June 1, 2016

Summary of Proposed Future Vision for Complex Frail Vulnerable – COPD Patient Population

A regional evidence-based pathway for Chronic Obstructive Pulmonary Disease (COPD) will improve the patient experience by ensuring optimal care for every patient at every hospital site in the southeast LHIN. It will ensure all patients in our region receive evidence-based care while empowering them with the knowledge they need to effectively manage their disease. This will improve patient outcomes, as well as patient and provider satisfaction, while helping us make the best use of our resources.

Current state

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in Canada and a leading cause of morbidity in Canadian adults. Acute exacerbations of COPD (AECOPD) are associated with accelerated decline in health and a substantial mortality rate. They are a major cause of hospitalization, emergency department (ED) visits, and overall health-care utilization in Canada.

Patients admitted to hospital with an exacerbation of COPD have a 6 per cent in-hospital mortality rate and a 9 per cent 30-day mortality rate. One of the strongest predictors for admission to hospital with COPD is a prior history of hospitalization with COPD. In fact, 20 per cent of patients admitted to hospital with AECOPD will be readmitted within 30 days.

Evidence-based guidelines are available for management of COPD. When implemented, these guidelines have been proven to reduce the frequency of AECOPD while also reducing hospitalization and ED visits. Currently, there is variability between hospitals in our LHIN with respect to the implementation of these guidelines, which may be due to available resources and expertise. There is an opportunity to reduce morbidity and mortality from COPD by implementing evidence-based guidelines at each hospital site in the SELHIN.

Opportunities considered

As part of the COPD Clinical Steering Team's deliberations, the Quality Based Procedures Clinical Handbooks from Health Quality Ontario and the Ministry of Health and Long-Term Care (MOHLTC) were reviewed for opportunities to implement provincially endorsed evidence-based guidelines consistently across all hospitals in the SE LHIN. In addition, we have reviewed tools implemented in other organizations.

For more information about evidence-based guidelines for management of COPD, see QBP Clinical Handbook COPD

Working Group process and engagement

A COPD Clinical Steering Team was launched in January 2016 with regional representation from a patient perspective, but including representation also from physicians, nursing and allied health professions from the seven hospitals, and from Community Care Access Centre (CCAC) and the community.

- ***See Appendix 1 for list of team members***

We have consulted with Dr. O'Donnell, KGH Respirologist, and other experts from a multi-disciplinary perspective, as the content experts. The team reviewed best practice and local patient journey maps to identify the gaps, opportunities and challenges with respect to how COPD patients are currently managed across each hospital site.

An overall engagement plan for Phase 2 of the Health Care Tomorrow – Hospital Services project created opportunities to gather meaningful input from all stakeholders between October 2015 and May 2016. This engagement included two surveys for staff from across the region. As the clinical work teams were not yet ready to engage staff in these surveys at the time of the broader project engagement strategy, questions about COPD were not included in that process.

Targeted individuals and groups who are involved in managing patients with COPD have been contacted to review the recommendations in this summary document and provide feedback via an online survey. Their feedback will be reviewed and incorporated in the COPD Clinical Steering Team's final set of recommendations.

Analysis undertaken

The COPD Clinical Steering Team conducted a best practice review and local patient journey mapping of the process from a patient's initial emergency department visit to their eventual discharge into the community. A summary of opportunities to improve practice, process, access and resources was completed. This analysis was compared to best-practice literature including the Quality Based Procedures Clinical Handbooks from HQO and MOHLTC, and a set of recommendations were created that leverage best practices while addressing variability and opportunities identified within our region.

Proposed future state

The COPD Clinical Steering Team is developing a plan to move to a regional best-practice patient journey that includes regional communities of practice and accountability mechanisms to encourage compliance with the recommendations and guidelines. The SECHEF Clinical Leaders will build on this work as a template for future regional initiatives within other clinical service areas.

