Summary of Proposed Future Vision for Complex Frail Vulnerable – COPD Patient Population

A regional evidence-based pathway for Chronic Obstructive Pulmonary Disease (COPD) will improve the patient experience by ensuring optimal care for every patient at every hospital site in the southeast LHIN. It will ensure all patients in our region receive evidence-based care while empowering them with the knowledge they need to effectively manage their disease. This will improve patient outcomes, as well as patient and provider satisfaction, while helping us make the best use of our resources.

Current state

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in Canada and a leading cause of morbidity in Canadian adults. Acute exacerbations of COPD (AECOPD) are associated with accelerated decline in health and a substantial mortality rate. They are a major cause of hospitalization, emergency department visits, and overall health-care utilization in Canada.

Patients admitted to hospital with an exacerbation of COPD have a 6 per cent in-hospital mortality rate and a 9 per cent 30-day mortality rate. One of the strongest predictors for admission to hospital with COPD is a prior history of hospitalization with COPD. In fact, 20 per cent of patients admitted to hospital with AECOPD will be readmitted within 30 days.

Evidence-based guidelines are available for management of COPD. When implemented, these guidelines have been proven to reduce the frequency of AECOPD while also reducing hospitalization and ED visits. Currently, there is variability between hospitals in our LHIN with respect to the implementation of these guidelines, which may be due to available resources and expertise. There is an opportunity to reduce morbidity and mortality from COPD by implementing evidence-based guidelines at each hospital site in the SELHIN.

Opportunities considered

As part of the COPD Clinical Steering Team's deliberations, the Quality Based Procedures Clinical Handbooks from Health Quality Ontario and the Ministry of Health and Long-Term Care (MOHLTC) were reviewed for opportunities to implement provincially endorsed evidence-based guidelines consistently across all hospitals in the SE LHIN.

For more information about evidence-based guidelines for management of COPD, see QBP Clinical Handbook COPD

Working Group process and engagement

A COPD Clinical Steering Team was launched in January 2016 with regional representation from medicine, nursing and allied professions from the seven hospitals, Community Care Access Centre (CCAC) and community**.**

- *See Appendix 1 for list of team members.*

We have consulted with Dr. O'Donnell, KGH Respirologist, and other experts from a multi-disciplinary perspective as the content experts. The team reviewed best practice and local patient journey maps to identify the gaps, opportunities and challenges with respect to how COPD patients are currently managed across each hospital site. .

An overall engagement plan for Phase 2 of the Health Care Tomorrow – Hospital Services project created opportunities to gather meaningful input from all stakeholders between October 2015 and May 2016. This engagement included two surveys for staff from across the region. As the clinical work teams were not yet ready to engage staff in these surveys at the time of the broader project engagement strategy, questions about COPD were not included in that process.

Targeted individuals and groups who are involved in managing patients with COPD have been contacted to review the recommendations in this summary document and provide feedback via an online survey. Their feedback will be reviewed and incorporated in the COPD Clinical Steering Team's final set of recommendations.

Analysis undertaken

The COPD Clinical Steering Team conducted a best practice review and local patient journey mapping of the process from a patient's initial emergency department visit to their eventual discharge into the community. A summary of gaps in practice, process, access and resources was completed. This analysis was compared against best-practice literature including the Quality Based Procedures Clinical Handbooks from HQO and MOHLTC, and a set of recommendations were created that leverage best practices while addressing the gaps and opportunities identified within our region.

Proposed future state

The COPD Clinical Steering Team is developing a plan to move to a regional best-practice patient journey that includes regional communities of practice and accountability mechanisms to ensure compliance with the recommendations and guidelines. Once the plan has been implemented and we have consolidated our accomplishments and lessons learned, our aim is to build on this work as a template for future regional initiatives within other clinical service areas.

