KNOWLEDGE IS POWER:

STRENGTHENING COPD PATIENTS WITH SUPPORT AND EDUCATION

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DISCLOSURES

I received some flip charts and teaching tools from Ed Williamson, a Respiratory Therapist and Drug Rep for GlaxoSmithKline (GSK) that helped support my COPD Group Medical Visits. I also received some free samples for patients with COPD.

0.4% OF ALL PEOPLE DIAGNOSED WITH COPD HAVE ACCESS TO PULMONARY REHAB

I BELIEVE

- That we can use the resources we already have in place and no extra funding is required

- Primary Care Teams are already assigned to a family physicians
- Billing for Group Medical Visits are already established
- Teaching resources (slide presentation, handouts) for COPD already developed by the Canadian Lung Association

Aim

- We aim to increase patient confidence in self-management thereby reducing ER/WIC visits and hospital admissions by providing incremental information

THE HOW

- Education on COPD to PCT by COPD educator February 9, 2018
- 1st GMV- Review of COPD meds indications how to take them
- Home follow up re meds , Office visit for exacerbation plan
- 2nd GMV- exacerbation plan and ???
- Telephone and or follow up re meds /exacerbations
- 3rd GMV- community resources
- Telephone or home visit by RN 1 month later scheduled office vist q3months and PRN

BC & CANADIAN DATA ON COPD

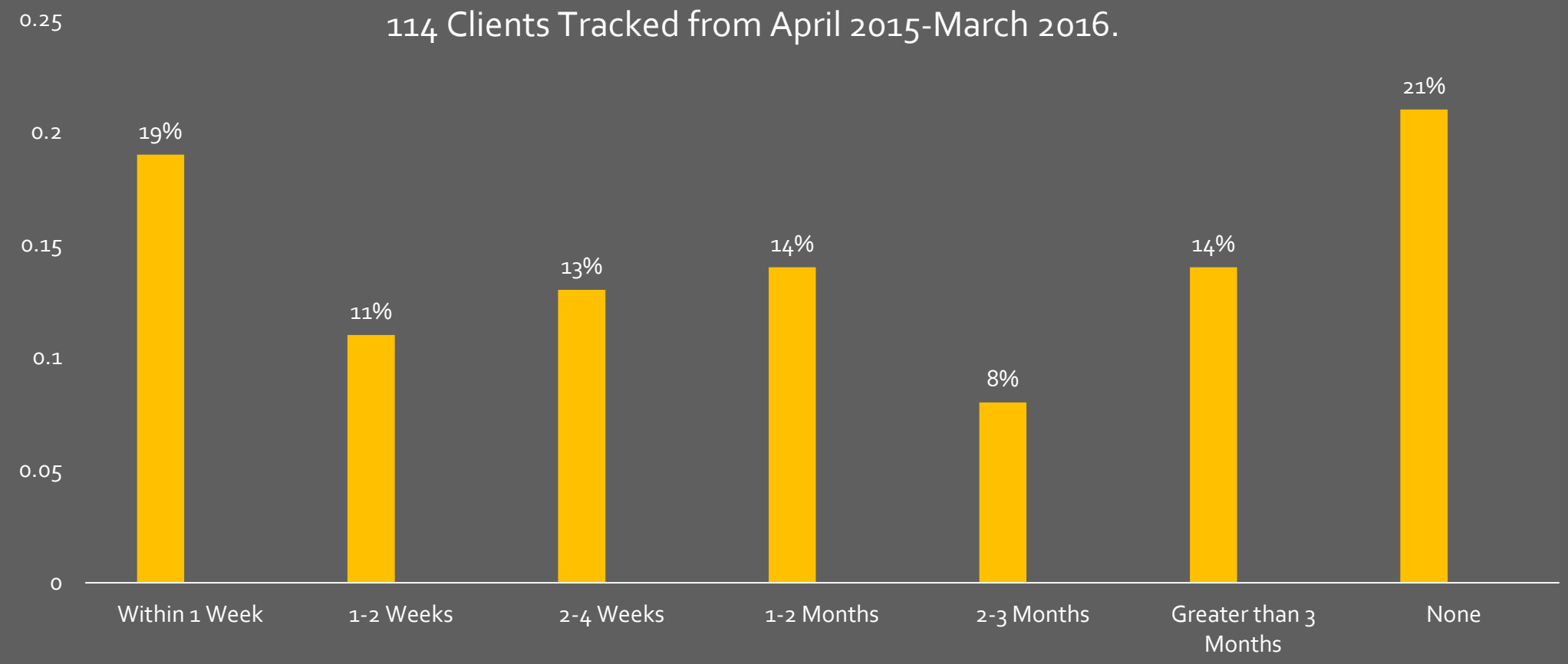
- 14% of people with COPD in BC were admitted to the hospital for an average length of stay of 13.2 days
- 9% of those people were readmitted to hospital within 15 days of discharge
- COPD is the 4th leading cause of death in Canada

