northern health
the northern way of caring

Location: Family Practice in Prince George
Contact: Dr. Denise McLeod
Date: December 2017- October 2018

KNOWLEDGE IS POWER: Strengthening COPD Patients with Support and Education

AIM STATEMENT

We aim to increase patient confidence in self-management thereby reducing Emergency Room/Walk In Clinic visits and hospital admission by providing incremental information.

BACKGROUND

- 0.4% of all people diagnosed with COPD have access to pulmonary rehab
- 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

CURRENT STATE

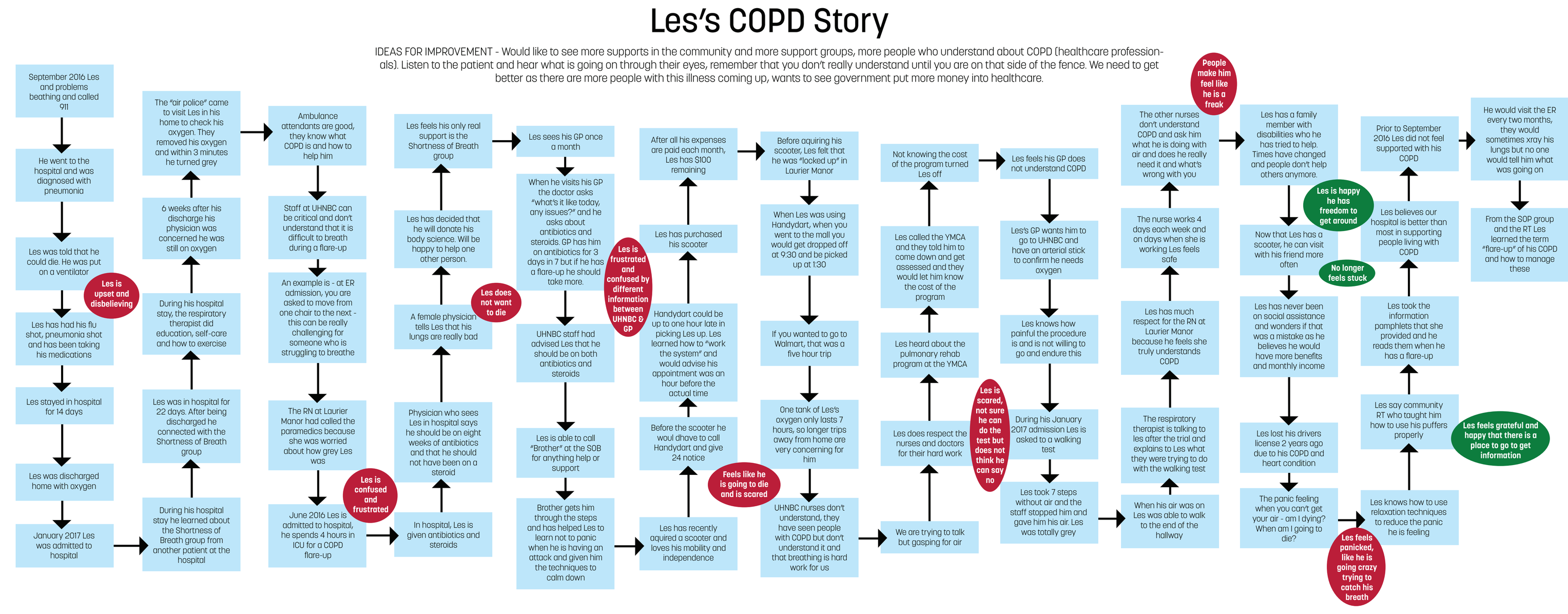
UHNBC DATA:

- COPD is nearly always the #1 reason for readmission to UHNBC with 28 days of discharge from the hospital
- For COPD patients that visited the ED 19% of them returned to the ED within 1 week
- By 2 weeks 30% of the COPD patients were back to the ED
- And by 4 weeks 43% of the COPD patients had returned to the ED
- Of COPD patients that had been admitted to UHNBC 21% of them were readmitted within 4 weeks

