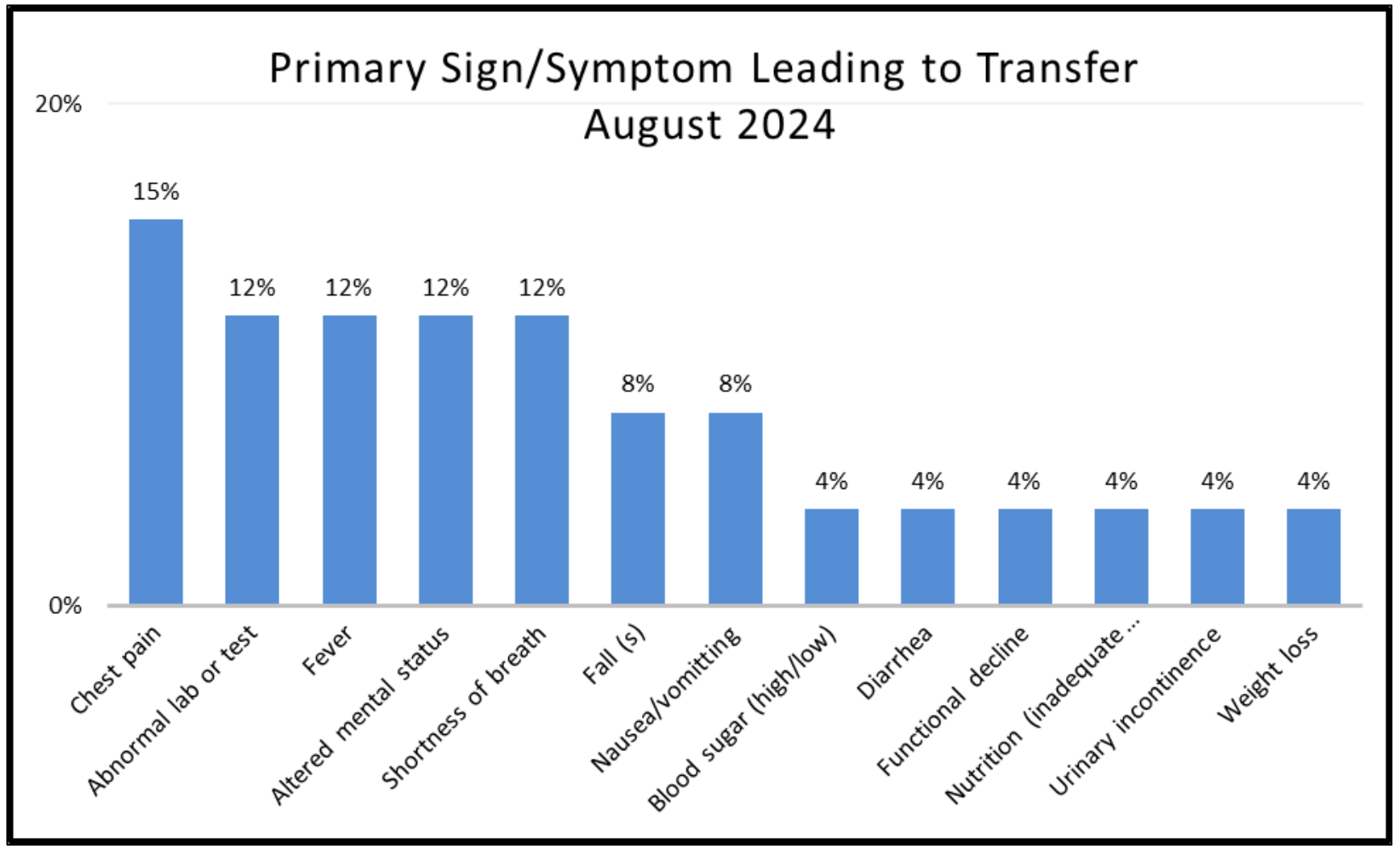


Report to QAPI Committee at Peaceful Pines Nursing Facility – Sept 2024 - Readmissions

- Readmissions – August 2024
- In August 2024, there were 23 different residents who were readmitted to a hospital. 35% (8) of the residents had a primary diagnosis of COPD. This is the highest number of COPD readmissions in the past 13 months.
- There were an additional 22% (6) residents with respiratory-related readmissions, CHF (2), pneumonia/bronchitis (2), respiratory distress (2), respiratory infection (1), and failure to thrive (1).