The recommendations

- Each patient admitted to an emergency room or hospital bed in the SELHIN with AECOPD should receive treatment based on an identical evidence-based COPD care pathway with a standard discharge checklist.
    - ***See Appendix 2 for detailed recommendations***
- The care pathway will include:
    - Management of the acute episode

  - Plans for the post-acute transition of care
  - Provision of a care map for each patient outlining evidence-based preventive and treatment strategies, identified gaps in care for that patient and a follow-up appointment with the primary care practitioner within seven days of discharge from hospital
  - Standardized referral decision process
  - Appropriate use of pulmonary rehabilitation
- Individual hospital sites in the SELHIN will implement the COPD care pathway in ways that are most practical, efficient and effective at that site
- Each hospital site will audit and report on utilization of the evidence-based care map after implementation

Key benefits of proposed future state

- Patients will have access to a standardized evidence-based optimal care pathway, regardless of local specialist expertise in COPD management
- Patients will be empowered with an individual care pathway to address treatment gaps and help them manage their disease effectively
- Communities of practice in COPD will standardize care practices among regional clinicians involved in COPD management
- Transitions of care for patients with COPD will be seamless between hospital and community settings
- Patients will experience fewer AECOPD episodes that require emergency department visits or hospital admission
- Consequent upon reduced frequency of AECOPD, the mortality risk from COPD will be reduced.
- Health care resources will be used efficiently through a hospital-community partnership in COPD

Appendix 1:

COPD Clinical Steering Team	
Dr Michael Fitzpatrick	Chief of Staff, HDH
Silvie Crawford,	Executive VP & CNE – KGH
Dr Denis O'Donnell,	Physician Specialist, Respirology-Queens
De Ingrid Harle	Palliative Medicine Program, Queen's
Delanya Podgers,	Nurse Practitioner, Asthma & COPD, KGH
Dr Ken Edwards	ED Physician, KGH, SE LHIN ED Lead
Annette Stuart	Respiratory Therapist ,LACGH
Patti Harvey,	Program Mgr. Amb. Care, Prov Care (& OP Resp. Rehab. Program)
Lorelei Samis,	Physiotherapist with the OP Resp Rehab, Providence Care
Kelly Madden	Respiratory Therapist, PSFDH
Cindy McLennan	Clinical Mgr, ED/ICU, PSFDH
Dawn McKiel	Palliative Care Nurse, PSFDH
Derk Damron,	Mgr, Respiratory Therapy and Pulmonary Rehabilitation, QHC
Heather Houlahan,	Respiratory Therapist,BGH
Kelly Mitten,	Respiratory Therapist,BGH
Lisa Whalen	Respiratory Therapist,BGH
Elizabeth Hill	Nurse Practitioner, COPD, Hotel Dieu.
Janine Schweitzer	Chief QI, Organizational Improvement, HDH
Christina Dolgowicz	Lung Health Coordinator for Lanark Renfrew Health & Community Services
Christina Nugent,	Care Coordinator, SE CCAC
Shannon Quesnel,	Rapid Response Nurse Coordinator. SE CCAC
Sabrina Martin,	Health System Design & Implementation Lead, SE LHIN
Laurel Hoard	SE LHIN, Health System Planner
Jean Lord	Regional Patient Advisor
Alice Carlson	LACGH Patient Advisor

A special recognition to the resources who supported the training and facilitated the local patient journey mapping including: Shari Brown-Providence Care; Damiano Loricchio-KGH, Viviane Meehan-QHC; Jessica Gerritsen-BGH, Sheryl Julien-Providence Care, and many other front-line providers.

2. Appendix 2: Standard Hospital and ER discharge checklist

- COPD Diagnosis confirmed by Spirometry
- Review of Vaccination status
- Provision of smoking cessation counselling
- Smoking cessation status & management plan
- Assessment of inhaler technique
- COPD personal action plan
- Confirm need for dual/triple therapy
- Ensure patient access to medications at Home
- Assessment re criteria for home oxygen. Includes ABG completed on room air.
- Oxygen prescription (LPM), if needed.
- Confirm patient's agreement for Pulmonary Rehab
- Completion of Advance Care Directives
- Follow-up with primary care team arranged within 1 week
- Discharge Summary sent to PHC
- Patient given COPD pathway guide

June 1, 2016

Summary of Proposed Future Vision for Complex Frail Vulnerable – Hip Fractures Patient Population

A regional evidence-based pathway for hip fractures will improve the patient experience by making care easy to access with smooth transitions at every step in the patient journey. It will improve patient outcomes, as well as patient and provider satisfaction, while helping us make the best use of our resources.