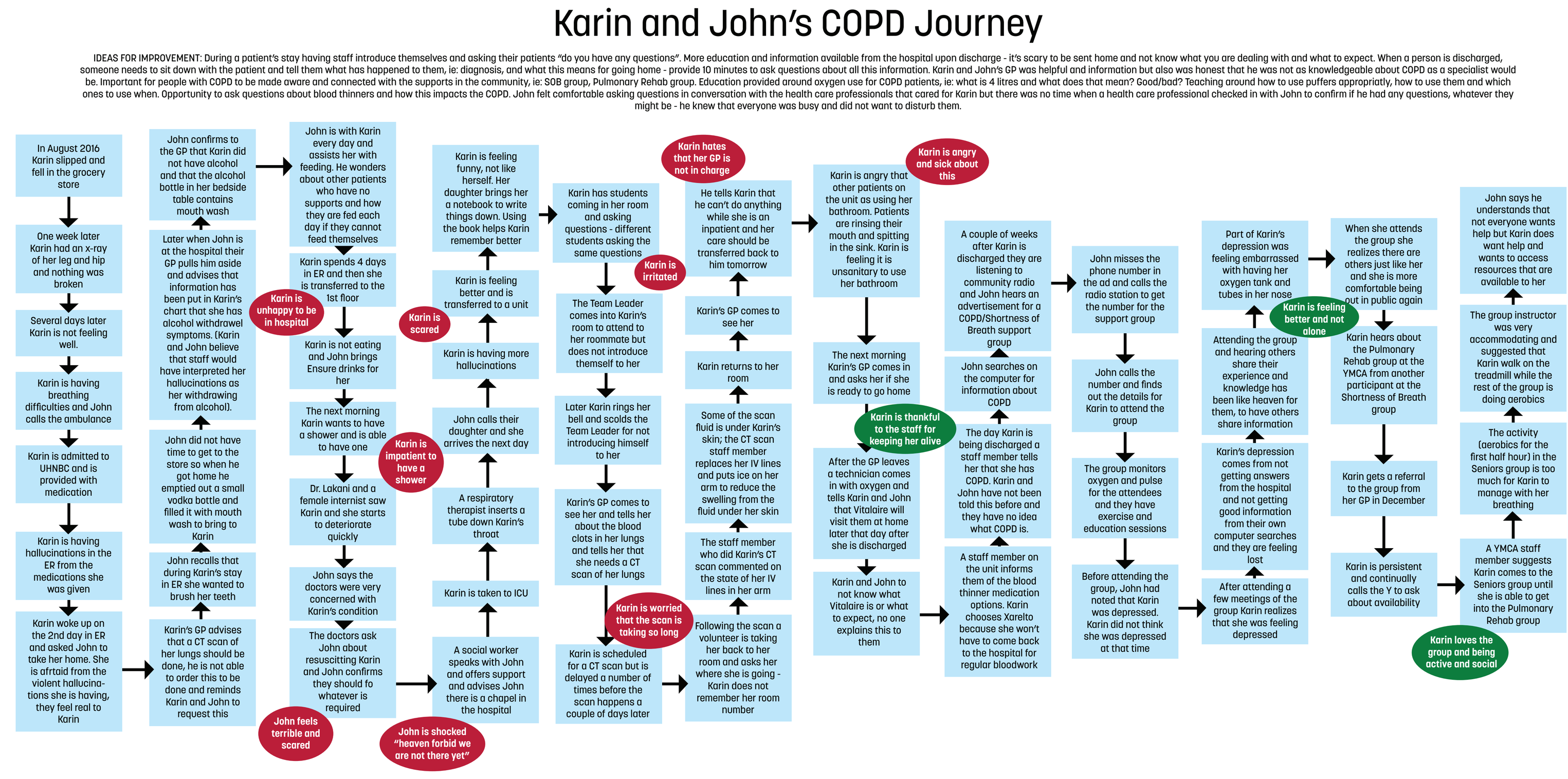
PATIENT JOURNEY MAPS OF PATIENTS LIVING WITH COPD REVEALED:

- Patients felt there was a lack of education and support for COPD

Les's COPD Story



Karin and John's COPD Journey



DR. MCLEOD'S OFFICE:

- 67 patients living with COPD of 1747 total patients
- 35 of the COPD patients had a least 1 other chronic disease
- 88% (59/67) had their pneumococcal vaccine
- 85% (57/67) has their FEV1 done at some point (measure of COPD)
- 64% (43/67) were non smokers
- 67% 945/67) had an activity assessment done in the last year

