The COPD Lower Mainland Initiative: Standardizing COPD Care Across 3 Health Authorities

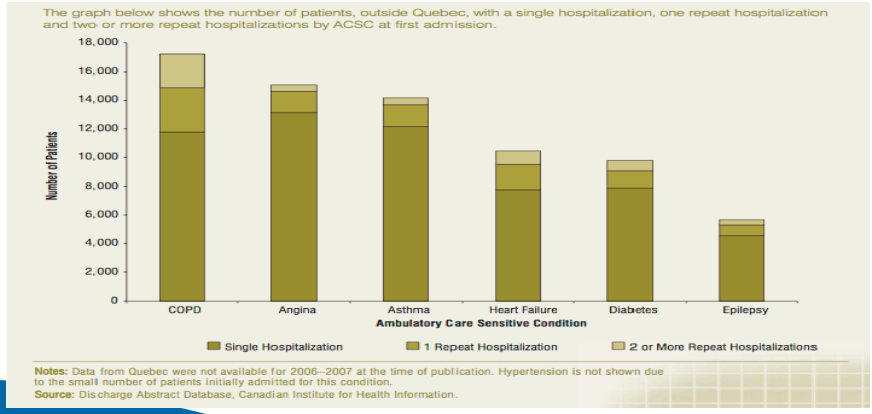
Erin Toplak, RRT CRE
VCH/PHC Project Manager
COPD Lower Mainland Initiative

Overview

- COPD burden and prevalence
- COPD LMIIF/Lower Mainland Initiative
- Community Goals and Accomplishments
- In-Hospital Goals and Accomplishments
- In-Hospital document descriptions
- Future Steps

COPD now accounts for the highest rate of hospital admissions among major chronic illnesses in Canada

- *(CIHI 2008)*



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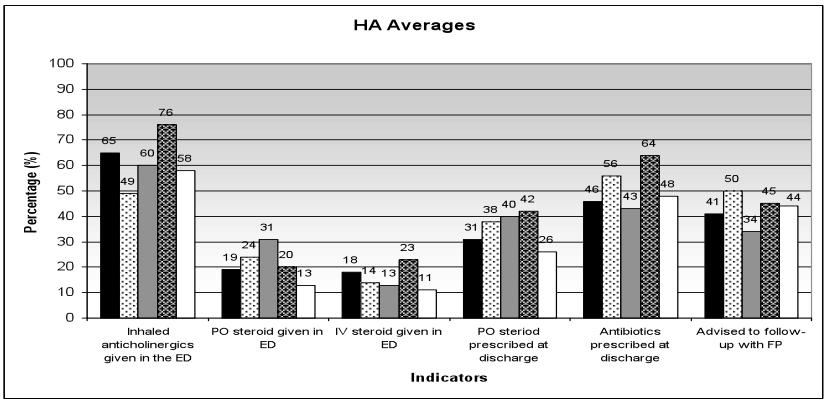
2007 ER Current Practice Indicator Project



Following up with COPD educator was less than 6% in one of the LM Health Authorities

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COPD Lower Mainland Initiative & Goals

- One time funding received from Lower Mainland Innovation & Integration Fund (LMIIF)
- Collaborative & multidisciplinary patient focused approach used to identify the care gaps in the current management of COPD patients in acute & community
- Goals:
  - Streamline & standardize COPD management across the Lower Mainland in both acute & primary care
  - Improve gap in care between acute & community care services

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Goals for Community Management

- Educate GPs and community staff about best practice standards
- Increase awareness, access, and availability of spirometry & COPD management services
- Simplify referral process for GPs
- Inform about in-hospital initiative to help keep the lines of communications open and improve continuity of care.

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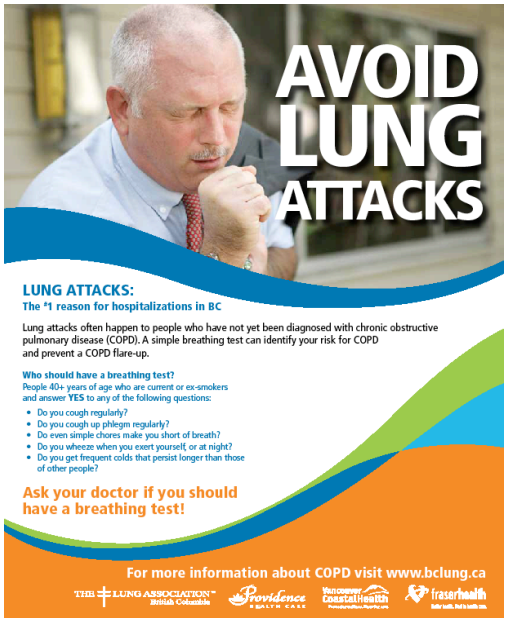
Key Approaches: Community Piece

