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

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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)

2007 ER Current Practice Indicator Project

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

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.
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 spirometry testing by 50% or more at most sites
• Decreased wait lists to < 2 weeks at most sites
• Improved quality of spirometry interpretations
• Added drop in spirometry 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.

“A exacerbation is in fact what Respiriologist 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
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 guidance 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

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
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

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

– Samuel Johnson
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