Source: A Snapshot of Chronic Obstructive Pulmonary Disease in British Columbia and Canada. BC Medical Journal. Volume 50(2), March 2008.

PRINCE GEORGE DATA ON COPD

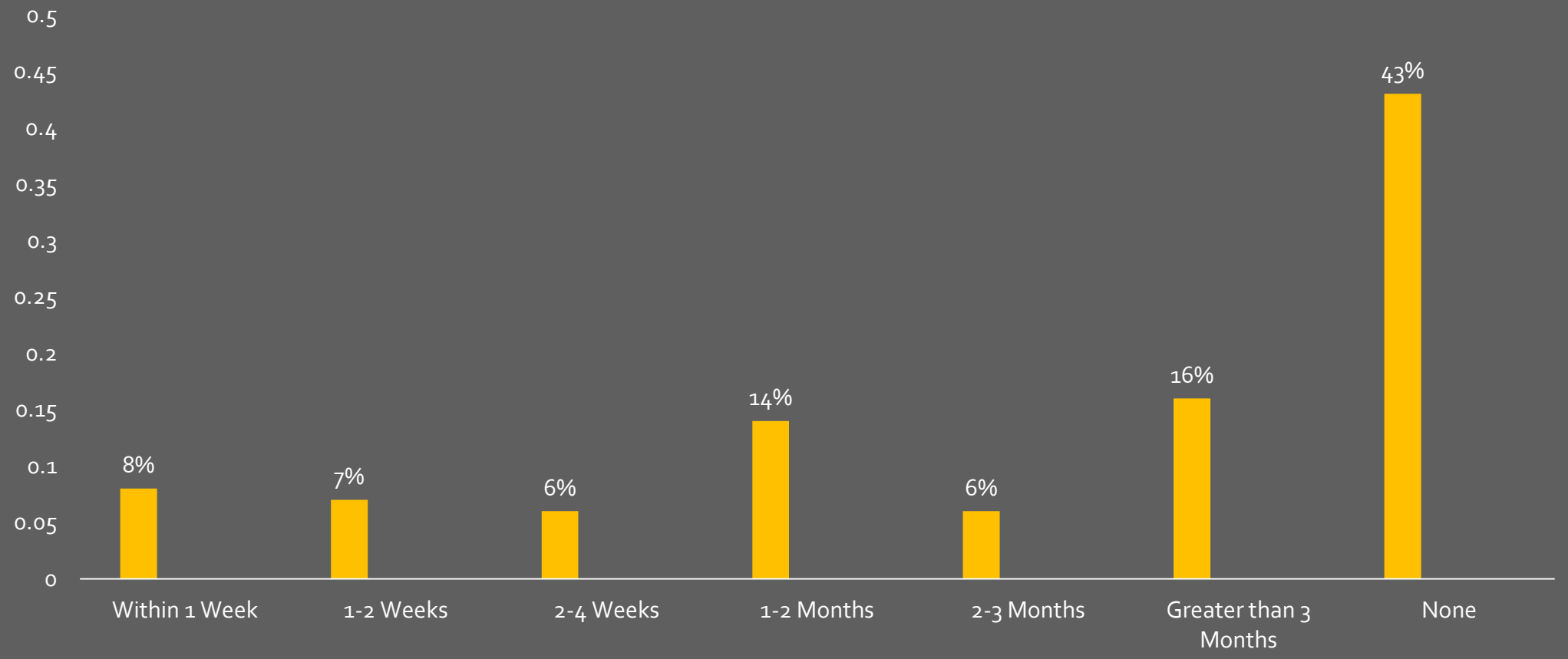
TOP 10 REASONS FOR DISCHARGE FROM UHNBC WITH READMISSIONS AGAIN WITHIN 28 DAYS

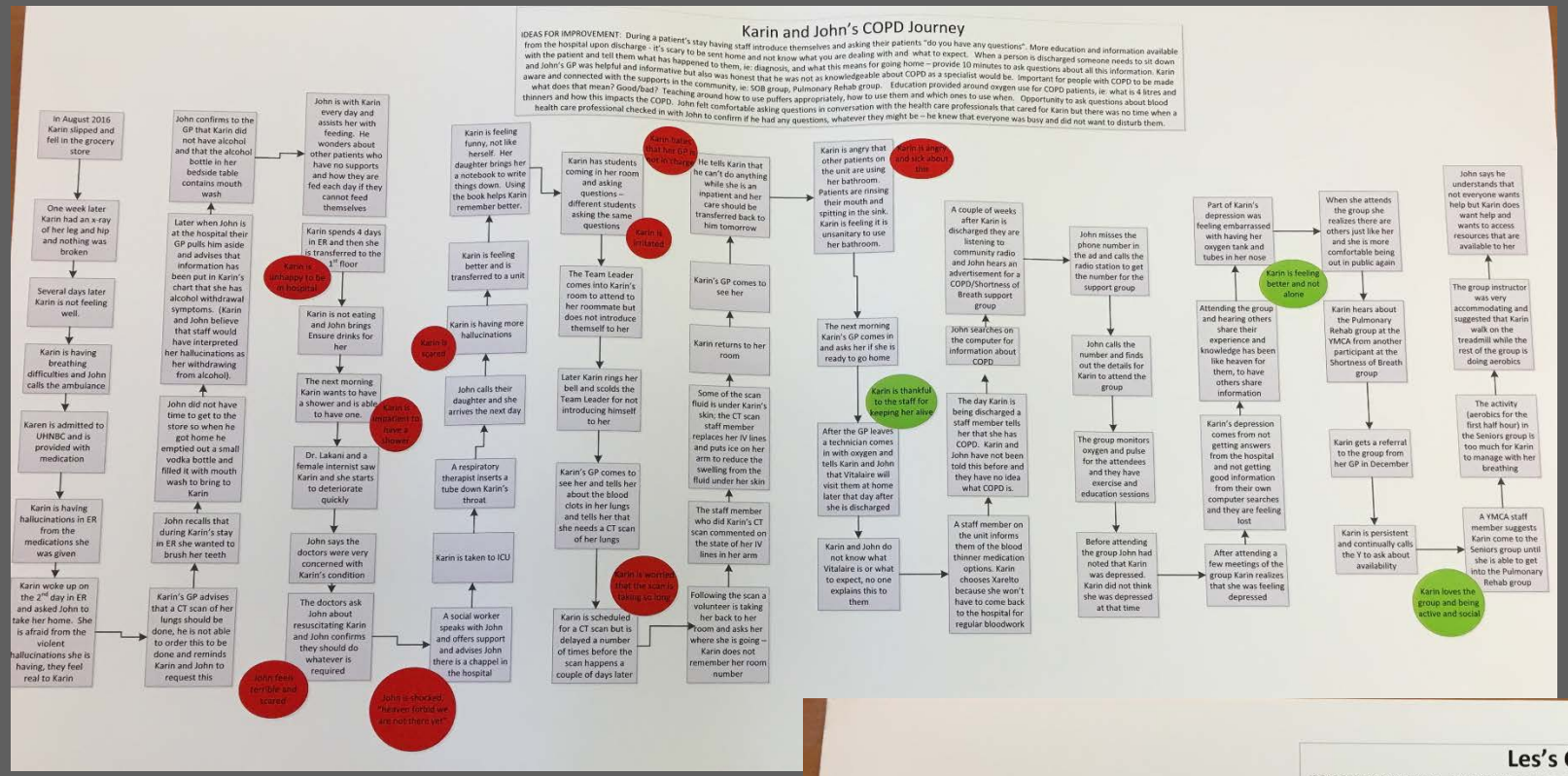
DAYS BETWEEN ED VISITS

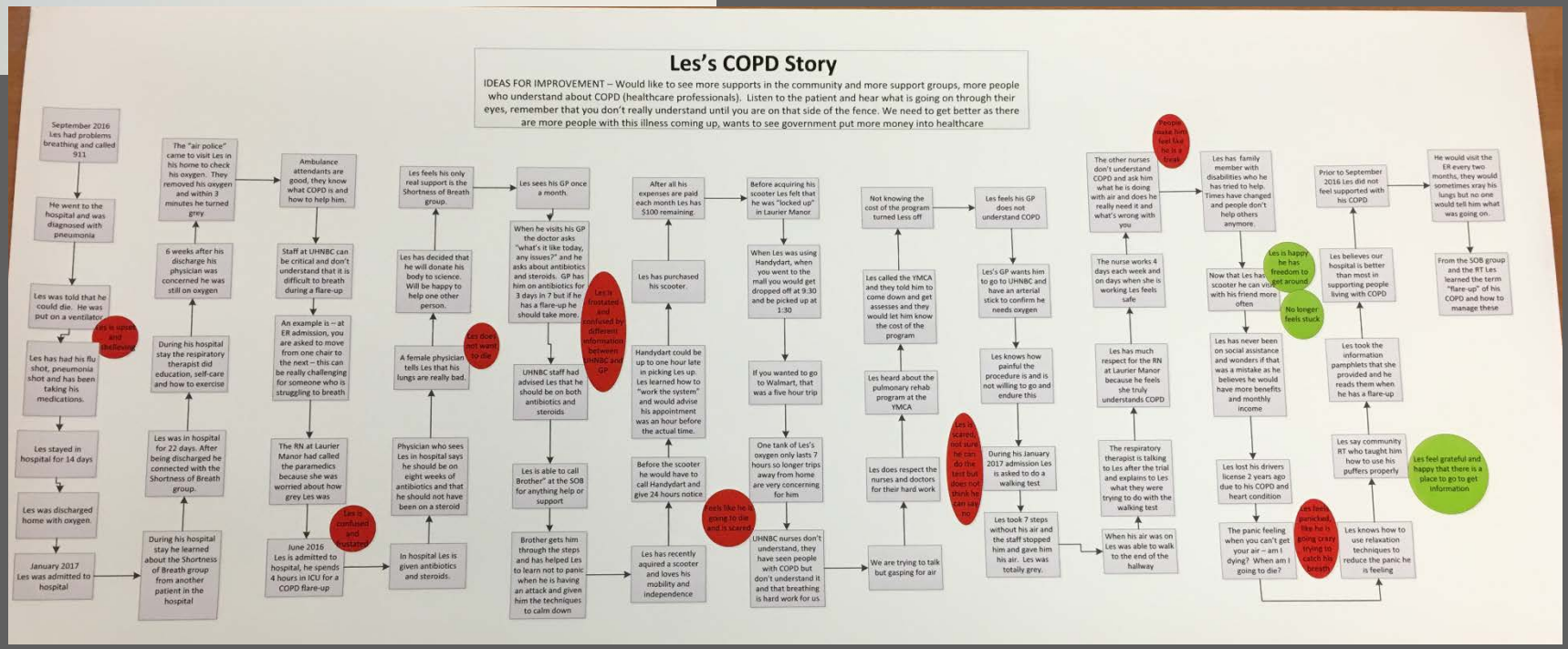


RE-ADMISSION DATA

80 Clients Tracked from April 2015-March 2016.




Karin and John's COPD Journey
IDEAS FOR IMPROVEMENT: During a patient's stay having staff introduce themselves and asking their patients "do you have any questions". More education and information available from the hospital upon discharge - it's scary to be sent home and not know what you are dealing with and what to expect. When a person is discharged someone needs to sit down with the patient and tell them what has happened to them, ie: diagnosis, and what this means for going home – provide 10 minutes to ask questions about all this information. Karin and John's GP was helpful and informative but also was honest that he was not as knowledgeable about COPD as a specialist would be. Important for people with COPD to be made aware and connected with the supports in the community, ie: SOB group, Pulmonary Rehab group. Education provided around oxygen use for COPD patients, ie: what is 4 litres and what does that mean? Good/bad? Teaching around how to use puffers appropriately, how to use them and which ones to use when. Opportunity to ask questions about blood thinners and how this impacts the COPD. John felt comfortable asking questions in conversation with the health care professionals that cared for Karin but there was no time when a health care professional checked in with John to confirm if he had any questions, whatever they might be – he knew that everyone was busy and did not want to disturb them.
In August 2016 Karin slipped and fell in the grocery store
One week later Karin had an x-ray of her leg and hip and nothing was broken
Several days later Karin is not feeling well.
Karin is having breathing difficulties and John calls the ambulance
Karen is admitted to UHNBC and is provided with medication
