Caring for my COPD

Soigner ma MPOC

AOHC Conference

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Disclosure of Commercial Support

Presenter Disclosure

Presenter: Keira Rainville
Patrick Martin

Relationships with commercial interests:

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- **Other:** None

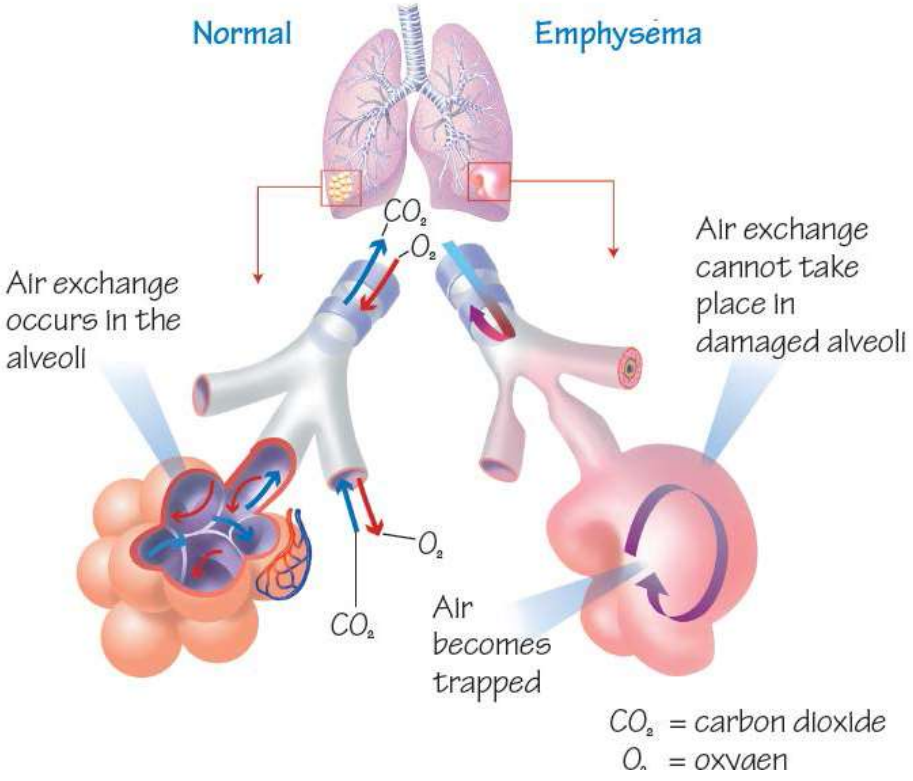
Agenda

- COPD
- What is pulmonary rehab?
- Background on HNHB LHIN
- Overview of the *Caring for my COPD* program
- The role of patient engagement
  - Development
  - Implementation
  - Evaluation
- Patient Stories
- Discussion & Questions