SOLUTION

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

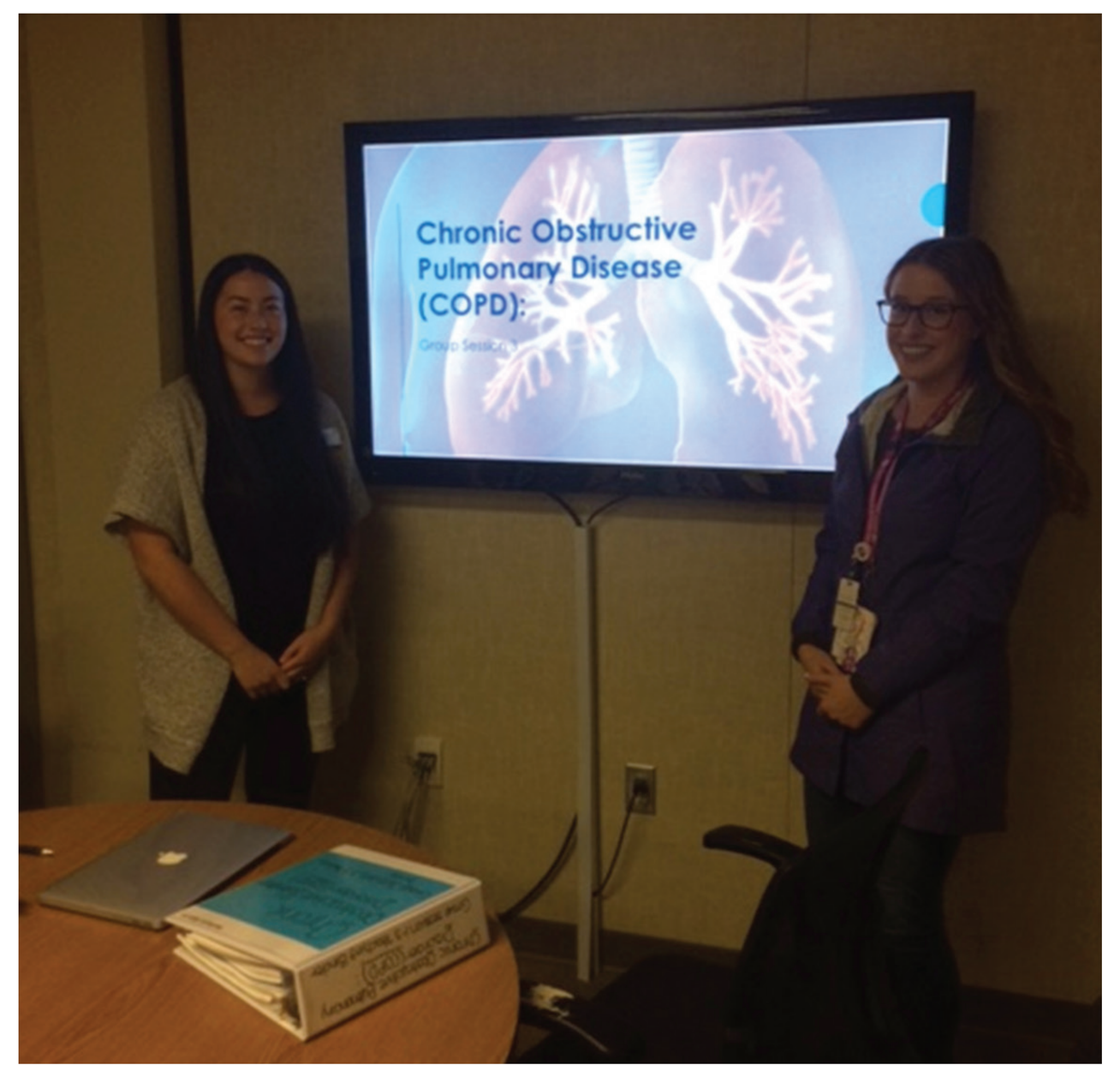
PATIENT/ CUSTOMER

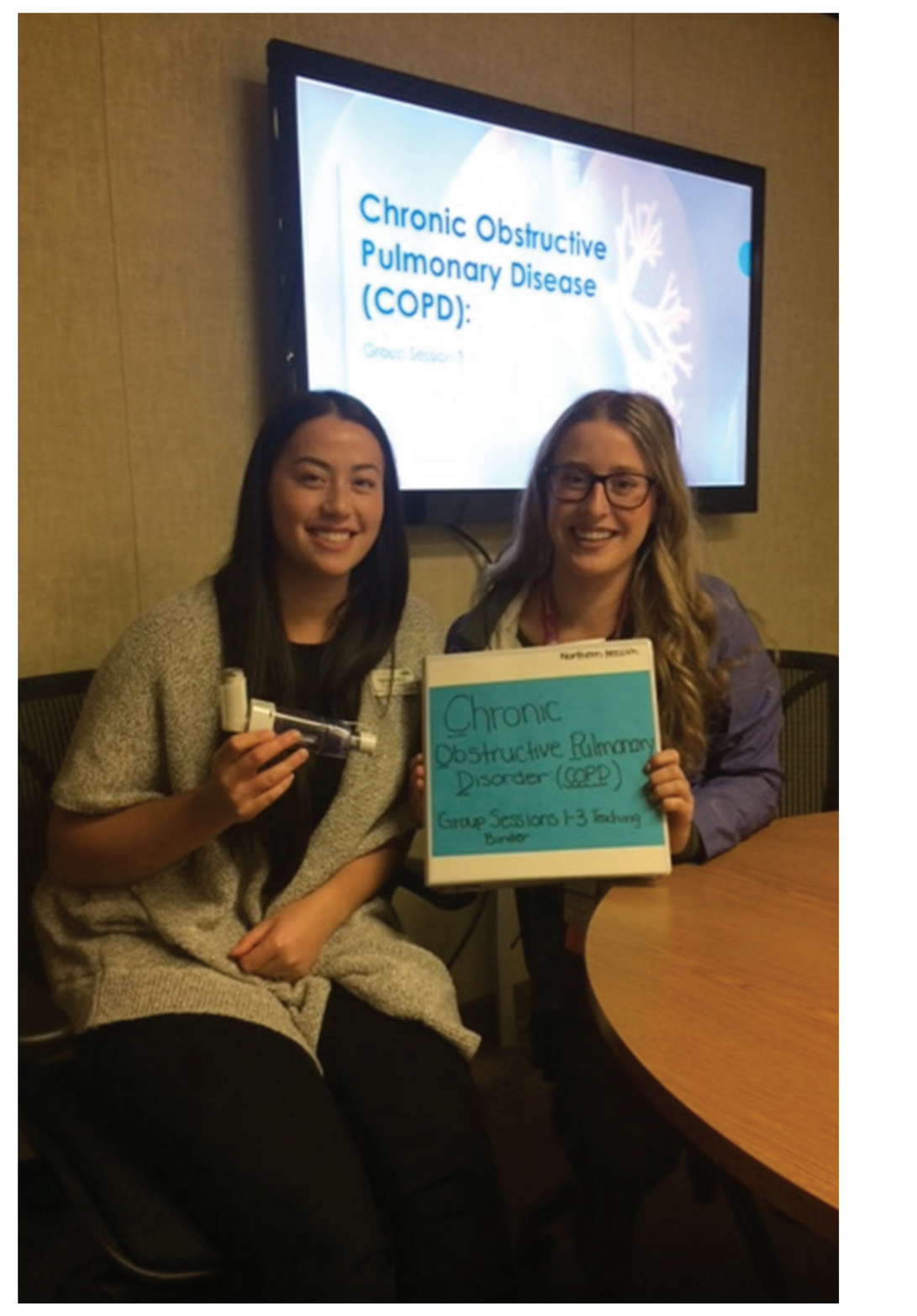
Patients living with COPD that were part of Dr. McLeod's practice.

RESULTS

Measures	Prior to 1st GMV	Current Data (from 1st GMV to Oct 2018)
# of emergency visits	17%	0%
# of walk in clinic visits	0%	0%
COPD exacerbations	33%	17%*
# of current actions plans	17%	100%
# of current Pulmonary Function Tests (PFTs)	17%	100%
Patient confidence with their self management (from survey)	30%	50%

*One patient had 3 exacerbations but they were all treated at home. No ER visits.





PATIENT FEEDBACK ON GROUP MEDICAL VISITS

Respondents **unanimously** identified interacting with other COPD patients (e.g. hearing their experiences and learning from them) as the **biggest benefit** of the session.

	YES	NO
Would you change anything about the GMV?	1	4
Can you understand and manage COPD better?	4	1
Would you come again?	4	1

"Slightly bigger room, with a larger group"

"No. Still trying to understand what COPD is and what causes it"

"Yes, how to use the inhalar that she was doing it correct"
"Definitely educate me on the disease and that he found he did not have COPD"

"Absolutely..."
"Definitely..."
"Yes, to support my husband"