Karin is having hallucinations in ER from the medications she was given
Karin woke up on the 2nd day in ER and asked John to take her home. She is afraid from the violent hallucinations she is having, they feel real to Karin
John feels terrible and scared
Karin's GP advises that a CT scan of her lungs should be done, he is not able to order this to be done and reminds Karin and John to request this
John confirms to the GP that Karin did not have alcohol and that the alcohol bottle in her bedside table contains mouth wash
Later when John is at the hospital their GP pulls him aside and advises that information has been put in Karin's chart that she has alcohol withdrawal symptoms. (Karin and John believe that staff would have interpreted her hallucinations as her withdrawing from alcohol).
John did not have time to get to the store so when he got home he emptied out a small vodka bottle and filled it with mouth wash to bring to Karin
John recalls that during Karin's stay in ER she wanted to brush her teeth
John is shocked: "heaven forbid we are not there yet"
John is with Karin every day and assists her with feeding. He wonders about other patients who have no supports and how they are fed each day if they cannot feed themselves
Karin spends 4 days in ER and then she is transferred to the 1st Floor
Karin is unhappy to be on hospital
Karin is not eating and John brings Ensure drinks for her
The next morning Karin wants to have a shower and is able to have one.
Karin is embarrassed to have a shower
Dr. Lakani and a female internist saw Karin and she starts to deteriorate quickly
John says the doctors were very concerned with Karin's condition
The doctors ask John about resuscitating Karin and John confirms they should do whatever is required
A social worker speaks with John and offers support and advises John there is a chappel in the hospital
Karin is taken to ICU
A respiratory therapist inserts a tube down Karin's throat
Karin is feeling funny, not like herself. Her daughter brings her a notebook to write things down. Using the book helps Karin remember better.
Karin is feeling better and is transferred to a unit