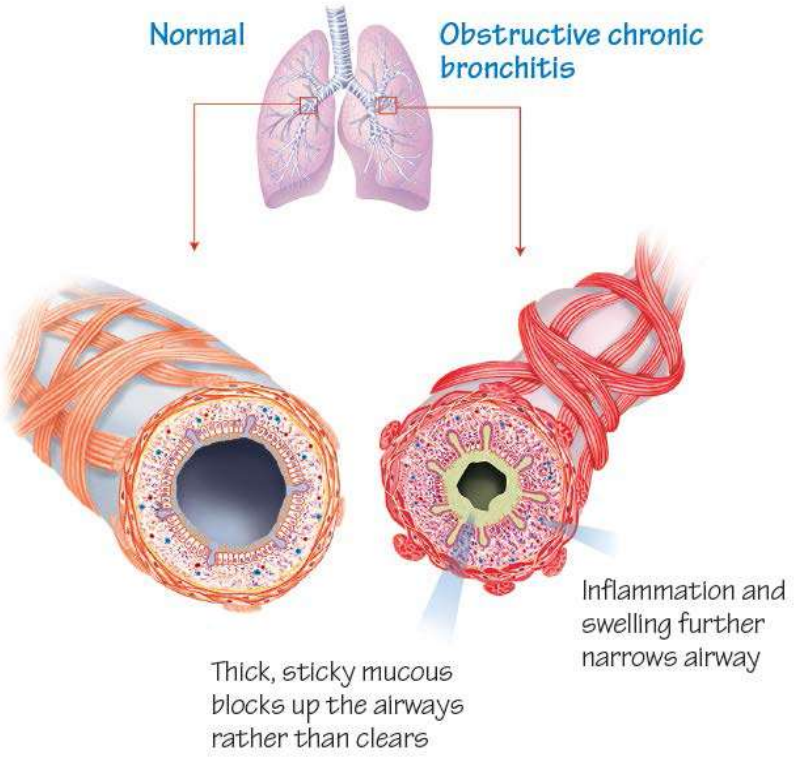
COPD

- Chronic Obstructive Pulmonary Disease

Emphysema



Chronic Bronchitis

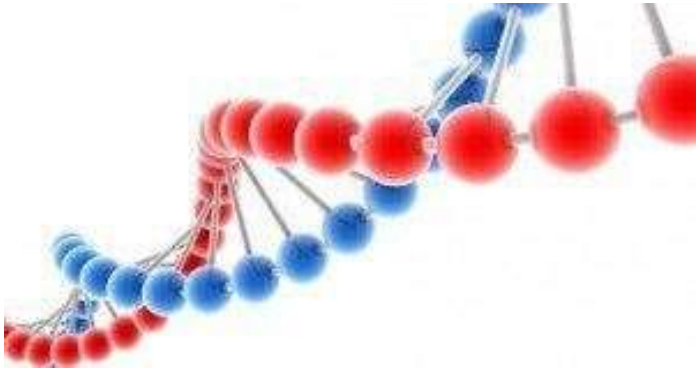


Causes of COPD

- **Sm**

- **En**

- **Genetic Factor**



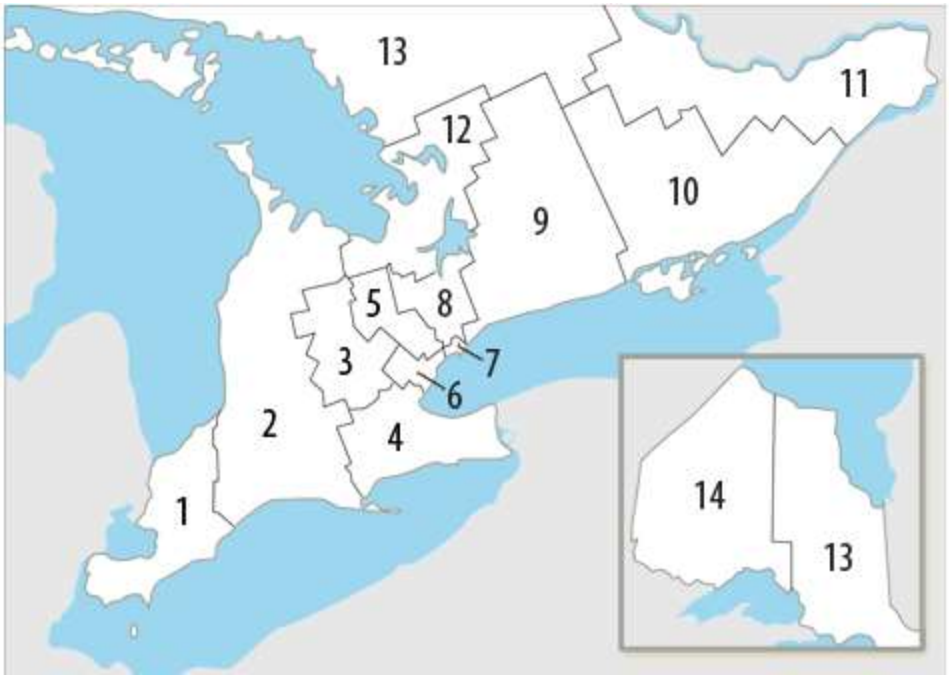
Pulmonary Rehab

- A program of exercise, education and support from a multidisciplinary team.

- Proven over and over to improve:
  - Physical fitness
  - Knowledge of COPD
  - Quality of life

- Only 1% of the population have access.

Local Health Integration Networks



The Local Health Integration Networks (LHINs) plan, integrate and fund local health care, improving access and patient experience.

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

Ontario's LHINs

Hamilton Niagara Haldiman Brant Local Health Integration Network (LHIN)

