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COPD Care Coordination Program

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COPD Care Coordination Program

By

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A thesis/project submitted to the faculty of Gardner-Webb University School of Nursing in partial fulfillment of the requirements for the Degree of Master of Science in Nursing

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Abstract

COPD is the fourth leading cause of death in the United States. Several studies confirm only 50% of COPD patients receive optimal care. The disease is greatly under-recognized and generally is not diagnosed until it is clinically apparent and moderately advanced. COPD is also a major resource consuming disease. Considering these facts, Mission Hospitals realized the opportunity to improve evidence based quality care for patients diagnosed with COPD as well as the development of a Care Coordinated Program to improve outcomes for the patient as well as the organization. The goal of the program is to provide correct, comprehensive, and consistent care for this specific group of patients. The overall program involves education and awareness, data and surveillance, research and treatment and community coordination and advocacy. The purpose of this project is to develop a process for early identification/diagnosis of COPD, creating a role description of the COPD Patient Education Navigator, and to provide education to current staff about the program.

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Chapter I

Introduction

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in America (American Lung Association [ALA], 2010). It is a leading cause of morbidity and mortality among the entire adult population worldwide (Wang & Bourbeau, 2005). COPD is the only leading cause of death that is increasing in prevalence rather than decreasing (Wang & Bourbeau). COPD is a group of conditions, characterized by airflow obstruction and associated with breathing-related symptoms such as chronic cough, exertional dyspnea, and mucus hypersecretion. The most common diseases are emphysema and chronic bronchitis. According to the ALA, COPD claimed the lives of 120,970 Americans in 2006. It is estimated that approximately 24 million adults in the United States have evidence of impaired lung function. However, only half of them have been diagnosed with COPD (ALA).

From a health care organization perspective, COPD is a major resource consuming disease nationally (Puhan, Scharplatz, Troosters, & Steurer, 2005). COPD patients have an average of one to four exacerbations of COPD a year. Concurrently the exacerbations have dramatic affects on the patients' health-related quality of life (HRQL) and overall patient outcomes (Wang & Bourbeau, 2005). The annual cost to the nation for COPD was 42.6 billion dollars in 2007 (ALA, 2010). This includes 26.7 billion dollars in direct health care expenditures, 8.0 billion dollars in indirect morbidity costs and 7.9 billion dollars in indirect mortality costs. Medicare expenses for COPD beneficiaries were nearly 2.5 times that of the expenditures of all other patients (ALA, 2010). The United States Department of Health and Human Services has estimated the cost to the

nation for COPD in 2010 to be approximately 49.9 billion dollars (United States Department of Health and Human Services [USDHHS], 2010).

North Carolina's population in 2008 was 8,856,505. The morbidity of COPD was 4.63% in the same year (ALA, 2010). The mortality rate of COPD for North Carolina was 69.0 to 78.1 per 100,000 in 2005 according to the Centers for Disease Control and Prevention's National Vital Statistics System (Centers for Disease Control and Prevention [CDC], 2006).

Considering each of these facts, it is important for organizations across the nation to develop or be involved in strategic planning for this specific group of people. The plan should include; raising awareness of COPD, symptoms and risk factors associated with the disease and improve the diagnosis and care of COPD patients. Prevention is desirable, however, when detected and treated early, symptoms can be controlled and the impact on quality of life is minimal (ALA, 2010). Programs that include prevention are not only beneficial for the patients, but important for financial viability of the organization as well.

Background

Information obtained from the finance department of an 800 bed hospital in Western North Carolina indicated that in 2009, 1334 patients were admitted with the primary diagnosis of COPD. One hundred and ninety-eight had additional complications such as hypertension, hyperglycemia and 408 had additional major complications such as pneumonia and Myocardial Infarction (MI). Reimbursements to organizations vary between insuring agencies. In 2009 alone, This Health Care Organization sacrificed 608,122 dollars due to insufficient reimbursement from insuring agencies.

