Edmonton Zone (EZ) Adult Medicine- INSPIRED COPD Collaborative-Transcendent Care of Complex Populations

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Informing Improvement Selection:

Process Assessment:
Phase 1: Literature and best practice reviews are ongoing and iterative. An extensive chart audit detailing individual, medical and system characteristics has been conducted.

Individual Characteristics: patients are elderly (71), live in an urban setting, have no legal guardian, few informal supports in the home (55%), use a mobility aide, are on home 02 (64%), are/were smokers (98%), have many co-morbidities (18), have had numerous UAH ED visits (60%) and a UAH length of stay (LOS) of 3.3 days. Half the patients have had between 1-3 additional inpatient stays, and the likelihood of readmission for AECOPD within 30 days of discharge is 53%.

Medical Characteristics: reflected complex admissions, a thorough work-up according to UAH guidelines, difficulty accessing PT visits, frequent medical consultations (71%), challenges with ongoing dyspnea management, and other arising complex medical issues.

System Characteristics: 75% of patients arrived via EMS; the average CISS score was 2, average stay in ED was 7.5 hours, little documentation of patient education during inpatient stay, few individuals were referred to community partners for follow-up on discharge, 94% of the population was at high risk for readmission based on their LACE score, only 50% of the time family physicians (FP) were notified of the discharge, 80% do not have a FP who completes home visits, only 51% of the population is linked with a CC program on discharge, and 89% are not connected with other community supports for their COPD.

Phase 2: Development of a high level process map (HiPDM) and 4 large cross functional maps (intake, care, discharge and community) outlining 41 care provider’s process steps involved in the COPD patient journey. Process maps identified numerous system characteristics, 358 hurdles and 231 system solutions. An EZ resource list providing insight into the existing resources available for complex and vulnerable patients was created.

SUSTAIN RESULTS

Reinforce Ownership, Measurement, & Continuous Improvement:
In the Fall of 2017, Plan, Do, Study Act (PDSA) cycles will begin by teams involved in the EZ COPD collaborative involving: patient and family centred assessments, medication optimization, discharge planning, patient, family and staff education, strengthened transitions with supports and resources in the community and exploring system solution problem-solving.

Lessons Learned
- System transformation with many interconnected hospitals, community partners and processes takes time and requires both patience and financial supports to view EZ as one COPD patient continuum
- Project segmentation is critical for project teams to maintain momentum with a focus and finish approach
- Increasing awareness of the complex and vulnerable patient characteristics and complex system requirements impacted the desire, knowledge and ability of all (care providers and patients) to ensure system level collaboration
- Various IT systems, with little to no integration, impacts patient care (EMS to ED to AC to Community) therefore the system is somewhat reliant on paper documentation moving with the patient
- Maintaining project momentum, change willingness and readiness for large EZ projects is challenging and impacts the ability to achieve improvements, foster culture change and sustain improvements

Involvement of CC in U of A Faculty of Nursing ORS e-HIP research project focusing on integrating Quality of Life Assessments into Home Care for Older Adults with Chronic Life-Limiting Illnesses
17. CMC Funding for INSPIRED COPD Collaborative-Transcendent Care of Complex Populations (March 2017)