Readmission Tracker (continued)



Documented Signs/Symptoms Leading to Transfer

Recommendation: Establish a multidisciplinary team to identify root causes for COPD and possibly respiratory-related readmissions.

Preparing To Care for a COPD Patient

System	Essential Elements

Staffing	• Staffing levels: RN, LPN, Nursing Assistant, Respiratory Therapy, etc.
	• Staff Competency
	  • Changes in condition
	  • SBAR
	  • Stop and Watch

Pharmacy/Medication Management	• Timely delivery of medications • Pharmacy engagement in medication review and deprescribing recommendations
Wound Care: Prevention and Management	• Turning and position schedules • Wound care supplies • Nutritional assessments and recommendations • Equipment availability (i.e. specialty mattresses)
Patient Education	• Disease understanding • The importance of medication adherence • Assessing ability to utilized inhalers
Discharge Planning	• Working through barriers (i.e., cost of medications, or lack of transportation to pick up medications or refills) • Home health referrals with warm hand-offs

Comprehensive Treatment Plans

A careful review of a COPD patient's treatment plan can proactively identify opportunities to mitigate readmission risk.

Considerations:

- Medication Reconciliation completed on admission and discharge can identify areas of risk related to duplicate medications and/or care partners' understanding of medication
- Patient-Centered Approach: Individualized interventions based on resident goals, preferences and priorities
- Specialty services and consults
  - Pulmonology
  - Psychiatry
  - Palliative Care
- Close monitoring by provider: physical exams, labs and radiology
    - Chest X-ray limitations