Many COPD patients have frequent admissions to the hospital and are often discharged without education or often receive inadequate information. Many times once discharged, COPD patients realize that medication is too expensive and neglect to fill their prescriptions. Readmissions within 30 days are an issue concerning COPD patients. Typically there is no reimbursement for patients readmitted within 30 days of discharge. There were 922 readmissions within 30 days for COPD patients in this organization in 2009.

An interdisciplinary team has been formed to evaluate the reason for readmissions, quality outcomes, and financial implications for the organization. The group began by performing a gap analysis of the current process, and what can be done to improve the quality of care, quality of life, and outcomes for individuals living with COPD. The primary intent of the planning process; is to develop a program that will raise awareness of COPD and the symptoms and risk factors associated with the disease and improve the diagnosis and care of COPD patients. This program will be the first, but critical step, in the fight to reduce the burden of the disease for this large organization and overall, Western North Carolina.

Theoretical Framework

This project will develop a care management program for patients with Chronic Obstructive Pulmonary Disease utilizing the Systems Model developed by Betty Neuman (1989). This model “reflects nursing’s interest in well and ill people as holistic systems and in environmental influences on health,” (Tomey & Alligood, 2006, p. 320). The Neuman Systems Model is an open systems model that sees nursing as being mainly concerned with defining appropriate actions in stress-related situations, since both client

and environment may be positively or negatively affected by each other (Neuman, 1989). Neuman views the client as having a central core consisting of energy resources which are represented by concentric circles. Each circle is composed of five variables (physiological, psychological, sociocultural, developmental, and spiritual) (Neuman). The concentric circles are referred to as the lines of resistance, the normal line of defense, and the flexible line of defense (Tomey & Alligood). The stability of the circles affects individuals' reaction to environmental stressors which can be intrapersonal, interpersonal, or extrapersonal.

The COPD management program will focus on protection of the central core by providing education about the disease with specific attention on primary, secondary and tertiary, prevention. The prevention is focused on keeping stressors and the stress response from having a detrimental effect on the body. The primary intention of the program is focused on protecting the normal line of defense and strengthening the flexible line of defense (Tomey & Alligood, 2006). This would be provided through programs such as smoking cessation and pulmonary rehabilitation. This education focuses on health promotion and maintenance of wellness. The secondary prevention is focused on strengthening internal lines of resistance, reducing the reaction of the stressors and increasing resistance factors in order to prevent damage to the central core (Tomey & Alligood). This portion of the program includes appropriate treatment of symptoms to attain optimal client system stability and energy conservation. This would be provided through standardization of care by development of protocols based on evidence based research. The concentration on tertiary prevention would be on readaptation and stability, and protects reconstitution or return to wellness or baseline after treatment. Tertiary

prevention offers support to the client and attempts to add energy to the system or reduce energy needed in order to facilitate reconstitution. Tertiary education would include early conversations about end-of-life decisions and provide ongoing support throughout this chronic disease process.

Purpose and Rationale

The purpose of this scholarly project is to develop a program at this 800 bed Health Care Organization that will be nationally accredited and recognized for providing top quality care for COPD patients. The goal of the program is to provide correct care, comprehensive care, and consistent care to this specific group of individuals. The program will create an organized comprehensive approach to performance improvement. Comparative data will be utilized to evaluate program processes and overall patient outcomes. Participants will have an active role in decisions related to care based on their personal perception of quality of care. In addition, available grant funding will allow the program to be extended beyond the hospital setting to provide education and awareness, collect data and surveillance, conduct research and treatment, and provide community coordination and advocacy.