HNHB

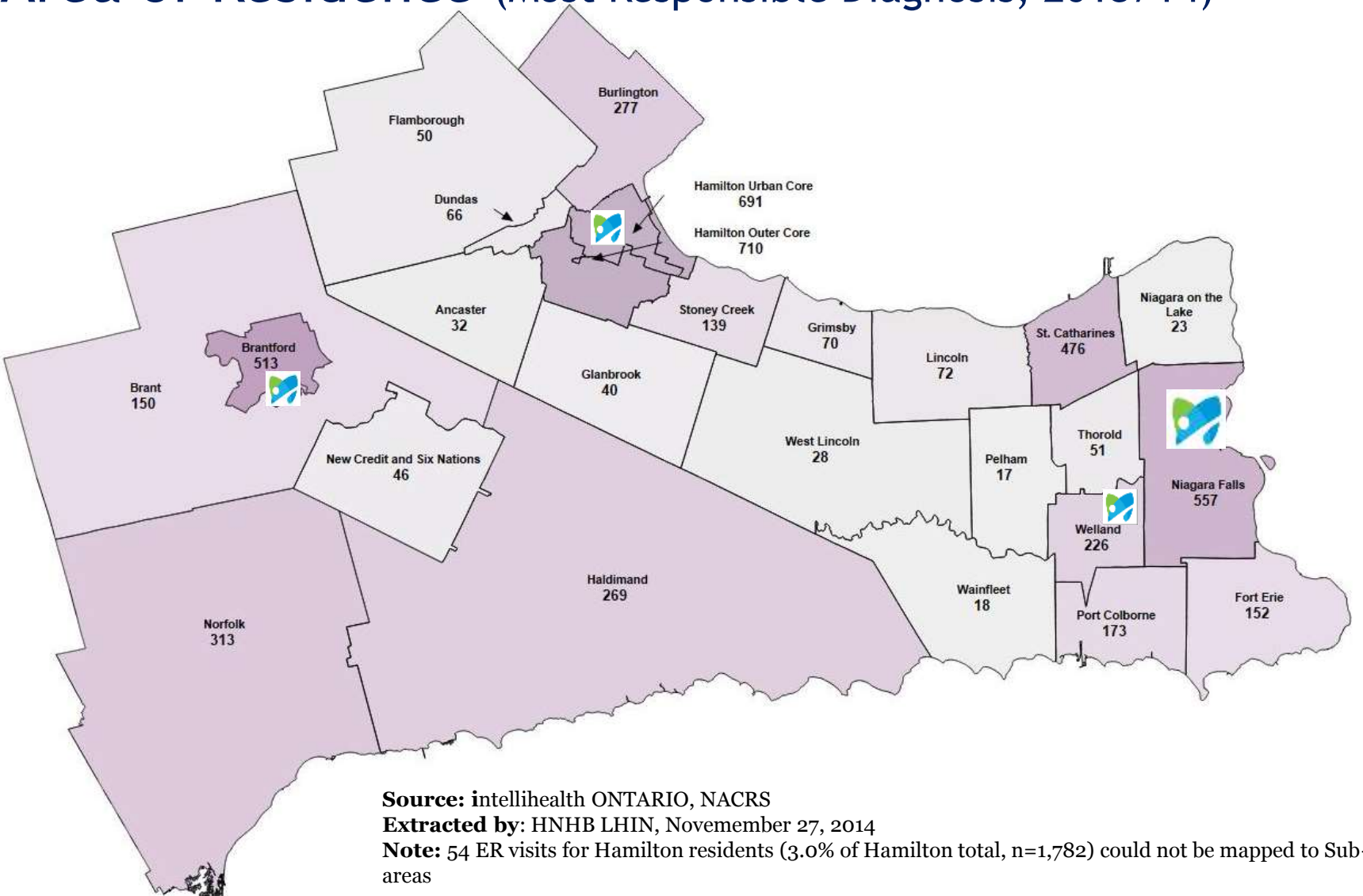
LHIN

- 7000 km_2
- 1.4 million people
- High # of seniors
- Higher prevalence of daily or occasional smokers

HNHB COPD Stats

HNHB COPD Statistics	FY2012	FY2013
ER Visits	5,044 ER (3,660 people)	5,206
Hospital Discharges	3,169 (2,460 people)	2,925 (2,236 people)
30 Day readmission	19.6%	20.2%
90 day readmission	34%	n/a

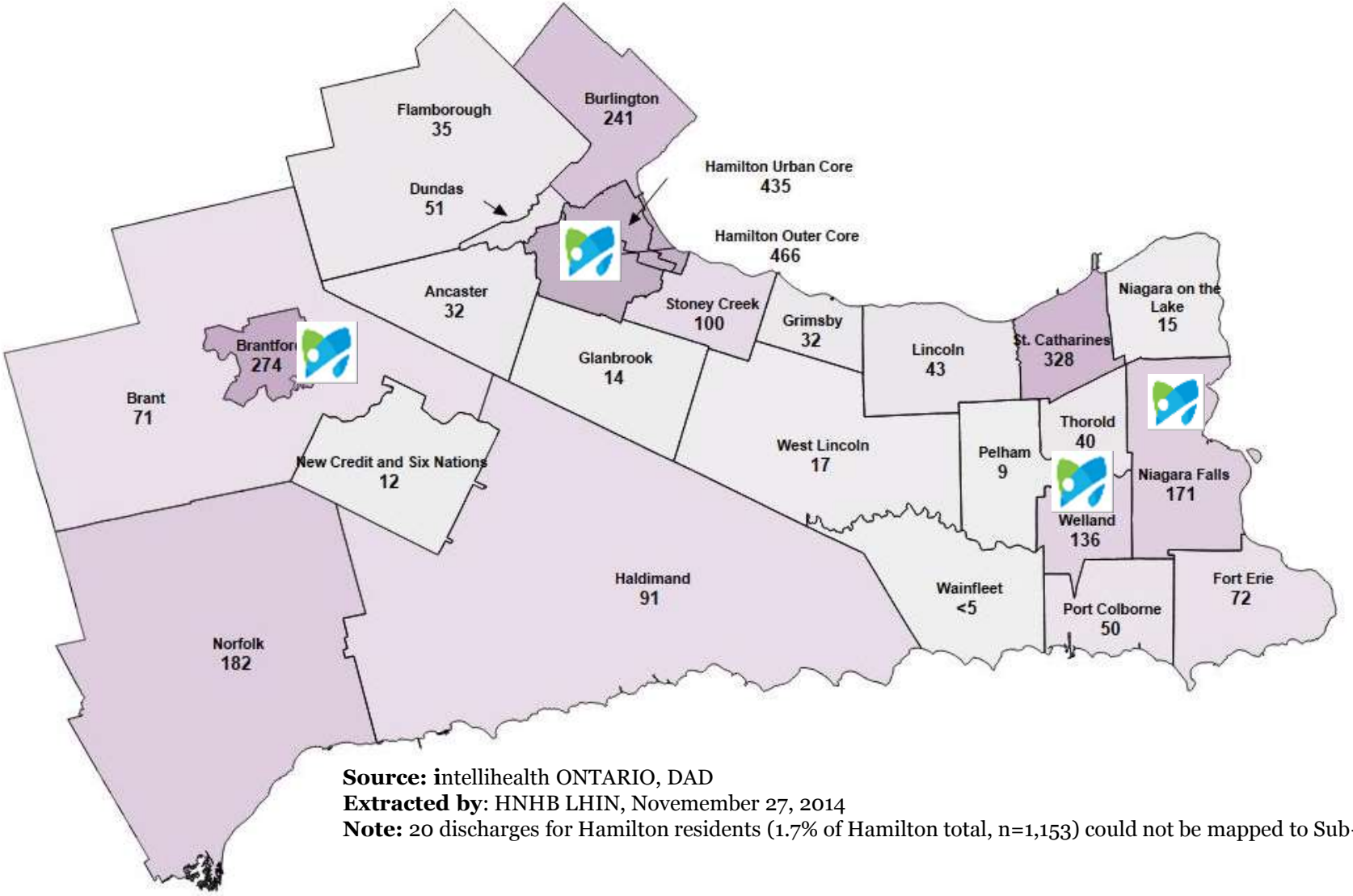
HNHB Emergency Department Visits with COPD by Area of Residence (Most Responsible Diagnosis, 2013/14)



