Improving COPD Care, the Hartford HealthCare Way

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Background:

COPD is currently the fourth leading cause of death in the world but is projected to be the 3rd leading cause of death by 2020. Globally, the COPD burden is projected to increase in the coming decades because of continued exposure to COPD risk factors and aging of the population. Through data analysis and use of internal and external benchmarks, the current COPD management had identified outliers in medication management, pulmonary conditioning and length of stay and cost efficiencies.

Project Design/Strategy:

In August of 2017, the COPD Clinical Care Redesign (CCR) team was charged to address care variation opportunities within the COPD inpatient population developing a clinical and data governance with the goals of **1)** evaluating current practice **2)** including clinical decision support for care management **3)** building and enhancing tools in the electronic health record **4)** implementing evidence based care across the continuum, and **5)** creating a performance improvement model to ensure reliable spread and sustainability across a developing system of five hospitals.

Actions taken:

Clinical teams and CCR leaders developed a standard care pathway integrating GOLD Guidelines standards. Internal electronic medical record teams were engaged to create order sets that direct COPD treatment. Education teams were deployed to successfully operationalize implementation strategies. Patient education materials were created to empower the patient and instill more confidence in the medical decision making process. A "Meds to Bed" program was created by Pharmacy to provide education on proper usage of medications at the bedside. Process measures were determined by researching best practices and evaluating baseline metrics. A Dyad Leadership model identified comprehensive teams with key expertise at each hospital to drive performance improvement and hardwire the CCR playbook.

Outcomes:

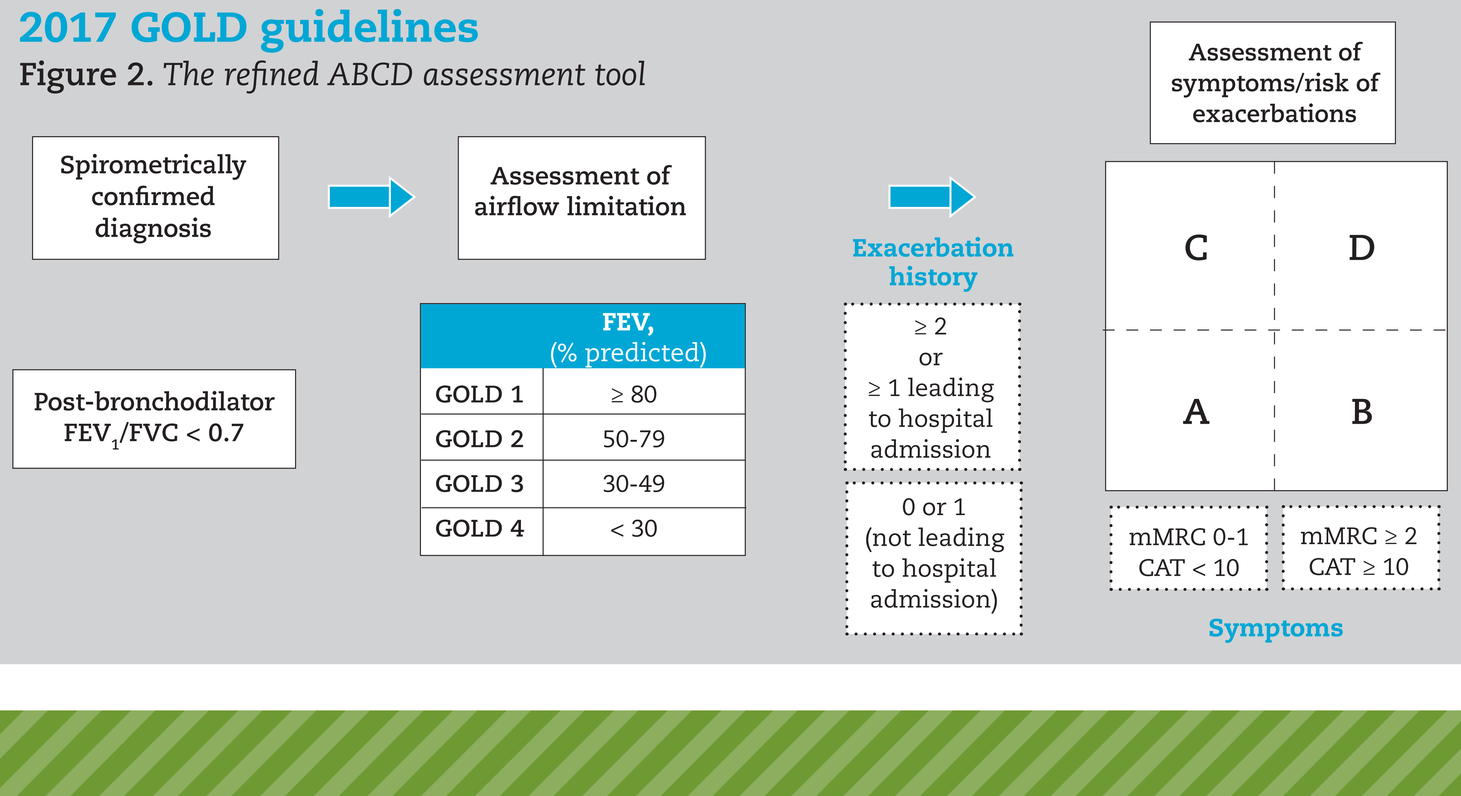
Creation of a COPD Care Pathway and patient education, established patient partnerships including a 48hr follow up phone call, high risk transition clinic, COPD triage line and home care coordination. Integrated of the CCR playbook across a developing system was critical to the success for aligning best practice, reduced care variation and embraces our system's unifying Vision: Most trusted for personalized coordinated care.

Key Elements of a Care Pathway

- **Admission and Discharge Criteria:** eligibility, exit and re-entry triggers
- **Scope:** disciplines and facilities involved, time-frame
- **Algorithm:** decision tree and time-based plan of care
- **Metrics:** utilization, key compliance indicator(s), critical process measures, key outcomes, and related cost measures
- **Monitoring Plan:** real time vs. retrospective, creation and distribution of reports, process for reviewing and responding to reports, includes leading and lagging process measures
- **Enabling Tools:** order sets, care bundles, checklists, patient education materials, BPAs, leveraging EHR functionalities, reports
- **Owner (s), Team & Sponsor(s) Identified**

2017 GOLD guidelines

Figure 2. *The refined ABCD assessment tool*



References:

Global Initiative for Chronic Lung Disease (2017). Pocket Guide to COPD Diagnosis, Management and Prevention. *Retrieved from:* https://goldcopd.org/wp-content/uploads/2016/12/wms-GOLD-2017-Pocket-Guide.pdf