Chapter II

Review of Literature

Numerous studies have been conducted with COPD patients related to quality of care, quality of life, co morbidities, and economic impact. Katz, Gregorich, Eisner, et al (2009), conducted a study to evaluate the effect of COPD on specific life activities and their effects on respiratory airways. The study found that out of the 591 individuals studied, half could not perform at least one of their valued life activities (VLA) (Katz et al., 2003). Almost the entire group reported that the disease affected at least one of their VLA. The American Thoracic Society suggests that the success of pulmonary rehabilitation is strongly affected by the individual's ability to perform daily activities (Katz et al., 2003). Inability to perform valued life activities is common among individuals with COPD. The disabilities are directly related to fatigue, symptoms, and functional limitations of the disease. The psychological status and life satisfaction is strongly affected by the patient's ability to perform valued life activities, concurrently affecting overall outcomes of disease management and rehabilitation (Katz et al., 2003).

Ricauda, Tibaldi, Leff, et al (2008) conducted a study that compared elderly patients with acute exacerbations of COPD being cared for in a traditional hospital setting versus being cared for by a geriatric home hospitalization service (GHHS). In addition, this study compared the risk, cost, and quality of life in the different environments. Elderly patients have a much higher risk for mortality and adverse events than younger patients (Ricauda et al., 2008). The study concluded that hospital-at-home care led by physicians' correlates with a significant reduction in hospital readmissions, lower healthcare costs, and improvement in quality of life (Ricauda et al., 2008). "Providing

acute hospital-level care in a patient's home can be a safe and efficacious alternative to hospital care," (Ricauda et al., 2008, p. 497).

In a recent study identified by Puhan et al (2005), readmission rates were found to be 63% during a 1.1 year follow-up. Inactivity was one of the major predictors for readmissions (Puhan et al., 2005). This study concluded that participation in pulmonary rehabilitation programs after acute exacerbation of COPD drastically reduced the risk for hospital readmissions, improved mortality and overall improved health-related quality of life scores (HRQL) (Puhan et al., 2005). Pulmonary rehabilitation has the possibility of assisting in the reduction of COPD- related cost related to hospital readmissions. Through education provided, patients may develop the ability to seek medical attention earlier for treatment that can be provided outside the hospital rather than the more costly inpatient setting (Puhan et al., 2005). "Current evidence suggests that respiratory rehabilitation reduces unplanned hospital admission and mortality and improves HRQL and exercise capacity when initiated immediately after acute exacerbations," (Puhan et al., 2005, p. 54).

Almagro et al. (2002) completed a study to evaluate variables associated with mortality in patients after hospitalization of acute exacerbation of COPD. The study found a 22% mortality rate within the first year after hospitalization for COPD exacerbation. Patients with greater functional dependence were also found to have an increased mortality rate (Almagro et al., 2002). Patients that were married lived longer in the study which is consistent with other studies on individuals with a chronic illness. This may be related to seeking medical attention sooner, psychological factors, or better compliance with prescribed treatment (Almagro et al., 2002). This study confirmed

several important factors in predicting outcomes for COPD patients after hospitalization; mainly, “hospital readmission, depression, unmarried status, and poor quality of life,” (Almagro et al., 2002, p. 1447).

Gonzalez, Servera, and Marin (2008) conducted a study to evaluate the impact of respiratory muscle overload and right cardiac overload on hospital readmissions within 1 year for patients with moderate-to-severe COPD. Muscular weakness in COPD patients is associated with greater utilization of health resources (Gonzalez et al., 2008). Patients have a much greater risk for respiratory muscle fatigue during exacerbations of COPD than their healthy counterparts. The study confirmed that patients with high respiratory load and have been on long term oxygen therapy are strong predictors for hospital readmissions in patients with moderate-to-severe COPD (Gonzalez et al., 2008).

This large population-based study conducted by Schneider, Jick, Bothner, and Meier (2010) explored the risk of developing depression in association with a previous diagnosis of COPD. Previous studies have discovered a wide range of depression prevalence in patients with COPD. The risk of depression seems to have some correlation with the severity of the disease (Schneider et al., 2010). This study found that COPD patients are at a higher risk of developing depression than the group without COPD. There is also a link to higher risk of mortality in individuals that have been diagnosed with depression. Therefore, COPD patients with depression have poorer survival rates after discharge from the hospital (Schneider et al., 2010). The risk of depression is greater with greater severity of the disease diagnosis. The study indicated that women were more likely than men to develop depression and in turn were at greater risk for dying within the first year after being diagnosed with depression. It is unclear if this is a

real difference between men and women or if it is related to the timing of the diagnosis since women tend to seek medical attention sooner than their counterparts (Schneider et al., 2010).