Source: intellihealth ONTARIO, NACRS
Extracted by: HNHB LHIN, Novemember 27, 2014
Note: 54 ER visits for Hamilton residents (3.0% of Hamilton total, n=1,782) could not be mapped to Sub-LHIN areas

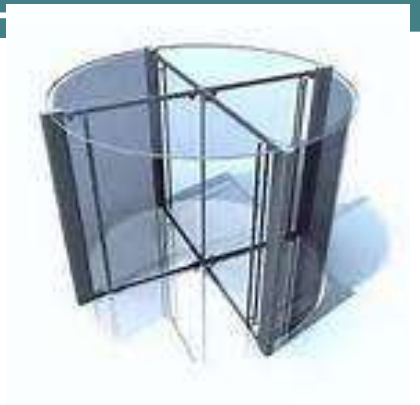
HNHB Hospitalizations with COPD by Area of Residence

(Most Responsible Diagnosis, 2012/13)



Source: intellihealth ONTARIO, DAD
Extracted by: HNHB LHIN, Novemember 27, 2014
Note: 20 discharges for Hamilton residents (1.7% of Hamilton total, n=1,153) could not be mapped to Sub-LHIN areas

Current Challenges



- Increase use of healthcare resources
  - E.g. ED Visits, Patient Days, Community
- How to decrease burden of suffering and increase “Hope”
- How to get resources working together (right care, right time, right place)

Community management of COPD

- Goals of COPD Integrated Model of Care:
  - Improve client's healthcare experience and knowledge to manager their health condition
  - Decrease COPD ER visits, hospitalizations, and readmissions within 30 days
  - Improve patients' quality of life

Program Locations

Centre de santé Communautaire Hamilton / Niagara

NorthHamilton Community Health Centre

Grand River Community Health Centre

NFCHC NIAGARA FALLS COMMUNITY HEALTH CENTRE
Empowering Individuals, Strengthening Community

Caring for my COPD

Caring for My COPD is a 10 –week program at the Centre de santé communautaire for people who have Chronic Obstructive Pulmonary Disease (COPD) including those recently hospitalized due to COPD.

If you experience acute flare-ups of Chronic Obstructive Pulmonary Disease, consider our community based program to help you gain better control of your COPD.

The Caring for My COPD program offers you:

- Group and individual COPD education
- Peer Support
- Educational sessions for family and caregiver to help support you
- Personalized exercise programs supervised by healthcare professionals and group exercises
- Smoking Cessation counselling and support
- Care giver support
- Review and assessment of your COPD Action Plan can support your efforts to better manage your breathing difficulties
- Personal counselling and spiritual support

Provides the following benefits:

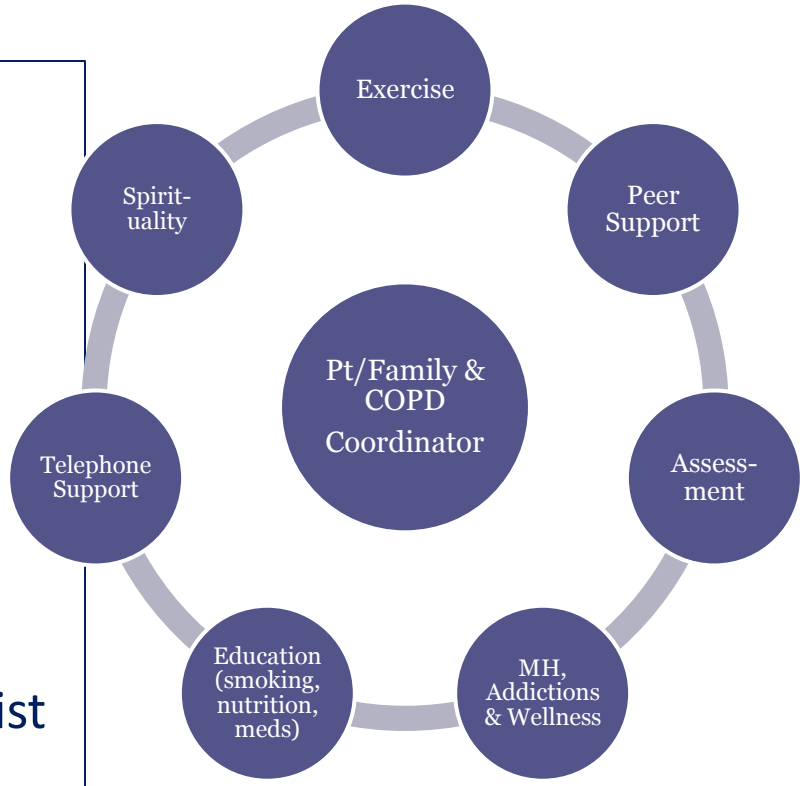
- There is **NO COST** for this program
- Better quality of life by learning how best to manage your COPD
- Opportunity to attend the program as frequently as you like
- Broad support network of people who understand your breathing issues
- Access to telephone support throughout the week from your COPD Coordinator and care team
- Updates to your primary care provider