Current state

Most hip fractures happen in elderly people as a result of a simple fall. The average age of people who experience hip fractures is approximately eighty. Seventy per cent of those are women. In 2012/13 there were 12,307 patients admitted to hospital for hip fracture surgery in Ontario. Of this patient population:

- 608 of these patients were in the South East LHIN;
- 77.1 per cent received surgery within 48 hours of initial presentation to Ontario hospitals against a target of 90 per cent as recommended by an expert panel;
- 33 per cent were discharged to rehabilitation following hip fracture surgery however hospital level results across the province ranged from a low of 6 per cent to a high of 71 per cent.

There is room for improvement.

A hip fracture is a very serious event that can cause permanent disability, loss of independence and, for many, premature mortality. Complex, Frail Vulnerable patients are at greater risk and our obligation is to improve their experience and outcomes.

Recent Ontario data on the care of hip fracture patients shows wide variability on the time it takes to get their surgery, length of stay in the hospital, ability to access timely rehabilitative care and the number of patients who are able to return to their homes following the incident. There are many opportunities to improve clinical practices by standardizing hip fracture care maps. In Canada there is a good understanding of best practices in hip fracture care, which we can leverage in the South East LHIN to ensure patients receive the best possible care.

Opportunities considered

As part of the Hip Fracture Clinical Steering Team's deliberations, the Quality Based Procedures Clinical Handbook on Hip Fractures from Health Quality Ontario and MOHLTC were reviewed for opportunities to implement provincially endorsed evidence-based guidelines consistently across all hospitals in the South East LHIN. For more information on this topic, see QBP Clinical Handbook Hip Fracture. In addition, we have reviewed best practices implemented in other organizations.

Working group process and engagement

A Hip Fracture Clinical Steering Team was launched in January 2016 with regional representation from a patient perspective, including representation also from physicians, nursing and allied health professions from the seven hospitals, SE Community Care Access Centre (CCAC) and community.

- ***See the Appendix for a list of team members.***

We have consulted with team members from a multi-disciplinary perspective as the content experts. The team reviewed best practice and local patient journey maps to identify the gaps, opportunities and challenges with respect to how hip fracture patients are currently managed across each hospital site.

An overall engagement plan for Phase 2 of the Health Care Tomorrow – Hospital Services project created opportunities to gather meaningful input from all stakeholders between October 2015 and May 2016. This engagement included two broader surveys for staff and physicians, followed by a targeted clinical stakeholder engagement from May 16th to 26th, 2016 to solicit specific feedback on the recommendations to inform a report to hospital executives and board members and further planning.

Analysis undertaken

The Hip Fracture Clinical Steering Team conducted a best practice review and local patient journey mapping of the process from a patient's initial presentation with a hip fracture to their eventual discharge into rehabilitation, their home or other community setting. A summary of opportunities to improve practice, process, access and resources was completed. This analysis was compared against provincial standard and a set of recommendations were created that leverage best practices while addressing the gaps and opportunities identified within our region.

Proposed future state

The Hip Fracture Clinical Steering Team is developing a plan to move to a regional best-practice patient journey that includes regional communities of practice and accountability mechanisms to encourage compliance with the recommendations and guidelines. The South East CCAC and Hospitals Executive Forum (SECHEF) Clinical Leaders will build on this work as a template for future regional initiatives within other clinical service areas

The recommendations

Patient Focus:

- Each patient admitted to an emergency room or hospital bed in the South East LHIN with hip fracture shall receive treatment based on an identical evidence-based hip fracture care pathway.
- The care pathway shall include management of the acute assessment, planning for surgery and the conduct of the surgical repair of the hip fracture that meet the needs of the patient.
- A plan for the post-operative or post-non-operative transition of care between the acute phase of the journey and the rehabilitation phase will be critical to the success of the final outcome for the patient.
- The care plan will include empowering the patient and family members with a care map that will outline evidence based post-operative and rehabilitative care and rehabilitation care to regain

mobility and independence to the extent possible. The care plan will include any identified gaps in care for the individual patient, and a follow-up appointment coordinated with the patient's primary care practitioner, continuing rehabilitation as needed upon discharge from hospital.