Shaya et al. (2009), reports that previous research and studies have demonstrated racial disparities in health-care utilization and outcomes for a number of diseases, including COPD. Recent data supports that COPD mortality rates have risen quicker in African Americans than in whites. This could be related to the rise in smoking among minorities as well as the rise in diagnosis of COPD among minorities. This particular study conducted by Shaya et al. “compared health services utilization and cost outcomes in Medicaid Managed Care adult beneficiaries with COPD, asthma, or coexisting COPD and asthma” (Shaya et al., 2009, p. 409). The study found that “African-Americans utilized fewer medical services, outpatient physician visits, and hospitalizations than their white counterparts” (Shaya et al., 2009, p. 409). Since this study group was restricted to Medicaid patients, there is no supportive evidence that economic status effected access to health care. The researchers feel that the findings could be related to environmental exposure due to recent rise in smoking among African-Americans which could lead to a future rise in African-Americans diagnoses with COPD therefore leading to a rise in utilization of healthcare resources (Shaya et al., 2009).

Chapter III

Project Description

COPD is the fourth leading cause of death in the United States (ALA, 2010). The American Lung Association has projected the cost of care for COPD patients to be 49.9 billion dollars in 2010. This includes 29.5 billion dollars in direct health care, 8.0 billion dollars in indirect morbidity costs and 12.4 billion in indirect mortality costs (ALA, 2010). In 2009, Mission Hospitals had 1447 patients admitted with the primary diagnosis of COPD. There were an additional 523 patients admitted with dual diagnosis of COPD and Heart Failure. Six percent of these patients had readmissions within 30 days. One patient was readmitted 13 times. An interdisciplinary team was formed that included: Nursing, respiratory, educators, case managers, performance improvement and pulmonary rehabilitation. During the first few sessions, a gap analysis was performed to identify where we were and where we wanted to be. The team was in agreement that as an organization, we could do a better job at providing correct, comprehensive, and consistent care for COPD patients. Once the gap analysis was complete, it was realized that support from senior level management as well as physicians was needed in order for the program to be successful. A series of meetings were conducted to communicate with these key groups. Leadership as well as the medical staff is supportive of this project. The team also realized that this could not be accomplished by one single department, but would require a collaborative effort between several departments.

The overall goal of the program is to have an all-inclusive Coordinated Care Program that focuses on consistent, comprehensive and correct care that occurs in every phase of their care from “Home to Home”. This is based on the belief that poor

transitions in care negatively impact patients' health and well being. That includes the transition from home to hospital as well as the transition from hospital back to home. The goals of the program are to enhance patient clinical outcomes as well as economic outcomes. As a result, there will be cost savings to the organization through reduction in readmission rates. This project is focused on the care during the hospital phase.

Project objectives will be:

1. Develop a process for early identification/diagnosis/staging of COPD exacerbation
2. Develop a process for Patient Education Navigator consult
3. Create a role description for the Patient Education Navigator
4. Develop education for staff related to the overall COPD Care Coordination Program and the role of the Patient Education Navigator

Clinical assessment of dyspnea using the Borg Scale (Appendix A) will be performed upon the patient's entry into the hospital emergency room. The Borg rating of perceived exertion (RPE) is based on physical sensations a person experiences during physical activity such as increased heart rate, increase respiration and breathing rate, increase sweating and muscle fatigue. Even though this assessment is very subjective, clinicians find it very useful in gauging the amount of exertion the individual is putting in to breathing.