Managing your COPD so you can enjoy the things you love to do!

Model

Key Program Features

- Case management by COPD Coordinator (CRE)
- Telephone access (during business hours)
- Intensive program for 10 weeks; followed by monthly phone calls for 12 months
- Communication with Primary Care/Respirologist



10 week customized program

Interdisciplinary team

- CRE Coordinator (RRT)
- Kinesiologist
- Administrative support
- Psychologist
- Health Promoter
- Dietician
- Director, Centre de santé

Who is this program for?

Who is eligible?

- Patients with a **CONFIRMED Dx OF COPD through spirometry with an FEV1/FVC ratio of less than .70**
- Patients who have been recently hospitalized or at risk of an acute exacerbation
- Ability to travel to a community centre for a core program of exercise and education
- Ability to participate in group settings
- Willingness to participate

Who is NOT eligible?

- Patients residing in long-term care facilities
- Medically unstable patients
- Patients with unconfirmed COPD

Caring for my COPD

Program Referrals

Caring for my COPD

Grand River Community Health Centre

Tel: 519-754-0777 ext. 235
Fax: 519-754-0757

Program Referral (Emphysema and / or Chronic Bronchitis)

REFERRAL DATE: mm dd yy	DATE OF BIRTH mm dd yy	HOSPITAL DISCHARGE DATE: mm dd yy	GENDER:

Surname:	First name:	Telephone:
Address:	City:	Postal code:
Health card number:		

REFERRING PHYSICIAN / NP	Name:	Address:
	Telephone#:	Fax#:

Recent: FEV_1 _____ % | FVC: _____ % | FEV_1/FVC ratio _____ % | Date: mm dd yy

NOTE: the FEV1/FVC ratio must be <70%

Smoker: ☐ YES OR ☐ NO

☐ Attach patient summary if available with referral form and complete sections below if not covered in patient summary

MAJOR DIAGNOSIS/ COMORBIDITIES:

- ☐ COPD (Dx confirmed by spirometry)
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Bronchiectasis
- ☐ CO_2 Retainer
- ☐ Diabetes Mellitus
- ☐ Stroke/TIA
- ☐ CHF
- ☐ Previous Myocardial Infarction
- ☐ Hypertension
- ☐ Heart Failure
- ☐ Osteoporosis
- ☐ Aneurysm
- ☐ Other: (Please list)

MEDICATIONS:

- ☐ Inhaled Bronchodilators
- ☐ Oral Bronchodilators
- ☐ Oral Steroids
- ☐ Inhaled Steroids
- ☐ Beta Blockers
- ☐ Anti-anginal
- ☐ Diuretic
- ☐ Insulin
- ☐ Anti-hypertensive
- ☐ Oxygen: _____ L/min at rest _____ L/min on exertion
- ☐ CPAP/BIPAP: _____
- ☐ Other: (Please list)

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Physician or NP's Clearance to Participate in Physical Activity Stream

To ensure client safety for graded levels of exercise, please indicate below if client is **medically stable and cleared to participate in moderate physical activity** (based on self perception of exertion).

◯ Client is **medically stable** and can **participate in exercise** at this time × _____ **Physician / NP signature**

◯ Client is **NOT medically stable.** Should enter **education stream only** × _____ **Physician/ NP signature**

If your client has any contradictions or restrictions for physical exercise, please note here

Examples of contraindications for entry into the COPD Exercise Stream. *May not be an exhaustive list*

- Unstable angina
- Uncontrolled hypertension >160 systolic/>95 diastolic
- Significant drop (20 mmHg or +) in resting systolic BP from client's average not explained by medication
- Moderate to severe aortic stenosis
- Acute systemic illness or fever
- Uncontrolled atrial or ventricular arrhythmias
- Uncontrolled tachycardia (greater than 100bpm)
- Third degree heart block
- Active pericarditis/myocarditis
- Recent embolism
- Thrombophlebitis
- Resting ST displacement (greater than 3mm)
- Uncontrolled diabetes
- Orthopedic problems that prohibit exercise
- Generally worsening conditions (until resolved)
- Symptomatic CHF

*If there are **any changes in your client's status** that would make them ineligible for exercise, please advise them to discontinue the exercise program and inform the COPD program staff until concern(s) is resolved.

Client may still be eligible for Education.