- Individual hospital sites in the South East LHIN will implement the hip fracture care pathway in ways that are most practical, efficient and effective at that site. Each hospital site will audit and report on utilization of the evidence-based care map after implementation.

Provider Focus:

- To establish a community of practice framework with the specific focus on post traumatic hip fracture care. This network will develop common goals, shared metrics and oversight of outcomes as a region.
- That all providers/facilities in the South East LHIN adopt the standardized and evidenced based fractured hip pathways for each phase of care enabled through common order sets and protocols that will lead to effective transitions of care from emergency room to primary /geriatric care as well as the appropriate destination for the patients.
- As a region, develop a capacity plan and improved processes to achieve a re-stated goal of 24 hours as time to surgery.
- Adopt a common decision support model for rehabilitation care using consistent and evidenced based processes of assessment found in leading practice rehabilitation readiness tools.
- Patients experiencing a hip fracture at home will have a defined discharge destination on day five with transfer on day six to the most appropriate rehabilitation services or to complex long or short term medical geriatric care. In situations where access to rehabilitation is delayed following the acute phase, the patient's care is transferred from the orthopaedic consultant to a model of care provision and provider that will continue to incorporate the expected outcomes of hip fracture rehabilitation and management of geriatric/primary care.

Key benefits of proposed future state

- Patients with hip fractures will have access to a standardized, evidence-based, patient- and family centred care pathway that uses the South East LHIN's specialized clinical resources and professionals in the most effective and efficient manner.
- Patients and their families will be empowered with an individualized care pathway that addresses treatment gaps while meeting their specific needs.
- Clinicians who manage hip fractures in the South East LHIN ill form a cohesive community of practice dedicated to continuous care-process improvement with a centralized registry of cases, interventions and outcomes.
- Patient will experience smooth transitions in care between hospital, rehabilitative services, the Community Care Access Centre and other community settings.
- The hip fracture rate will be reduced through fragility fracture intervention and follow up for patients presenting at any South East LHIN access point. Health care providers will participate in risk assessment/education and escalation fall prevention initiatives developed by community partners.
- The risk of mortality will be reduced for hip fracture patients.
- Inter-professional care will be the norm and focus on caring for the whole patient, not just the hip fracture.
- Health-care resources in the South East LHIN will be used efficiently through a hospital-

community of practice environment that follows best practices and continuously improves processes to deliver the perfect patient experience.

Appendix

Complex Frail Vulnerable –Hip Fractures Clinical Steering Team Members	
Michele Bellows	VP, Patient Care Services, PSFDH
Dr Dick Zoutman	COS, QHC
Janet Baragar,	Director Surgery Program, QHC
Dr David Birchard	Orthopedic Surgeon, QHC
Derk Damron,	Mgr, Respiratory Therapy and Pulmonary Rehabilitation, QHC
Katie Clement	Physiotherapist , LACGH
Susan Lambert,	Manager, Kidd 4 (ortho) KGH
Patricia Lunt	Nurse Practitioner, Orthopaedic Surgery, KGH
Cynthia Phillips,	Mgr, Interprofessional Collaborative Practice & Education, KGH
Dr Gavin Wood	Orthopedic Surgeon, KGH
Colwell, Kathi	RN, Program Manager-Inpatient Rehabilitation, Prov Care
Julie Evoy	Physiotherapist, Prov Care
John Hope	Advanced Physiotherapist, HDH
Sherry Anderson	Director of Medical Inpatients, Palliative and Rehab-BGH
Dr Jay Gambrel	Orthopedic Surgeon, BGH
Michelle St. Pierre	Quality Improvement, BGH
Dr Mark Roberts	Orthopedic Surgeon, PSFDH
Susan Roberts	Patient Care Manager, PSFDH
Dr Adina Birenbaum	Bone Health Program, FHT Kingston
Marianne Hunter	Care Coordinator, SE CCAC
Laurie French,	Senior Manager, Clinical Support & Utilization , SE CCAC
Sabrina Martin,	Health System Design & Implementation Lead, South East LHIN
Megan Jaquith	Health Planner, South East LHIN
Kristen Spring	Regional Patient Advisor
Richard Stillwell	Regional Patient Advisor

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