The early use of spirometry will be the main diagnostic tool for diagnosing and severity staging of COPD. There are four different stages of COPD based on diagnostic findings with FEV₁ being the main indicator. Spirometry is a method of assessing lung function by measuring the volume of air the patient can expel from the lungs after a

maximal expiration (Global Initiatives for Chronic Obstructive Lung Disease website, 2009). Spirometry measures the Forced Vital Capacity (FVC) and Forced Expiratory Volume in one second (FEV_1). The results are reported as the FEV_1/FVC ratio. The degree of spirometric abnormality reflects the severity of COPD.

The BODE (Body Mass Index, Obstruction, Dyspnea, Exercise tolerance) (Appendix B) index will be used as a tool to predict COPD mortality. This tool takes into account the body mass index (BMI), airway obstruction (FEV_1), dyspnea, and exercise tolerance. A high BODE score correlates with increase risk of death. However, it is important to know that each indicator of the BODE index can be improved through education and change in lifestyle.

Initiation of Bi-level Positive Airway Pressure (BiPap) will also be considered with initial assessment. This treatment provides two levels of pressure: inspiratory positive airway pressure as well as expiratory positive airway pressure. BiPap can prevent the need for endotracheal intubation with patients experiencing respiratory failure related to a severe exacerbation of COPD.

Once a diagnosis of COPD has been established, the computer will generate an order for a COPD Patient Education Navigator (PEN). This is a specialized health care professional who follows patients with the specific diagnosis of COPD. The PEN's are specialized healthcare professionals who follow patients throughout their disease process. These individuals act as a liaison for the patient and family, addressing their concerns and questions as well as providing a bridge between multifaceted healthcare providers across the continuum of care. The Navigator will focus on 5 areas of service: clinical services, education, survivorship and data and research management.

The PEN will serve as a primary point of entry for providers and patients requiring extensive coordination of care and will help the patient overcome obstacles to a timely diagnosis and treatment. The duties of the navigator will include reviewing the patients' charts to assure appropriate diagnostic tests and treatments have been ordered. They will serve as a contact for patients, families, and healthcare providers during the hospitalization as well as after discharge. Access to community resources and financial services will be facilitated by the PEN in order to reduce barriers to care.

The navigator will conduct an interview with each COPD patient regarding their current health practices and identify the degree of compliance as well as the barriers to compliance. Through documentation of the findings will be in place to ensure proper communication and referrals to all members of the multidisciplinary team. The PEN will be responsible for periodic review and evaluation of the effectiveness of plan of care on desired outcomes. They will serve as an advocator for the patients' rights and appropriate utilization of services, including symptom management.

Education by the PEN will promote the knowledge of the disease process for the patient, family and care providers. The patient and care givers will be educated on the appropriate assessment and importance of health and mental status. Education will be provided for specific medications and proper administration techniques for inhaler and nebulizers. The value of exercise as well as energy conservation techniques and building endurance will be included in the education plan. The patient will receive instruction on anxiety and fatigue reduction techniques using a holistic approach. Practitioners involved in the patients care during hospitalization will be included in the education to provide reinforcement during direct care. Wellness guidelines will also be provided and

encouraged in the educational process. The PEN will assist the patient in gaining knowledge of the treatment options in order to make informed decisions related to care. The navigator will connect the patient with scheduled wellness screenings including immunizations, smoking cessation, and preventative measures and treatments.

The PEN will also be involved in continuing education for care providers in the hospital setting. They will also collaborate with existing community organizations in educational initiatives. This will include education on the use of the BORG scale with individuals experiencing dyspnea as well as effective use of medications to prevent the need for admission/readmission to the hospital.

Survivorship is related to living with COPD and the necessary changes in life style to survive. The PEN is responsible for the patient from the time of diagnosis or admission to the hospital through treatment and continuing through survivorship. Each patient will be evaluated for appropriateness of referral to the Pulmonary Rehabilitation Program. The navigator will conduct periodic follow-up through telephone calls to document the patients' progress through the health care continuum. The patient will be guided in post hospitalization support, wellness education and reinforcement as well as survivorship opportunities such as palliative care and end of life decisions as appropriate. The navigator will work with community partners and providers of care to promote early detection of decline as well as promotion of wellness.