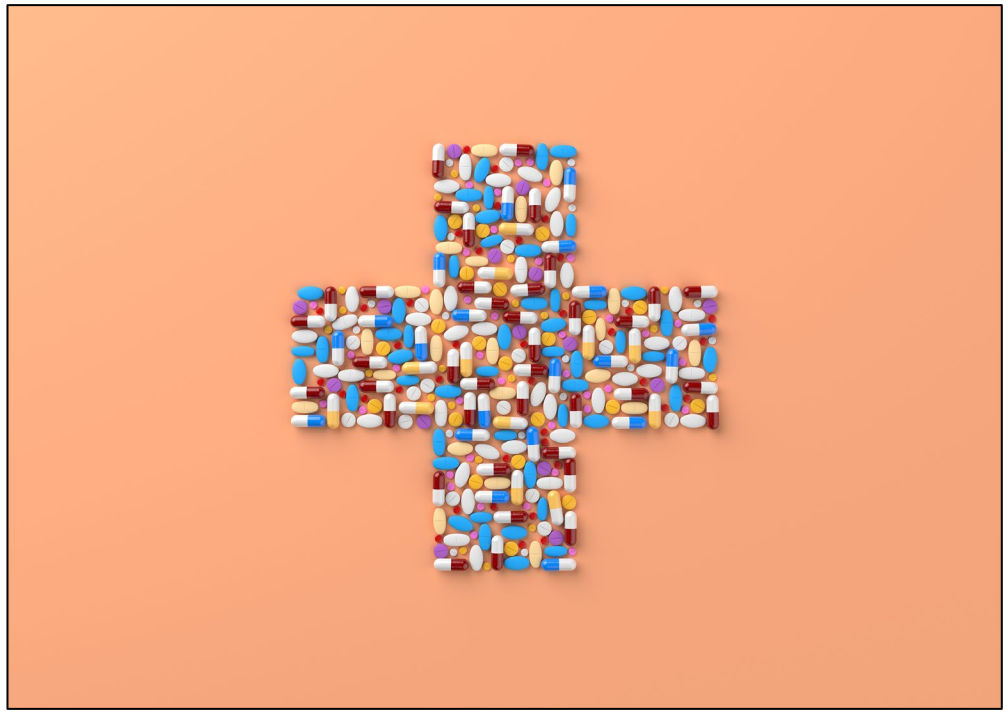
Nutrition

Goals

- Achieve and maintain a healthy weight.
- Ensure adequate protein intake to prevent **p**rotein-**e**nergy **m**alnutrition (PEM).
- Determine the need for Vitamin D supplementation.
- Assess the need for Calcium supplementation.
- Evaluate the need for oral nutritional supplements.
- Facilitate opportunities for small, frequent meals & snacks throughout the day. Allow for rest periods before and during meals.
- Provide feeding assistance and adaptive eating equipment, as needed.
- Connect patients to community food assistance, meal delivery services, nutrition education, and self-management resources.
- Recommend referral to medical nutrition therapy, pulmonary rehab and tobacco cessation support if not currently attending.

Medication Management

- Medication reconciliation
- Resident limitations
- COPD medication delivery options
- Nursing considerations
- Reassess Resident often