We will send communications to your office once the client enters the program and upon graduation. We also have the option of sending a mid-program report if you wish. **Please indicate below if you would like to receive this report:**

◯ **NO** I do not wish to receive a mid-program report at 5 weeks
◯ **YES** Please send me the mid-program report at 5 weeks

Physician / Nurse Practitioner Signature:

×

➤ ***Send signed and completed form to:***

Attention: Kate Balkwill, Administrative Assistant
Grand River Community Health Centre

Telephone: 519-754-0777 ext. 235 **Fax:** 519-754-0757 **Email:** kbalkwill@grchc.ca

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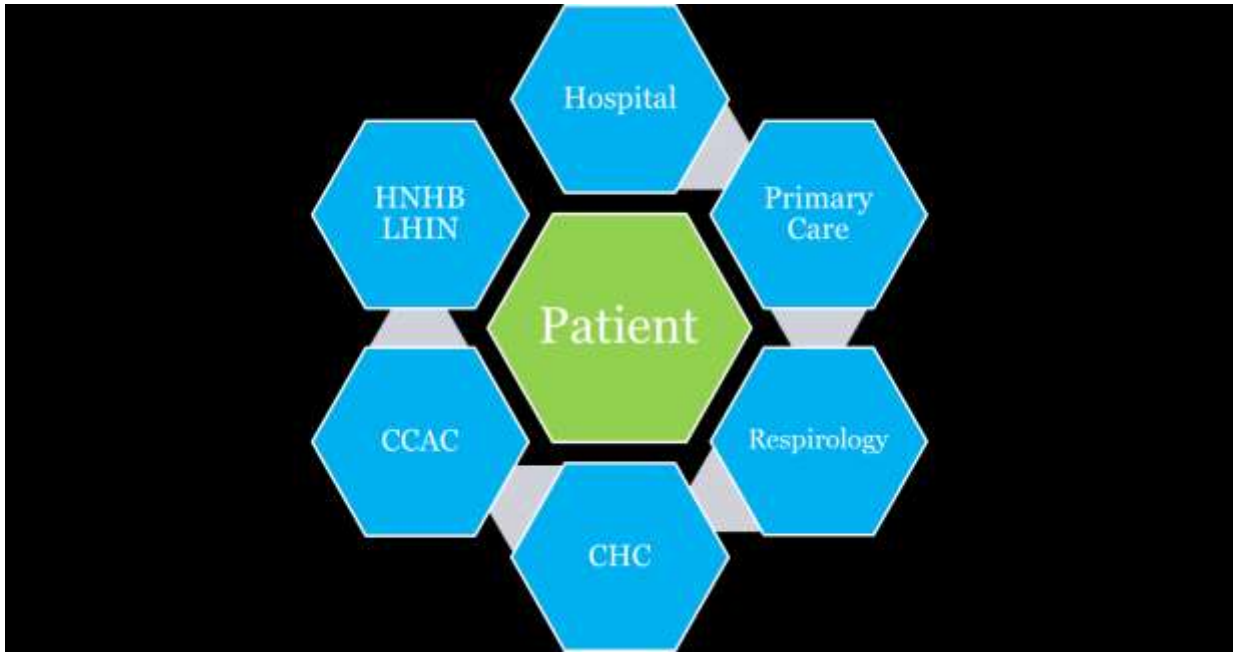
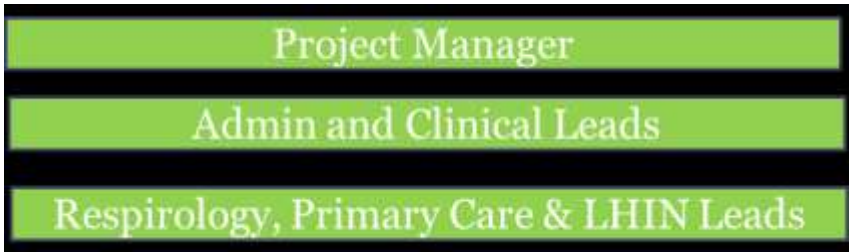
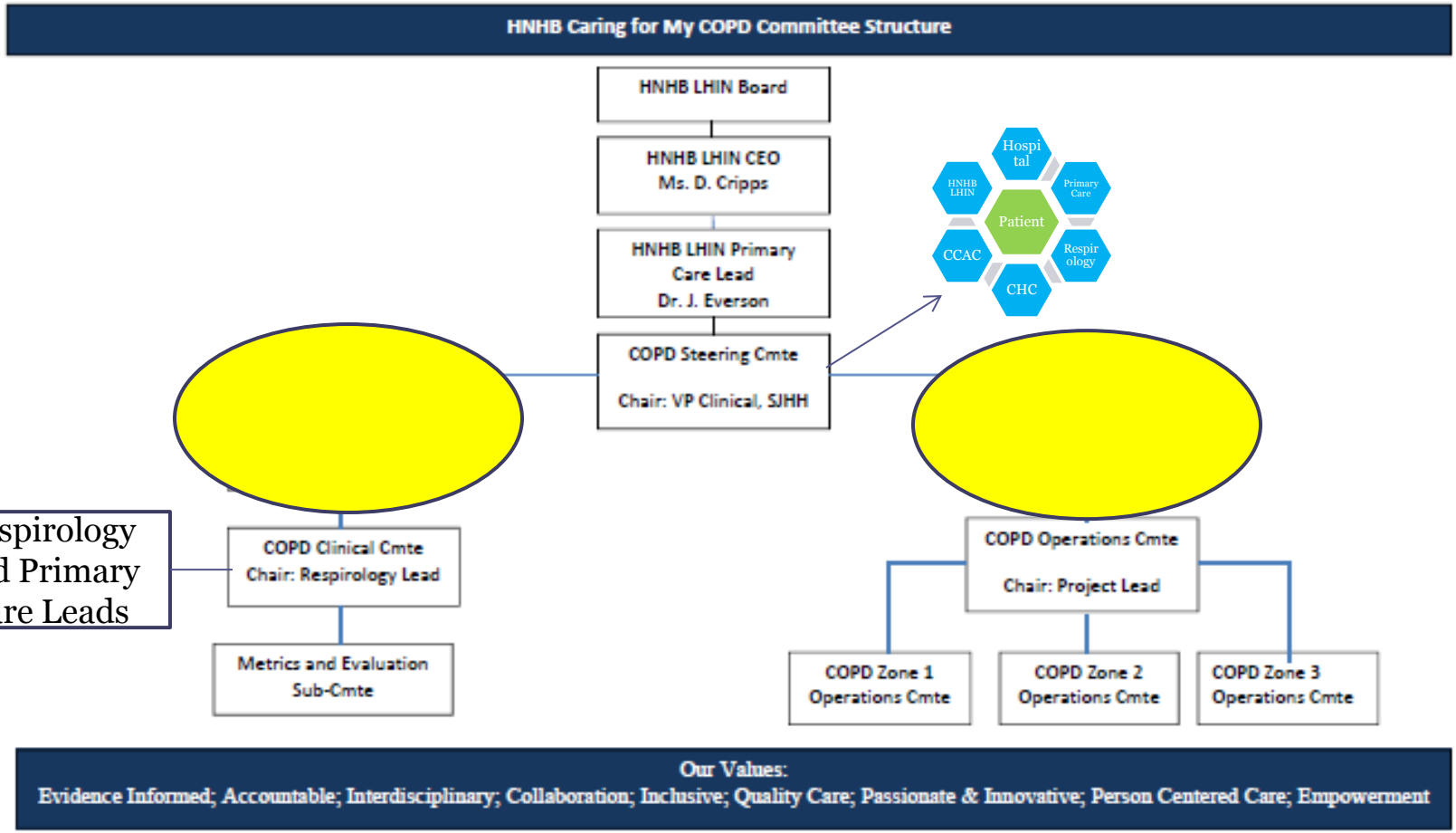
Key Success Factors