Karin is having more hallucinations
Karin is scared
John calls their daughter and she arrives the next day
Karin has students coming in her room and asking questions – different students asking the same questions
Karin is irritated
Karin hates that her GP is not in charge
The Team Leader comes into Karin's room to attend to her roommate but does not introduce themself to her
Later Karin rings her bell and scolds the Team Leader for not introducing himself to her
Karin's GP comes to see her and tells her about the blood clots in her lungs and tells her that she needs a CT scan of her lungs
Karin is worried that the scan is taking so long
Karin is scheduled for a CT scan but is delayed a number of times before the scan happens a couple of days later
He tells Karin that he can't do anything while she is an inpatient and her care should be transferred back to him tomorrow
Karin's GP comes to see her
Karin returns to her room
Some of the scan fluid is under Karin's skin; the CT scan staff member replaces her IV lines and puts ice on her arm to reduce the swelling from the fluid under her skin
The staff member who did Karin's CT scan commented on the state of her IV lines in her arm
Following the scan a volunteer is taking her back to her room and asks her where she is going – Karin does not remember her room number
Karin is angry that other patients on the unit are using her bathroom. Patients are rinsing their mouth and spitting in the sink. Karin is feeling it is unsanitary to use her bathroom.
Karin is angry and sick about this
The next morning Karin's GP comes in and asks her if she is ready to go home
Karin is thankful to the staff for keeping her alive
After the GP leaves a technician comes in with oxygen and tells Karin and John that Vitalaire will visit them at home later that day after she is discharged
Karin and John do not know what Vitalaire is or what to expect, no one explains this to them
A couple of weeks after Karin is discharged they are listening to community radio and John hears an advertisement for a COPD/Shortness of Breath support group
John searches on the computer for information about COPD