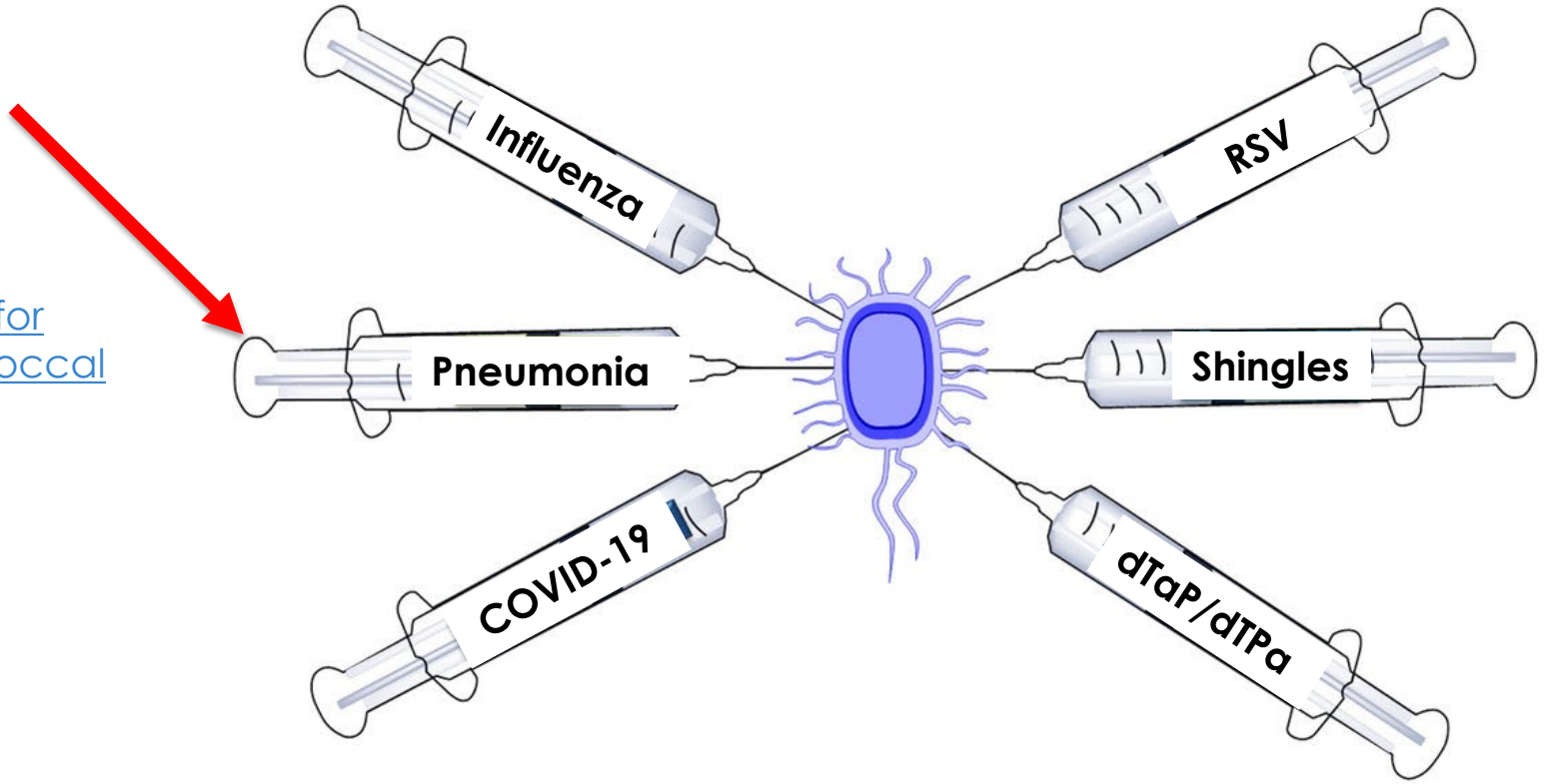


Source: Current Opinion in Pulmonary Medicine (lww.com)

Immunizations

CDC's PneumoRecs VaxAdvisor Mobile and Web Versions

[PneumoRecs VaxAdvisor App for Vaccine Providers | Pneumococcal | CDC]



COPD and Emotional Health

Understand the relationship between a chronic illness and emotional well-being:

- Desire to continue with normal daily activities, pursue interests and the physical challenges of COPD can be at odds with each other.
- Cycling between the desire for connection, adventure and learning and fear, sadness and worry can be exhausting.

Ensure competence to recognize and treat anxiety, panic and depression:

- Regularly assess mood and coping
- Use shared decision-making to identify goals and interventions of care to support well-being
- Refer patients for behavioral health intervention

Develop a portfolio of effective interventions:

- Collaborate with providers and clinicians with expertise in treating COPD patients.
- Collaborate with community partners (including vendors) for resources and training.
- Adopt the practice of warm handoffs at transitions.
- Promote meaningful activities, sleep and exercise.
- Care plans to specifically address shortness of breath, anxiety, fear, sadness, and panic.
- Staff competency at all levels on bedside interventions that improve mood and comfort.
- Support for caregivers and family.

Source: https://www.lung.org/lung-health-diseases/lung-disease-lookup/copd/living-with-copd/coping-with-emotions#:~:text=Anxiety%20and%20depression%20are%20both,than%20just%20improve%20your%20mood

Person-Centered Discharge Planning

Begin on day of admission

- Actively engage patients, caregivers, staff and community partners
- Discuss the pre-admission care plan and changes needed to reflect the current assessment
- Outline functional capacity needed for a safe transition
- Identify health-related social needs and disparities

Safe transition home

- Set up: appointments, transportation to appointments (MD, rehab, community support), medication/equipment delivery,
- Make contacts with community services (e.g., Meals on Wheels, smoking cessation class, chronic disease self-management class)

