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April 14th, 2016

Integrating Care for Patients with COPD in the Hamilton, Niagara, Haldimand, Brant (HNHB) LHIN
Case for Change

Current State

- Hospital
  - Team
  - Record
  - Process
  (+/- QBP, Order Sets, Discharge Bundle, Care Path)
  - Hand Off - New Episode of Care

- CCAC
  - Team
  - Record
  - Process

- Home Care Provider
  - Individual Providers
  - Record
  - Process
  - New Episode of Care

- Community Provider
  - Primary Care Provider
  - Specialist
  - Rehabilitation
  - Out-patient Clinic
  - Community Health Centres
  - Hand Off - New Episode of Care

- Unplanned ED visit or readmission?

Future State

- Single Collaborative Clinical Team
- Single Integrated Care Path (Hospital to Home)
- Single Medical Record
- Single Point of Contact
Integrated Comprehensive Care (ICC)

- St. Joseph’s Healthcare System (SJHS) Integrated Comprehensive Care project bundled care across the continuum and demonstrated better outcomes and lower cost.

- HNHB LHIN partners approved by the MOH (Integrated Funding Models) to test innovative approaches to integrate care and funding over a patient’s episode of care.
  - Spread SJHS ICC program across HNHB LHIN for patients hospitalized with COPD and CHF.

- All LHIN partners motivated to work together to test a new model of care with demonstrated benefit to patients and organizations.
Goals

• To establish a seamless patient centered care continuum from hospital to home, from both the patient and funders perspective

• To improve the patient experience by implementing the Integrated Comprehensive Care Program LHIN wide

• To improve quality outcomes and reduce unwanted or unwarranted variation in patient care pathways (reduced LOS, reduced ED Visits and unplanned hospital readmissions, improve productivity of hospital and homecare and reduce overall cost)
Goals

- To improve efficiency of the healthcare system by integrating resources across the continuum.

- To inform policy by implementing the SJHS Integrated Comprehensive Care program scaled LHIN wide.

- To fully engage key stakeholders (e.g., physicians) and patients/family in the HNHB LHIN Integrated Comprehensive Care program.
ICC 2.0 - Key Principles

- **Scaling of the SJHS Integrated Comprehensive Care Program** to provide a centralized and accessible single model of care

- **Integrated Care Coordinators** - to manage the seamless care pathway across the continuum

- **Integrated Care Paths** to standardize care across LHIN hospitals and community care to minimize unwarranted variation, complications, and unnecessary health care resource utilization and ensure care is provided in the most cost effective setting

- **Lead Homecare Agency** to maximize continuity, expertise and efficiency

- **Strong Client Engagement** to improve health outcomes and develop personalized action plans
ICC 2.0 Key Principles

• **High Team Engagement** to ensure continuity of care and thorough assessment of patient needs over the care path

• **24/7 Availability** for patients to have access to an Integrated Comprehensive Care Team Member

• The Integrated Comprehensive Care Team will have *timely access* to **Medical Expertise** to prevent readmissions; and when admitted to maintain continuity of care

• Access to clinical information that is integrated across the continuum - electronic Client Health Record
Key Learnings:

• Partner organizations begin the project with varying levels of comfort with:
  o Open and transparent dialogue (vulnerability)
  o Tolerance for ambiguity and uncertainty
  o Trust
  o Shared risk (and shared gains)

• Change management strategies, communication and engagement are key to support project partners through this process

• Valuable role for patients and family in the development, implementation and evaluation
Impact on patients:

The program is “Excellent, Excellent, Excellent!!” Everything about the program is excellent. Couldn't ask for better staff. All were really nice and very good to me. Was not using her puffers correctly for 2 years, was not breathing properly and was not exercising properly. With all the staff support and ongoing education, she now has better insight and knowledge about the disease process. Has found the modules very helpful and feels they have increased her knowledge about her chronic disease and how to manage it. Her only ongoing problem is her back pain, which she states is in follow up with her family doctor, and has recently been having better pain control, which initially impacted her at the beginning of the program. She stated the program has increased her quality of life. She wants to know if she can still call the number if she has a question, even after discharge from the program.

She keeps asking how she is going to pay for all this. We informed her that it is covered under her OHIP and she cannot believe this is possible.

“He has never been this well for so long. It shows the program is working.”

The program was beyond my expectations. Very well done!”
Case for (more) Change

• 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)
Integration with Community
• Community based program for patients with recent COPD hospitalization or at risk of acute exacerbation of COPD

• Bundle of services using principles of Chronic Disease Management

• Focus on case management and strengthening self-management

• 10 week intensive program, followed by monthly telephone calls and access to Caring for My COPD Coordinator
Who is this program for?

• Patients with a **CONFIRMED Dx OF COPD** and who have been recently hospitalized or at risk of an acute exacerbation
• Patients with modifiable COPD
• Ability to travel to a community centre for a core program of exercise and education
• Ability and willingness to participate (in group)

Who is NOT eligible?

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

- Hospital
- Primary Care
- Respirology
- CCAC
- Respiratory Rehabilitation
- Self-referral
Key Features of Program

10 week customized program

Patient/Family

- Exercise
- Spirituality
- Peer Support
- Assessment
- Telephone Support
- Education (smoking, nutrition, meds)
- MH, Addictions & Wellness

CLIENT

- CRE COPD
- Psychologist
- Social Worker
- OT
- PT
- Dietitian
- Kin
Formal Evaluation (Feb 2015)

• Essential to the implementation of new health care programs is the ability to evaluate change in relevant outcome measures such as:
  o Health care resource utilization and health system related outcomes (wait times, program adherence)
  o 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
Primary Study Outcome Measures

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

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

• Health-related quality of life measures
  o Chronic respiratory questionnaire (CRQ-SAS)
  o EQ-5D-5L
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<th>Niagara Falls</th>
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*Satisfaction/Experience – target of >90% on 3 questions measuring the clients’ care experience.
Patient/Client Engagement

Planning

- Client interviews to:
  - Understand experience living with COPD, managing COPD in the community, and being hospitalized
  - Receive input and feedback on Caring for My COPD program

- Patient experience mapping sessions

- Consultation with St. Joseph’s Pulmonary Rehab Breathing Buddies peer support group & OLA Peer Support in Niagara
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 – have woven into multiple program elements (education, exercise, maintenance, support group)
- Importance of family support – have included in Caring for My COPD program
- 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
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”.

“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”