- Developed in partnership with key stakeholders HNHB LHIN (patients and providers)





Key Success Factor: Formalized Structure & Leadership



Key Success Factors

- Alignment with LHIN, hospital and community priorities
- Partnership with Community Health Centres
- CRE COPD Coordinators and multi-disciplinary team
- Partnership and collaboration with patients and family members
- Tight timelines, clear vision and a common goal to work towards
- Robust communication plan

Caring for my COPD

Key Success Factor: Patient/Client Engagement

Planning

- Client interviews
- Patient experience mapping sessions
- Consultation with St. Joseph's Pulmonary Rehab Breathing Buddies peer support group

Key Success Factor: Patient/Client Engagement

Delivery

- Graduates of Caring for my COPD program invited to provide peer support to new clients in program
- Patient/Family Advisors on Caring for My COPD Committees

Evaluation

- Patient satisfaction/client experience survey
- Patient experience mapping sessions (Brantford, Hamilton)
- Focus groups to understand strengths and areas for improvement for program

What we learned…..

- Peer support is a HUGE component
- Importance of family support
- Exercise and education are key components to the program
- Patient feedback:
  - Patients/Clients would like to receive information on program while in hospital (written and verbal)
  - Encourage those afraid to leave house
  - Need to reinforce learning at home (homework)
  - Provide list of gym facilities (location and cost)
  - Liked multi-disciplinary team and frequency of program

CRE – COPD Coordinator Perspective

- Clients who fully engage in the program have better personal outcomes
- Clients become more confident in their ability to tackle their day to day activities
- Clients can overcome their smoking addiction with support and where available, NRT
- Clients who learn why it is important to take medications in a certain way are more likely to do so.
- Family and supporters find the program has a big impact on how their loved one is coping and managing.
- Clients find peer supports, a friendly community and hope to dream again.

Formal Evaluation

- Essential to the implementation of new health care programs is the ability to evaluate change in relevant outcome measures such as:
  - Health care resource utilization and health system related outcomes (wait times, program adherence)
  - Improvement in clinical outcomes and quality of life.