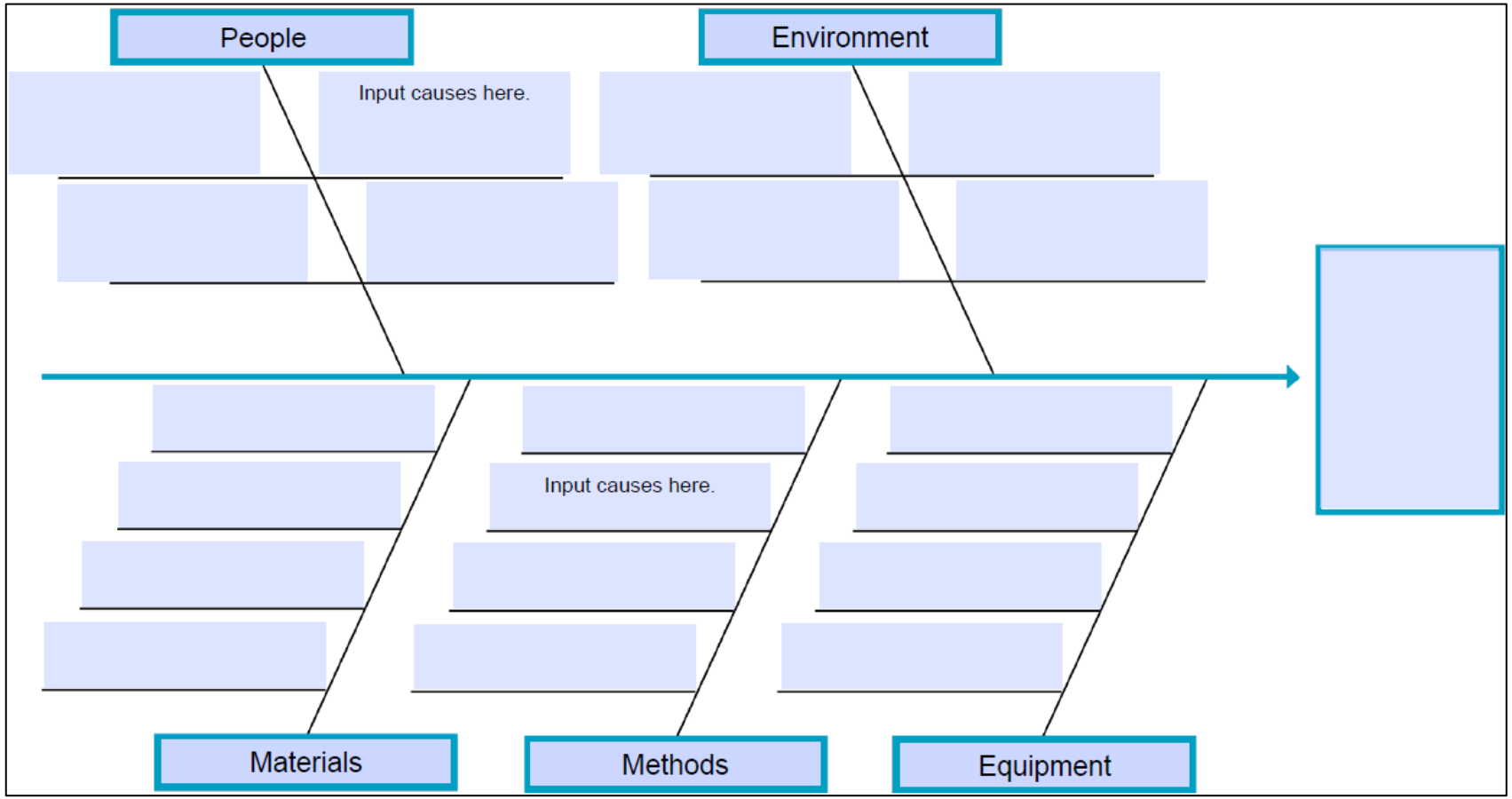
Patient education during course of care

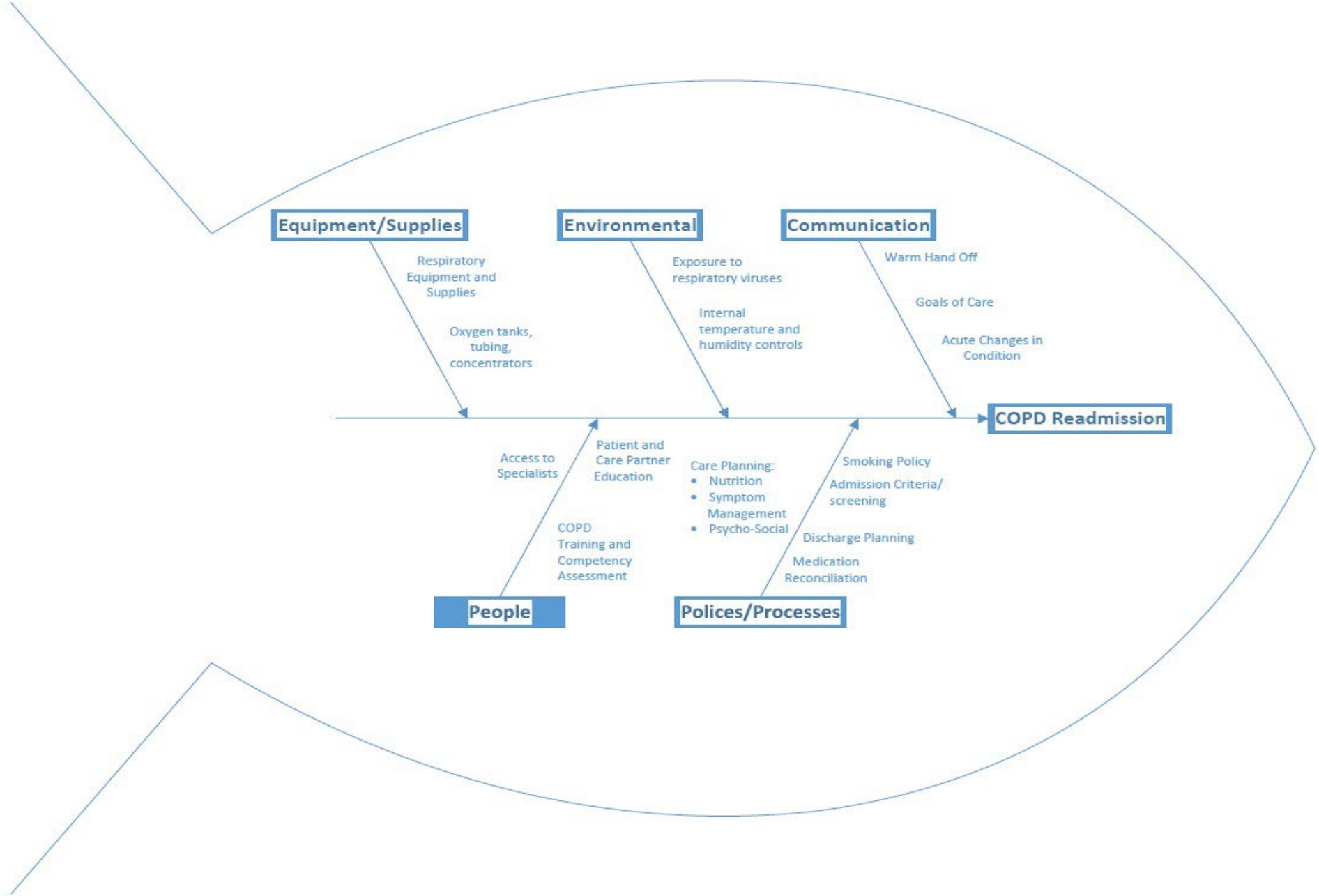
- Clarify patients' knowledge of current health status and expectations of care
- Use education materials, i.e., zone tools
- Medication reconciliation
- Use teach-back for the use of medical equipment and inhalers
- Discuss the availability of community resources and the impact on discharge planning/readmission prevention

Incorporate information gathered during post-discharge calls to QAPI initiative to reduce COPD readmissions

Let's Brainstorm Cause and Effect

[COPD Fishbone Jamboard]