The role of the PEN in research and data management will involve education and collaboration with the multidisciplinary team to plan and implement clinical research as well as appropriate informing the patients and families of the research. A COPD data registry will be maintained by the navigator in collaboration with community liaisons.

The PEN role will involve promotion and participation in quality improvement activities based on evidence based practices. They will also assist in quality data collection and monitor outcomes. When system barriers to care are identified, the PEN will collaborate with Community Liaisons to utilize community resources to develop plans that address these issues on a programmatic level.

The researcher developed a general education web based learning module about the new program for staff. (Appendix C). Staff will be assigned the module and given 30 days to complete. The education will include the four areas of development that is needed to obtain The Joint Commission disease specific accreditation: education and awareness, data and surveillance, research and treatment, community coordination and advocacy.

There are five main areas at the 800 bed hospital that admit the greatest population of COPD patients; 2 ICU's and 3 pulmonary and step-down areas. For these identified units, the researcher attended shared governance and staff meetings to provide face-to-face education and allow opportunity for questions and discussion. Due to the difficulty of meeting with the Hospitalist and the Pulmonary Group, one-on-one information was provided by the researcher as opportunity arose to these key groups.

Additional communication will be provided to all staff through an article published in The Health Care Organization's newsletter "SCOPE" and in "Happenings" email which is distributed to all staff electronically throughout the system. These communications will provide a broad overview of the program as well as the goal to become nationally recognized in providing top quality care to individuals diagnosed with COPD.

Chapter IV

Outcomes and Evaluation

The outcomes and evaluation of the program will be based on the data that is collected by the COPD Patient Education Navigator. One of the major goals of early diagnosis of COPD is to raise awareness among health care providers and the general public. Once the patient is diagnosed, they can be enrolled in programs to slow the disease process and prevent further damage to the lungs. This would be evaluated by enrollment in to smoking cessation, Palliative Care and Pulmonary Rehabilitation programs. This will be a continuous process that will help identify areas needing increase focus.

The effectiveness of the PEN will be evaluated by enrollment in to the previously mention programs as well as financial impact to the organization. In 2009, the organization's current data analysis concluded that 6% of the COPD patients were readmitted within 28 days of discharge. In 2009, the hospital lost 608, 122 dollars due to lack of reimbursement from insuring agencies. One of the goals of PEN would include reduction in financial loss to the organization due to reimbursement.

The evaluation of the PEN would be conducted using the Performance Management Tracking Tool (PMTT). The PMTT is the tool that is used for all employees at the hospital and is based on the individual's role description. This tool will evaluate the specific PEN's job performance in areas of clinical services, research and data management, community outreach, survivorship, and education. This evaluation will be ongoing and will include a review of the progress directly with the PEN bi-annually.

The post test after completion of the web-based learning module will be used for the summative evaluation. Failure to pass with a minimum of 80% will alert unit based educators and managers of deficiencies related to comprehension of the program and the PEN role. This will signal the unit based educators to provide one on one time to ensure understanding of the program and the navigator and how to utilize these resources for their patients. Continuous interaction with the bedside nursing staff will allow for identification of problems and questions and can be addressed as they arise. Ongoing evaluation is necessary for success of the program and overall outcomes for the COPD patients.

Staff participants in this program are expected to experience greater satisfaction and competence in relation to their particular skill set through ongoing education that will be provided. Team building activities are expected to result in improved peer relationships. Patients will also benefit from the reduction in the potential for medical errors. This will be measured by annual staff satisfaction survey conducted annually by Morehead Associates.

Patient satisfaction is expected to improve due to increase in knowledge related to their disease process. Participants are also expected to increase self-management confidence with their skill set. Patient satisfaction is collected by random sampling and results are provided monthly by Press Ganey Associates.