"Would not take up a valuable spot and have another patient with COPD partake"

LESSONS LEARNED

- A community Respiratory Therapist would be a very big asset to the team both in the sessions and for one on one follow-up with patients.
- Team education prior to undertaking the teaching made things very smooth.
- Projects over the summer are difficult on the staff and patients. But, the primary care teams were familiar with the patients because of the GMVs and they did home visits during the wildfires in the summer to check on them.
- GMVs should be 2-3 months apart with a primary care team home visit and an individual doctor's appointment in between.
- We need to improve our teaching slides.

NEXT STEPS

- Present results at a Family Practice Rounds or Divisions of Family Practice meeting.
- Speak at the Practice Support Program COPD Module for the Divisions of Family Practice to promote the use of GMVs for COPD work.
- Begin a second group of GMVs for people living with COPD in my practice.
- Increase the group size of the GMVs

PRIMARY EMAIL CONTACT: mcleoddc@telus.net

TEAM MEMBERS : Dr. Denise McLeod, Johanna Tolsdorf (MOA), Dr. Sharla Olsen (Respirologist), Renee Pigeon (Respiratory Therapist), Roberta Miller (Primary Care Team Lead), Annick McIntosh (Primary Care RN), Karen Gill (Practice Improvement Coach), Shelley Movold (Facility Improvement Coach)