The day Karin is being discharged a staff member tells her that she has COPD. Karin and John have not been told this before and they have no idea what COPD is.
A staff member on the unit informs them of the blood thinner medication options. Karin chooses Xarelto because she won't have to come back to the hospital for regular bloodwork
John misses the phone number in the ad and calls the radio station to get the number for the support group
John calls the number and finds out the details for Karin to attend the group
The group monitors oxygen and pulse for the attendees and they have exercise and education sessions
Before attending the group John had noted that Karin was depressed. Karin did not think she was depressed at that time
Part of Karin's depression was feeling embarrassed with having her oxygen tank and tubes in her nose
Karin is feeling better and not alone
Attending the group and hearing others share their experience and knowledge has been like heaven for them, to have others share information
Karin's depression comes from not getting answers from the hospital and not getting good information from their own computer searches and they are feeling lost
After attending a few meetings of the group Karin realizes that she was feeling depressed
When she attends the group she realizes there are others just like her and she is more comfortable being out in public again
Karin hears about the Pulmonary Rehab group at the YMCA from another participant at the Shortness of Breath group
Karin gets a referral to the group from her GP in December
Karin is persistent and continually calls the Y to ask about availability
Karin loves the group and being active and social
John says he understands that not everyone wants help but Karin does want help and wants to access resources that are available to her
The group instructor was very accommodating and suggested that Karin walk on the treadmill while the rest of the group is doing aerobics
The activity (aerobics for the first half hour) in the Seniors group is too much for Karin to manage with her breathing
A YMCA staff member suggests Karin come to the Seniors group until she is able to get into the Pulmonary Rehab group