Chapter V

Discussion

Project Summary

COPD is the fourth leading cause of death in the United States ((CDC, 2006). During the past decade, providers, patients and policymakers have increasingly recognized that evidence based practice care is not routinely received by those who seek professional assistance. Several studies confirm that only 50% of COPD patients' receive optimal care. The urgency of the development of a COPD Coordinated Care Program and reevaluation of our current treatment management for persons with COPD is not only due to the knowledge that 50% of chronic care patient's do not receive optimal care, but the realization of the global health care burden presented by COPD. Mission Hospital is confident that higher levels of performance can be achieved by the development of this COPD Coordinated Care Program. Extending the roles of respiratory care practitioners, such as nurses and respiratory therapist, enables the program to add years to patients' life as well as life to their years. These Patient Education Navigators will follow all persons diagnosed with COPD throughout their gamut of care, focusing on education, survivorship and clinical services. The PEN will help facilitate patient treatment regimen compliance by accelerating patients' confidence to self-manage and control their disease. Patients will be empowered to be active participants in securing appropriate, effective, safe and responsive care. This program will also integrate strategic counseling, provide high-level care, optimize revenue, grow and thrive as a business, as well as manage data collection for this specific group of individuals.

The overall Mission of the program is to provide comprehensive, correct and consistent care for all persons diagnosed with Chronic Obstructive pulmonary Disease in Western North Carolina. The Vision is to have a regional integrated health system providing superior care and service to patients diagnosed with COPD and their families through a full continuum of integrated services, education and research. The goal of the Patient Education Navigator Role is to directly impact patients with the specific diagnosis of COPD, affecting both their clinical and economic outcomes.

Implication for Nursing

The new role of the COPD Patient Education Navigator will provide an opportunity for experienced nurses to provide care to patients on a different level. The average age of nurses are increasing. The PEN role would allow seasoned nurses to stay in the work force and share expertise that has been developed through experience.

Nurses at the bedside will benefit from extra support from the navigator. The navigator will assist in providing education to nurses as well as patients. Effective education must be provided in an unhurried manner. While patient education is provided by the PEN, the nurse will have more time to provide other care.

Specific education will be provided to new staff as well as ongoing education for current staff. Pulmonary nurses will have increase knowledge base related to the disease process as well as medications and treatments. Increase knowledge will lead to increase comfort and expertise in caring for COPD patients. Staff satisfaction is predicted to increase due to this increase in knowledge and the comfort of caring for these patients. Evidence suggests that if staff is satisfied, the patient satisfaction scores also increase.

Further Study

Further studies are needed to identify barriers for COPD patients related to care. It is felt that many patients are readmitted to the hospital because they cannot afford medications to continue treatment at home. COPD is a progressive, debilitating disease. Patients with COPD encounter great physical and psychosocial losses. Therefore, depression, anxiety and panic have also been identified as possible returns to the hospital. Could treatment of depression and anxiety reduce or prevent readmissions? Integrative Healthcare at the organization has successfully used meditation and relaxation techniques with COPD patients. Could expansion in the use of these techniques reduce length of stay related to anxiety for leaving the hospital?

Development of a community coordination and advocacy program will be important for the success of the program. The goal for community coordination and advocacy program would be to strengthen the relationships between primary care physicians, clinics, healthcare agencies and outlying emergency departments. This will build a network of care surpassing present day standards and open doors for collaboration and idea sharing to eliminate or reduce barriers to care for COPD patients.

The organization plans to apply for The Joint Commission disease specific certification for COPD in 2011. The COPD specific requirements were developed using the Global Initiative for Obstructive Lung Disease (GOLD) standards. Accredited programs must have specific staff education requirements, use of spirometry, smoking cessation programs, patient education and coordination of care. The ultimate evaluation will be successful Joint Commission survey for certification for COPD.

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Appendix A

Appendix B

Appendix C