- Focus on community setting:
  - Standardized referral forms (Spirometry & COPD Management Services), tied into COPD incentive fee
  - Posters & GP Quick Reference Cards
  - BCMA COPD Action Plan
- Communicated to GPs through newsletter articles, mailed packages, CME talks, and GP meeting presentations
- RTs connected with GPs, RNs, NPs, Pharmacists, allied health, and patients to educate and increase awareness
- All forms available online

Community Accomplishments

- Increased spiro testing by 50% or more at most sites
- Decreased wait lists to < 2 weeks at most sites
- Improved quality of spiro interpretations
- Added drop in spiro clinics at some sites
- Developed universal requisition for spirometry
- Developed universal referral for COPD Services



Poster

8 x 11.5 poster size
Provided to GP offices, hospitals, local pharmacies.
Designed to increase awareness and promote early detection.

"An exacerbation is in fact what Respirologist call a 'lung attack', which has the same consequences as a heart attack in terms of patient's quality of life, future hospital admissions and mortality."

Goals for COPD In-hospital Management

- Reduce LOS
- Reduce Readmission rates
- Prevent disease progression
- Improve overall management of AECOPD according to best practice guidelines (CTS, GOLD)
- Create links between acute and primary care
- Create links with community programs and follow-up
- Improve patient QOL

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Key Approaches: Acute Piece

- Focus on Acute setting:
  - Pre-printed physician (admission) orders
  - COPD Exacerbation Care Planning Pathway
  - Acute/ER COPD Discharge Plan

COPD Exacerbation Admission PPO

- Ensures patient receives appropriate treatments on admission (no delay)
- Physicians across 3 Health Authorities agreed on content
- Standardized content with some flexibility to allow for site specific policies and resources
- Based on CTS and GOLD guidelines

Goals of Care Planning Pathway

- Ensure best practice guidelines are followed
- Prevent delay in treatments, consults, and care
- Ensure patient is getting proper education needs
- Flag potential issues that will affect LOS & QOL
- Provide appropriate guideance during admission and post discharge (reduce re-admission)

COPD Care Planning Pathway

- Adapted from Credit Valley (Ontario)
- Divided into phases rather than days (allows more flexibility)
- Indicators define what phase the patient is in
- Guidance on what to do if patient not moving through
- Multidisciplinary document
- CPD developed for detailed guidance on using the document
- Attempts to fill gaps in care (ex. links to primary care)

Links to Programs & Support

- **Smoking cessation: QuitNow program**
- **Links to COPD Discharge Plan**
- **Referral to Spirometry and COPD Management Services**
- **List of patient education materials on back of pathway**

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COPD Discharge Plan

- Developed by ED physician in FHA
- Guides patient with post-discharge directions
- Serves as a referral to spirometry, pulmonary rehab, and/or COPD Clinic
- Copy of plan goes home with the patient
- Improve gap between acute and primary care

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Next Steps

- Complete pilots for in-hospital documents at 7 sites across VCH, PHC, and FHA
- Finalize documents by mid-November
- Regional Implementation to begin Dec 2010/Jan 2011
- Evaluation of impact

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"Nothing will ever be attempted if all possible objections must first be overcome"

– Samuel Johnson

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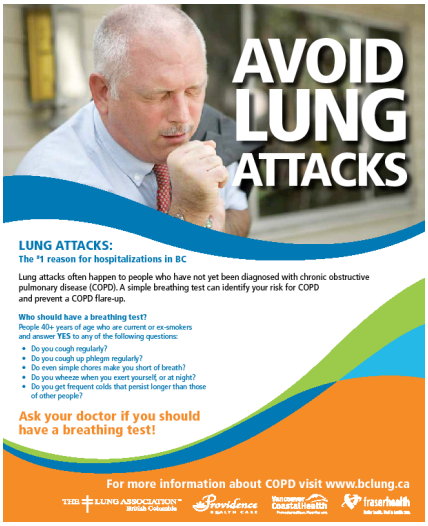
For more information on the COPD Lower Mainland Initiative contact:
Erin Toplak
Phone: 604-875-4111 (67914)
email: Erin.Toplak@vch.ca



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