Hoag Presbyterian Hospital

Newport Beach, California

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Hoag implemented the Pulmonary Disease Navigator position in March of 2014 to reduce COPD readmission. The navigators provide COPD patient education and guidance t/o the admission. The navigators makes plan of care recommendations according to COPD GOLD standards and best practice. They coordinate with CM for discharge planning, directing to SNF, HH or home with respiratory DME as indicated.

Over the phone patient follow up is provided weekly for 30 days post d/c, then monthly for a total of 3 months. The Navigators also provide community education and outreach to partner SNF and HH agencies to ensure Hoag patients are getting the best standard COPD care possible. Metrics are set and training is provided. Providing this training has been the most effective way to ensure these agencies are utilizing COPD best practices.

Audits are performed to ensure adherence to the metrics. Hoag overall average COPD readmission rates before program implementation - 17% Navigator program patient readmission rate as of February 2015- 4%