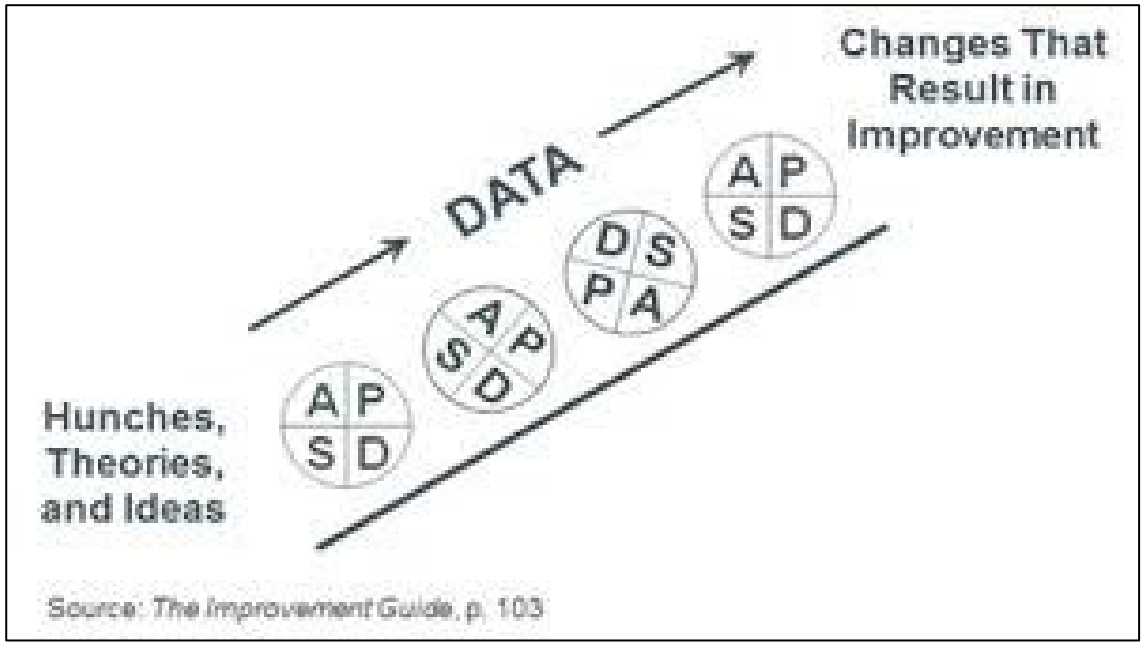



Equipment/Supplies
Respiratory Equipment and Supplies
Oxygen tanks, tubing, concentrators
Environmental
Exposure to respiratory viruses
Internal temperature and humidity controls
Communication
Warm Hand Off
Goals of Care
Acute Changes in Condition
COPD Readmission
People
Access to Specialists
Patient and Care Partner Education
COPD Training and Competency Assessment
Polices/Processes
Care Planning:
Nutrition
Symptom Management
Psycho-Social
Smoking Policy
Admission Criteria/ screening
Discharge Planning
Medication Reconciliation

Using QAPI to Decrease Your COPD Readmissions

- Review your readmissions data for people with COPD:
- What patterns or trends do you see?
- What if you add in other respiratory related – do you see other patterns or trends?
- Other sources of information:
  - Interviews with staff, residents and care partners
  - Chart reviews
  - Quality Measure Performance
- Root cause analysis to test hypothesis
  - Involve stakeholders (multi-disciplinary team, resident/family, etc.)
  - Evidence-based intervention to address the root cause
  - Initiate a small test of change
  - Pre and post-test of change data collection

https://www.ihi.org/how-improve-model-improvement-testing-changes



Toolkit for Improvement

- **Data:** AHS Nursing Home Readmission Tracking Sheet
- **Root Cause:** AHS Fishbone Bone Diagram Worksheet
- **SNF Care Transitions:** Re-Ignite the Warm Handoff to Reduce Readmissions
- **SNF Care Transitions:** SNF to ED Transfer Handoff and Capabilities List
- **Care Transitions Interview Tools:** Circle Back Interview Tool
- **SNF Rehospitalization Risk Assessment Tool** Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment Tool (allianthealth.org)

Toolkit for Improvement

- **COPD Zone Tool for Patient Education:** ZONE TOOL | COPD (allianthealth.org)
- **Teach-Back Tools:** Transitions of Care: MAKE TEACH-BACK AN ALWAYS EVENT!
- **Individualized Care Plans**: My Care Plan My Questions
- **Discharge Planning:** Re-Engineered Discharge (RED) Toolkit
- **Post-Discharge Follow-Up:** Post Discharge Follow Up Call Script
- **Medication Reconciliation Auditing:** Medication Reconciliation Audit Tool – Discharge
  Medication Reconciliation Audit Tool – Admission
- **Track and Trend Medication Discrepancies:** Medication Reconciliation Data Collection Tool

Use Tomorrow

- Use the Alliant Health Solutions Readmission Tracker or data from your EHR to analyze your COPD readmissions data.
- Share the results with your interdisciplinary team.
- Ask: "How well are we serving people with COPD and other respiratory diseases?"