The recommendations

- Each patient admitted to an emergency room or hospital bed in the SELHIN with

AECOPD should receive treatment based on an identical evidence-based COPD care pathway with a standard discharge checklist.
    - *See appendix 2 for detailed recommendations.*

- The care pathway will include:
    - Management of the acute episode
    - Plans for the post-acute transition of care
    - Provision of a care map for each patient outlining evidence-based preventive and treatment strategies, identified gaps in care for that patient and a follow-up appointment with the primary care practitioner within seven days of discharge from hospital
    - Standardized referral decision process
    - Appropriate use of pulmonary rehabilitation
- Individual hospital sites in the SELHIN will implement the COPD care pathway in ways that are most practical, efficient and effective at that site
- Each hospital site will audit and report on utilization of the evidence-based care map after implementation

Key benefits of proposed future state

- Patients will have access to a standardized evidence-based optimal care pathway, regardless of local specialist expertise in COPD management
- Patients will be empowered with an individual care pathway to address treatment gaps and help them manage their disease effectively
- Communities of practice in COPD will improve cohesion among regional clinicians involved in COPD management
- Transitions of care for patients with COPD will be seamless between hospital and community settings
- Patients will experience fewer AECOPD episodes that require emergency department visits or hospital admission
- The risk of mortality from AECOPD will be reduced
- Health care resources will be used efficiently through a hospital-community partnership in COPD

Appendix 1:

COPD Clinical Steering Team	
Dr Michael Fitzpatrick	Chief of Staff, HDH
Silvie Crawford,	Executive VP & CNE – KGH
Dr Denis O'Donnell,	Physician Specialist, Respirology-Queens
De Ingrid Harle	Palliative Medicine Program, Queen's
Delanya Podgers,	Nurse Practitioner, Asthma & COPD, KGH
Dr Ken Edwards	ED Physician, KGH, SE LHIN ED Lead
Annette Stuart	Respiratory Therapist ,LACGH
Patti Harvey,	Program Mgr. Amb. Care, Prov Care (& OP Resp. Rehab. Program)
Lorelei Samis,	Physiotherapist with the OP Resp Rehab, Providence Care
Kelly Madden	Respiratory Therapist, PSFDH
Cindy McLennan	PSFDH
Dawn McKiel	Palliative Care Nurse, PSFDH
Derk Damron,	Respiratory Therapist, QHC
Heather Houlahan,	Respiratory Therapist,BGH
Kelly Mitten,	Respiratory Therapist,BGH
Lisa Whalen	Respiratory Therapist,BGH
Elizabeth Hill	RN, HDH
Janine Schweitzer	Chief QI, Organizational Improvement, HDH
Christina Dolgowicz	Lung Health Coordinator for Lanark Renfrew Health & Community Services
Christina Nugent,	SE CCAC
Shannon Quesnel,	SE CCAC
Sabrina Martin,	Health System Design & Implementation Lead, SE LHIN
Laurel Hoard	SE LHIN, Health System Planner
Jean Lord	Regional Patient Advisor
Alice Carlson	LACGH Patient Advisor

A special recognition to the resources who supported the training and facilitated the local patient journey mapping including: Shari Brown-Providence Care; Damiano Loricchio-KGH, Viviane Meehan-QHC; Jessica Gerritsen-BGH, Sheryl Julien-Providence Care, and many other front-line providers.

2. Appendix 2: Standard Hospital and ER discharge checklist

- COPD Dx by Spirometry
- Review of Vaccination status
- Provision of smoking cessation counselling
- Smoking cessation status & management plan
- Assessment of inhaler technique
- COPD personal action plan
- Confirm need for dual/triple therapy
- Ensure patient access to medications at home
- Assessment re criteria for home oxygen. Includes ABG completed on room air.
- Oxygen prescription (LPM), if needed.
- Confirm patient's agreement for Pulmonary Rehab
- Completion of Advance Care Directives
- Follow-up with primary care team arranged within 1 week
- Discharge Summary sent to PHC
- Patient given COPD pathway guide