**QI Project:** Building Capacity in Patient-Centered Care for COPD

**Health Theme:** Efficiency, Integration, Patient-Centredness

**Health Sector:** Acute Care, Primary Care

**Location:** Ontario - Waterloo Wellington LHIN

**Project Uploaded:** Nov 2014

**Summary**

Every year, acute exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) is responsible for approximately 196,000 emergency department (ED) visits across Canada. Currently, AECOPD is the leading cause of hospital admission and readmission above all other chronic conditions. Recent studies indicate that there is a need for close collaboration between acute and primary care providers to improve chronic disease management in the community. Improving the care for patients with Chronic Obstructive Pulmonary Disease (COPD) in Cambridge, Ontario is a priority for Cambridge Memorial Hospital. The goal of the project is to promote capacity with self-management in patients with COPD by partnering with the individual patient to provide information and focus attention on specific issues related to identification of educational needs, and developing a plan for follow up and monitoring. Supporting patients with chronic conditions to effectively self-manage is the goal of the team of health care professionals. This project is based on the philosophy that building the capacity to self-manage is paramount to successful chronic illness management.

**Approach**

**Aim**

Initially at Cambridge Memorial the goal was to reduce the 30-day readmission rate for COPD Exacerbations; however, after completing the IDEAS program, the focus shifted to align with the Quality Based Procedures for COPD. The team at the COPD Clinic at Cambridge Memorial Hospital decided to review the diagnosis and coding process and educational needs of the patient/caregiver and community.

**Change Ideas**

Root Cause Analysis: Root cause analysis helped the team at Cambridge Memorial Hospital identify factors that contributed to COPD hospitalization such as, the need for education and follow up. Affinity: We identified solutions that we thought would be effective to help us understand what caused patients with COPD exacerbation to present to hospital. We targeted patients experiencing an exacerbation of COPD and an area where we could make the biggest impact through supporting patients.

**Measures**

<table>
<thead>
<tr>
<th>Type</th>
<th>What Measure</th>
<th>How are you measuring?</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Volume of admittance</td>
<td>Admissions/readmissions to hospital for COPD</td>
<td>↓ Decrease</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Satisfaction for patients with COPD</td>
<td></td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Awareness</td>
<td>patient education related to self-management of COPD for patients</td>
<td></td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Screening</td>
<td>number of pulmonary function testing for confirmatory</td>
<td></td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Process</td>
<td>Patients contacted</td>
<td>Number of patients reviewed/ contacted</td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Care plan for patients</td>
<td>Care Plan components including patient identified goals of care/ questions patient may have</td>
<td></td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Medications for patients</td>
<td>Number of medication needs identified by patient</td>
<td></td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Screening for patients</td>
<td>Number of appointments for diagnostic testing scheduled during telephone review</td>
<td></td>
<td>↑ Increase</td>
</tr>
</tbody>
</table>

*IDEAS (Improving & Driving Excellence Across Sectors), is a province-wide learning initiative to advance Ontario's health system priorities by building capacity in quality improvement, leadership and change management across all health care sectors. Participants apply IDEAS quality improvement program learnings to applied projects from their own organization or local health systems over the course of the five-month Advanced Learning Program.*
Results and Learnings

Documented results of the implementation of a QI project’s change ideas that include key learnings, experience and insights. These contribute valuable information to others and contribute to overall QI knowledge to support sustainability and spread.

Data Highlights

The key process and outcome results of the project

Through the IDEAS initiative, the team at the COPD Clinic at Cambridge Memorial Hospital was able to analyze and determine which intervention was necessary to make the greatest change. For example, the Process Mapping exercise outlines gaps in providing care on discharge to assist patients.

Sustainability

What has been done to sustain improvements since the initial QI project end cycle, or why and how the initial project plan has evolved over time

The COPD Clinic at the Cambridge Memorial Hospital has been successful in obtaining Phase I funding for one 17.5 hr/wk RN to complete this project.

Spread

The degree to which the project improvements and learnings have been adopted and adapted by others within the same setting and/or by other settings, or to identify the main target audience for potential spread

We have provided details of our project and QI indicators to Family Health Teams, Community Health Centers, and the Nurse Practitioner Led Clinic in our area. This project has been presented at the Annual General Board of Directors meeting, and at Grand Rounds.

Setting

The most valuable setting-specific learnings, insights, experiences from the project that will be relevant to the spread to other settings

- Resources
The team of dedicated specialized respiratory care professionals at Cambridge Memorial Hospital includes clerical support responsible for first-line patient reception and appointment scheduling, Respiratory Therapists, and Respirologists.

- People
Collaboration between acute and primary care providers will ensure that patients receive the right care, by the right provider at the right time to prevent exacerbations and reduce hospital admission and readmission rates.

- Organizational Enablers
This project creates a culture of collaboration between hospital, community and primary care providers working seamlessly to communicate the needs of each individual patient and their goals of care.

- System Factors
Primary care will be positively impacted as will the broader health care system through the identification of individual care needs for health promotion and illness prevention and the facilitation of scheduled appointments, follow up and clinical investigations.
Lessons Learned

1. complete an environmental scan, so that efficiency is optimized
2. partner with stakeholders to examine all of the issues
3. continually evaluate and edit the project in response to changes noted

Contact Information

Name: Loretta McCormick  Title: Nurse Practitioner  Organization: Cambridge Memorial Hospital
Email: lmccormick@cmh.org  Telephone: 519621-2330 ext 1524