Be Curious

Questions?

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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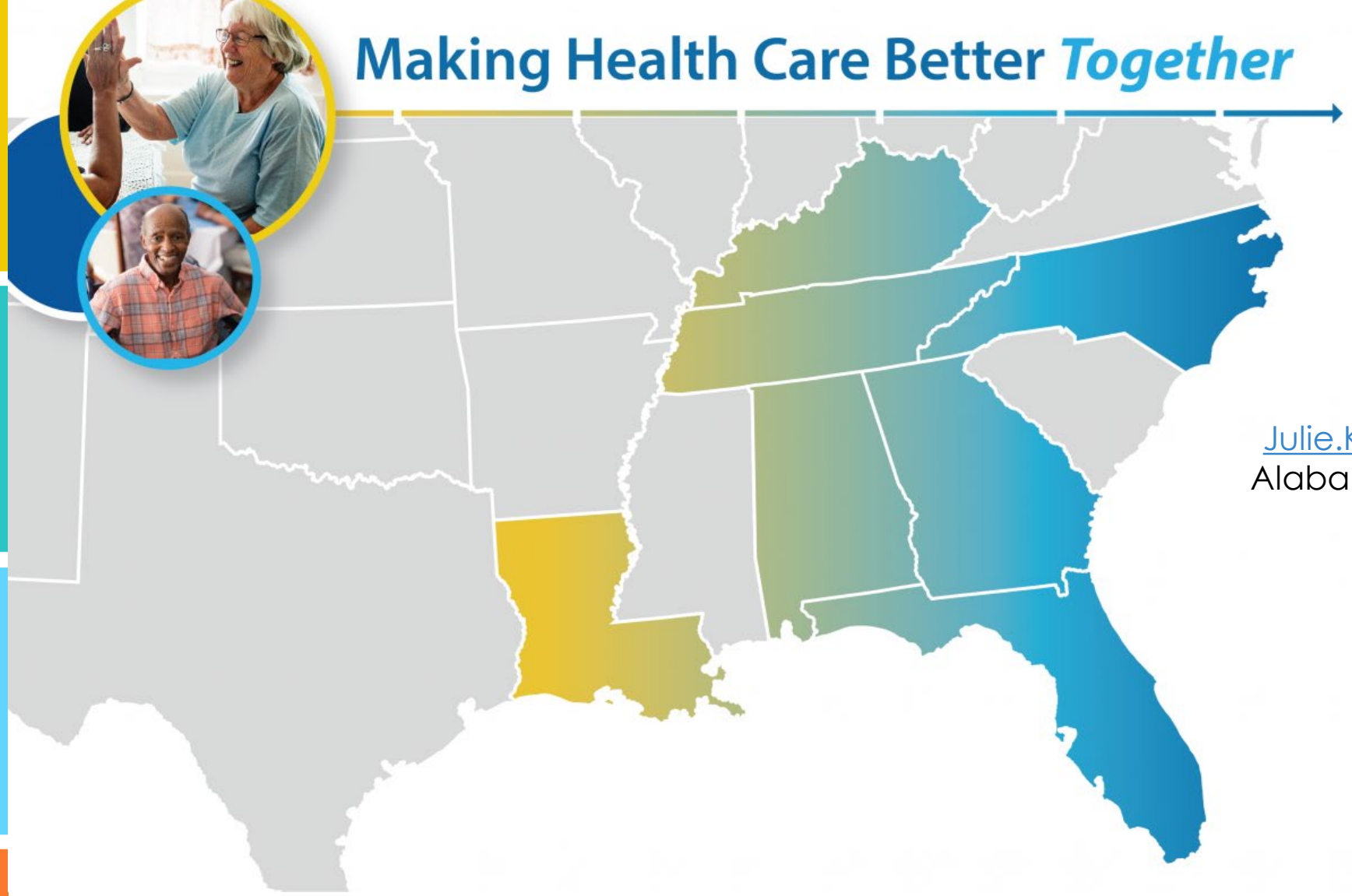

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