Les's COPD Story
IDEAS FOR IMPROVEMENT – Would like to see more supports in the community and more support groups, more people who understand about COPD (healthcare professionals). Listen to the patient and hear what is going on through their eyes, remember that you don't really understand until you are on that side of the fence. We need to get better as there are more people with this illness coming up, wants to see government put more money into healthcare
September 2016 Les had problems breathing and called 911
He went to the hospital and was diagnosed with pneumonia
Les was told that he could die. He was put on a ventilator
Les is upset and distressed
Les has had his flu shot, pneumonia shot and has been taking his medications.
Les stayed in hospital for 14 days
Les was discharged home with oxygen.
January 2017 Les was admitted to hospital
The "air police" came to visit Les in his home to check his oxygen. They removed his oxygen and within 3 minutes he turned grey
6 weeks after his discharge his physician was concerned he was still on oxygen
During his hospital stay the respiratory therapist did education, self-care and how to exercise
Les was in hospital for 22 days. After being discharged he connected with the Shortness of Breath group.
During his hospital stay he learned about the Shortness of Breath group from another patient in the hospital
Ambulance attendants are good, they know what COPD is and how to help him.
Staff at UHNBC can be critical and don't understand that it is difficult to breath during a flare-up
An example is – at ER admission, you are asked to move from one chair to the next – this can be really challenging for someone who is struggling to breath
The RN at Laurier Manor had called the paramedics because she was worried about how grey Les was
June 2016 Les is admitted to hospital, he spends 4 hours in ICU for a COPD flare-up
Les is confused and frustrated
In hospital Les is given antibiotics and steroids.
Les feels his only real support is the Shortness of Breath group.
Les has decided that he will donate his body to science. Will be happy to help one other person.
A female physician tells Les that his lungs are really bad.
Les does not want to die
Physician who sees Les in hospital says he should be on eight weeks of antibiotics and that he should not have been on a steroid
Les sees his GP once a month.
When he visits his GP the doctor asks "what's it like today, any issues?" and he asks about antibiotics and steroids. GP has him on antibiotics for 3 days in 7 but if he has a flare-up he should take more.
Les is frustated and confused by different information between UHNBC and GP
UHNBC staff had advised Les that he should be on both antibiotics and steroids
Les is able to call Brother" at the SOB for anything help or support
Brother gets him through the steps and has helped Les to learn not to panic when he is having an attack and given him the techniques to calm down
After all his expenses are paid each month Les has $100 remaining.
Les has purchased his scooter.
Handydart could be up to one hour late in picking Les up. Les learned how to "work the system" and would advise his appointment was an hour before the actual time.
Before the scooter he would have to call Handydart and give 24 hours notice
Les feels like he is prone to die and is scared
Les has recently aquired a scooter and loves his mobility and independence
Before acquiring his scooter Les felt that he was "locked up" in Laurier Manor
When Les was using Handydart, when you went to the mall you would get dropped off at 9:30 and be picked up at 1:30
If you wanted to go to Walmart, that was a five hour trip
One tank of Les's oxygen only lasts 7 hours so longer trips away from home are very concerning for him
UHNBC nurses don't understand, they have seen people with COPD but don't understand it and that breathing is hard work for us
Not knowing the cost of the program turned Les off
Les called the YMCA and they told him to come down and get assesses and they would let him know the cost of the program
Les heard about the pulmonary rehab program at the YMCA
Les does respect the nurses and doctors for their hard work
We are trying to talk but gasping for air
Les feels his GP does not understand COPD
Les's GP wants him to go to UHNBC and have an arterial stick to confirm he needs oxygen
Les knows how painful the procedure is and is not willing to go and endure this
During his January 2017 admission Les is asked to do a walking test
Les took 7 steps without his air and the staff stopped him and gave him his air. Les was totally grey.
Les is scared, not sure he can do the test but does not think he can say no
The other nurses don't understand COPD and ask him what he is doing with air and does he really need it and what's wrong with you
People looked him/feel like he is a freak
The nurse works 4 days each week and on days when she is working Les feels safe
Les has much respect for the RN at Laurier Manor because he feels she truly understands COPD
The respiratory therapist is talking to Les after the trial and explains to Les what they were trying to do with the walking test
When his air was on Les was able to walk to the end of the hallway
Les has family member with disabilities who he has tried to help. Times have changed and people don't help others anymore.
Now that Les has a scooter he can visit with his friend more often
Les is happy he has freedom to get around.
No longer feels stuck
Les has never been on social assistance and wonders if that was a mistake as he believes he would have more benefits and monthly income
Les lost his drivers license 2 years ago due to his COPD and heart condition
The panic feeling when you can't get your air – am I dying? When am I going to die?
Les feels panicked, like he is going crazy trying to catch his breath
Les knows how to use relaxation techniques to reduce the panic he is feeling
Prior to September 2016 Les did not feel supported with his COPD
Les believes our hospital is better than most in supporting people living with COPD
Les took the information pamphlets that she provided and he reads them when he has a flare-up
Les say community RT who taught him how to use his puffers properly
Les feel grateful and happy that there is a place to go to get information
He would visit the ER every two months, they would sometimes xray his lungs but no one would tell him what was going on.
From the SOB group and the RT Les learned the term "flare-up" of his COPD and how to manage these