- 12-month longitudinal observational study, pre-post design, in a cohort of patients recruited over a period of 6 months at 4 community health centres (CHCs) in HNHB
  - Subject recruitment goal = 128 subjects (approx 32 per site) completed by June 30, 2015

Primary Study Outcome Measures

- Healthcare resource utilization:
  - ER visits, hospitalizations/readmissions, primary care and specialist visits
  - Utilization of the Caring for My COPD program

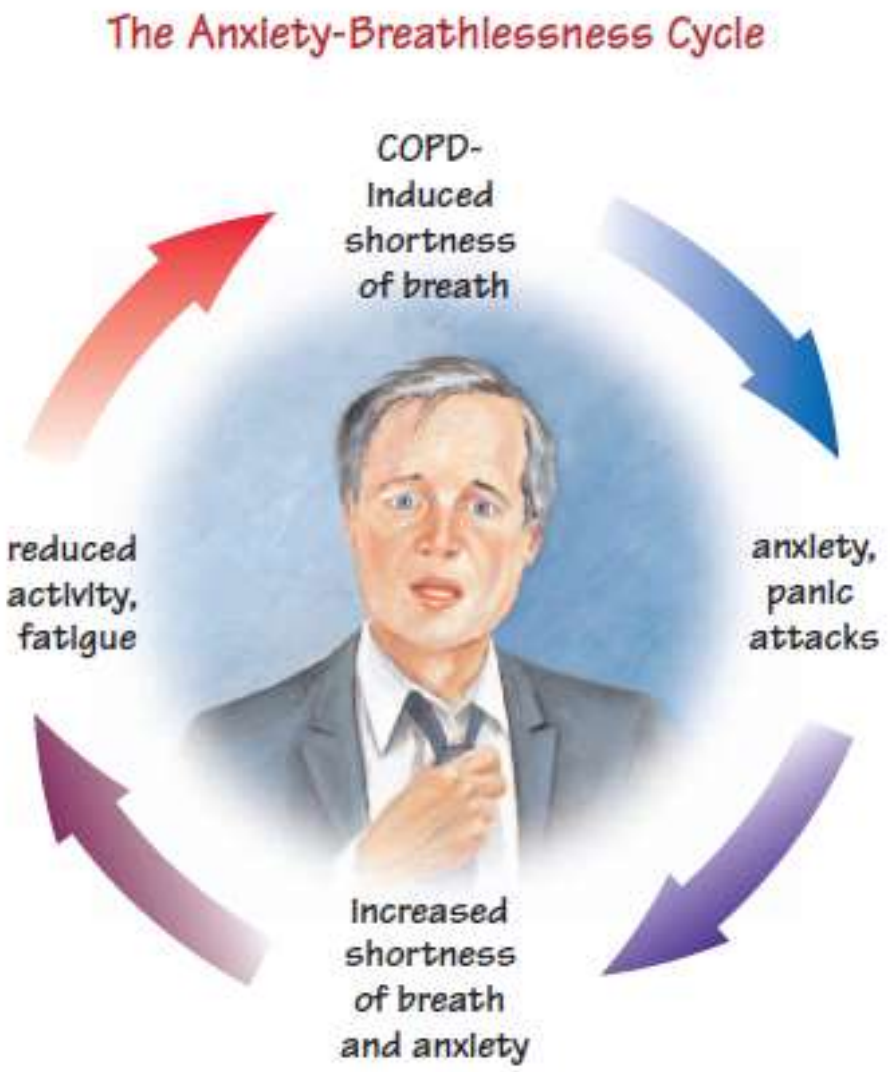
- Clinical measures
  - 6 minute walk test (6MWT)
  - Spirometry
  - COPD Assessment Test (CAT)
  - Borg Scale
  - Depression Anxiety Stress Scale (DASS-21)
  - Smoking Status
  - Perceived Health Status Question

- Health-related quality of life measures
  - Chronic respiratory questionnaire (CRQ-SAS)
  - EQ-5D-5L

Caring for my COPD

The Patient/Client Experience

A patient's 10 week journey



Start of the program
- Anxiety, Fear, Hopelessness
- Little to no knowledge of COPD
- Exercise Avoidance

During the program
- Building Confidence
- Celebrating the small accomplishments
- Learning active COPD management
- Gaining hope
- Learning how to exercise safely
- Developing a social support network

At the End of the Program
- Confident
- Proud
- Hopeful
- Becoming peer leaders

Living well with COPD, Managing your Stress and Anxiety.

Patient Stories

Case 1 – Alice

68 year old female
Very Severe COPD
Diagnosed over 10 years ago
Support – Husband
Participated twice in the Firestone Clinic

Patient Stories

Case 2 – Ron

59 year old Male
Moderate COPD
Diagnosed 5 years ago
Drastic lifestyle changes over last 4 years

Patient Stories

Case 3 – Jim

57 year old male
Moderate COPD
Diagnosed < 1 year ago
Lack of Support
Smoker
Anxiety and breathlessness cycle
Mistrust of the system

Patient Experience

"This program helped me realize I can exercise my butt off without dying".

"I don't worry anymore".

"I go out more in past three months vs last three years".

"It has really helped me, it has changed my life".

"I'm no longer scared to leave the house".

" I have had three exacerbations without going to hospital since starting this program".

"Went from 'worry' to 'relief'"

"Helps you to live better"

"On the whole, can't beat this program"

"Action Plan is key"

"Invisible condition – good to have help with advocacy"

A community based program for people with Chronic Obstructive Pulmonary Disease (COPD) including those recently hospitalized due to COPD.

Centre de santé Communautaire Hamilton / Niagara

Call us at 905-714-9935 ext. 2285

For more information contact:

Elsa Deyell

Program Coordinator

Caring for my COPD, Welland

Elsa.deyell@cschn.ca