CURRENT STATE

- McLeod Medical Clinic – Dr. Denise McLeod with MOA Johanna Tolsdorf
- Panel Size – 1747
- COPD patients – 67
- Complex Care COPD patients* - 35
- COPD & pneumococcal vaccine – 88% (59/67)
- COPD & FEV1 at anytime - 85% (57/67)
- COPD & non-smoker – 64% (43/67)
- COPD & Activity Assessment in last year – 67% (45/67)

*Patients that have COPD and at least 1 other chronic disease

THE TEAM

Family Physician: Dr. Denise McLeod
Medical Office Assistant: Johanna Tolsdorf

Respirologist: Dr. Sharla Olsen

Respiratory Therapist: Renee Pigeon
Primary Care Team Lead: Roberta Miller

Primary Care Nurse: Annick McIntosh
Practice Improvement Coach: Karen Gill

Facility Improvement Coach: Shelley Movold
Literature Review: Julius Bankola (PhD student at UNBC)

MILESTONES

December 2017 –	Planning and identifying goals and measures with the primary care team, practice support coach, physician QI coach
January 2018 –	Identify patients to invite
February 9, 2018 –	Planning of training session with Renee Pigeon, RT and the primary care team
February 22, 2018-	First Group Medical Visit at McLeod Medical Clinic
March 2018-	1:1 Doctor's visit with GMV participants followed by home visit with the primary care team
April 2018 -	Second Group Medical Visit
May 2018 –	Third Group Medical Visit

MEASURES

Outcome measures

- Number of emergency or walk in clinic visits per year for COPD patients (MOIS)
- Number of COPD exacerbations, identified by antibiotic use
- Number of action plans created or updated with patients (MOIS)
- Number of current Pulmonary Function Tests
- Increase patient confidence in self-management (questionnaire at beginning of first GMV and end of third GMV)

Process measures

- Patient satisfaction with GMV (verbal feedback at the end of GMVs)
- Time commitment for planning and executing each GMV
- Patient attendance or attrition
- Team satisfaction in provision of care

FIRST GMV SURVEY MEASURES- WHERE WE ARE STARTING….

Measure	Data
Number of emergency visits in 2017	17%
Number of walk in clinic visits in 2017	0
COPD exacerbations in 2017 (antibiotics prescribed)	33%
Number of current action plans	17%
Number of current Pulmonary Function Tests	17%
Patients confidence in their self management (from survey)	30%

QUADRUPLE AIM

It is my belief that this project addresses the quadruple aim in all aspects:

- Better outcomes
- Team satisfaction
- Patient satisfaction
- Cost effective

SUMMARY

As measured by CAT scores and ER and walk in admissions.

GMV have already been implemented and supported for physician reimbursement and primary care teams are already established and working in the community.

Shared team responsibilities in education and monitoring will improve team and patient interactions.

Patients will feel heard, supported and involved in their management.

BEING A LEADER DOES NOT HAVE TO BE A LONELY JOB