醫院管理局
HOSPITAL AUTHORITY

Hospital Authority Convention 2013

Corporate Scholarship Presentation session on Paediatric and Rehabilitation services

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Enhancing Primary & Community Care of Patients Suffering from Chronic Lung Diseases Through a Self Management Program

Presenter

Aileen Chu, OTI

PMH

Living Well with COPD™
Chronic Obstructive Pulmonary Disease
A plan of action for life

- **Participants**
- Aileen CHU, OTI, PMH (coordinator)
- Grace CHOI, OTI, PWH
- George Lam, PTI, NDH
- Eric Leung, PTI, UCH
- Polly LO, PTI, KH
- Ashley Ng, OTII, SH
- **Visiting Institution**
- Montreal Chest Institute
- McGill University
- Montreal, Quebec Canada

Overseas Training Program in LWWCOPD

- Program schedule & content (3 Oct to 14 Oct 2011)

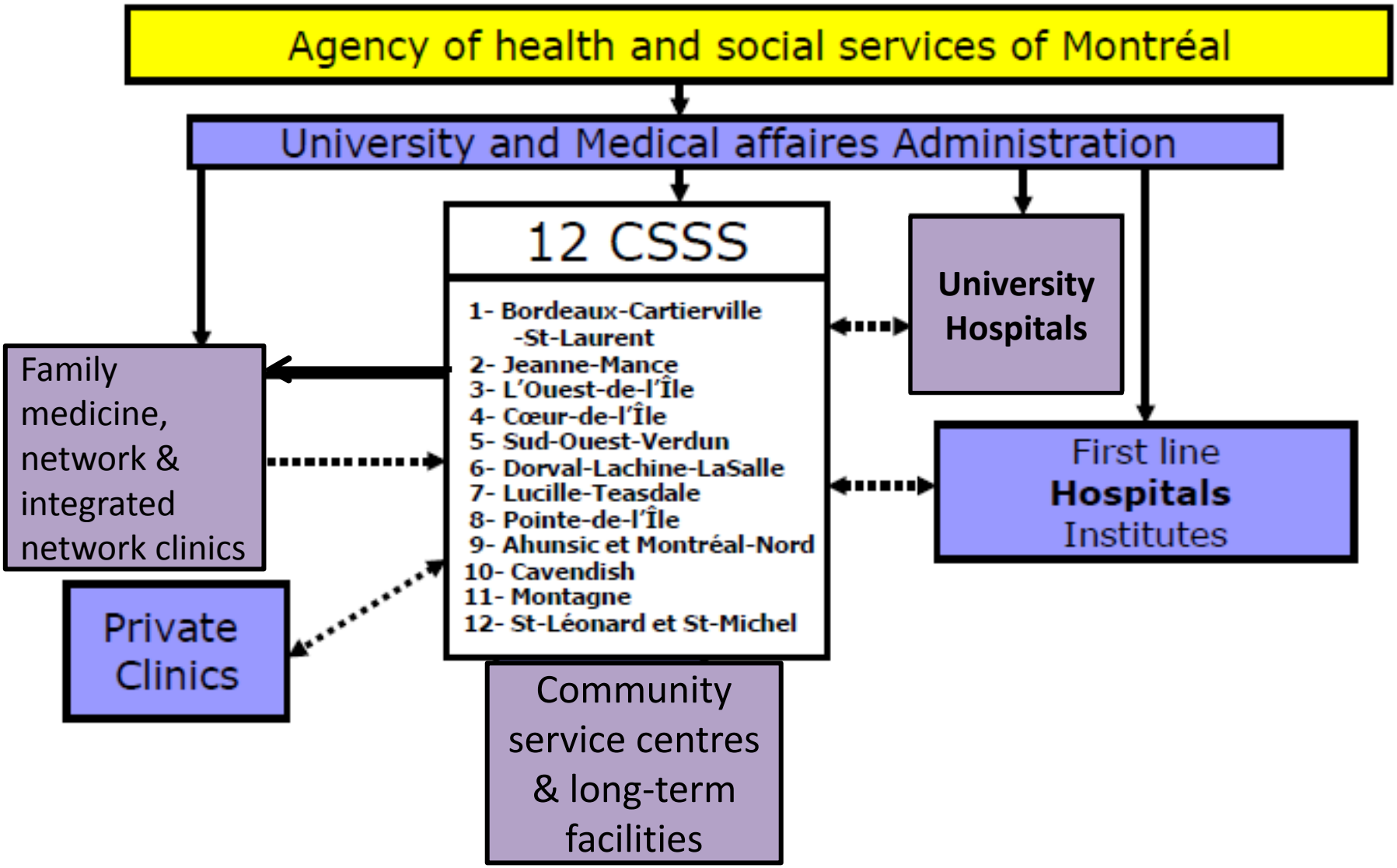
Date of visit	Major Tasks
3 Oct	Theoretical background of LWWCOPD Share experiences and expectations to program Expert patient meeting
4 Oct	Motivational interviewing Role of CM & techniques in group & individual education
5 Oct	Multidisciplinary meeting (PEP meeting) for patient recruitment Use of inhaled medications (by Resp. therapist) Patient F/U visits in MCI clinic, PT or OT sessions
6 Oct	Pathophysiology of COPD & Dyspnea Breathing & coughing technique, exercise training (by PT) Principles of energy conservation (by OT) Stress management, relaxation techinque (by Social Worker)

LWWCOPD Program

Date of visit	Major Tasks
Oct 7	Plan of action: theoretical base & group process (Nurses) Integration of program: healthy lifestyle Nutrition in COPD (Dietitian)
Oct 8	Team building activity for HK and MCI team
Oct 9-10	Sunday & Thanksgiving holiday
Oct 11	Expert meeting: COPD care in HK (HK team) Experiences of model implementation (MCI team)
Oct 12	PEP meeting (patient recruitment & review) Attachment in PT / OT sessions Clinical afternoon at MCI clinic
Oct 13	Lung function & exercise test labs Tour in in-patient wards, MCI Patient initial evaluation visits at MCI clinic Smoking cessation clinic
Oct 14	Wrap up of training

Service Organization

Montreal, Quebec, Canada



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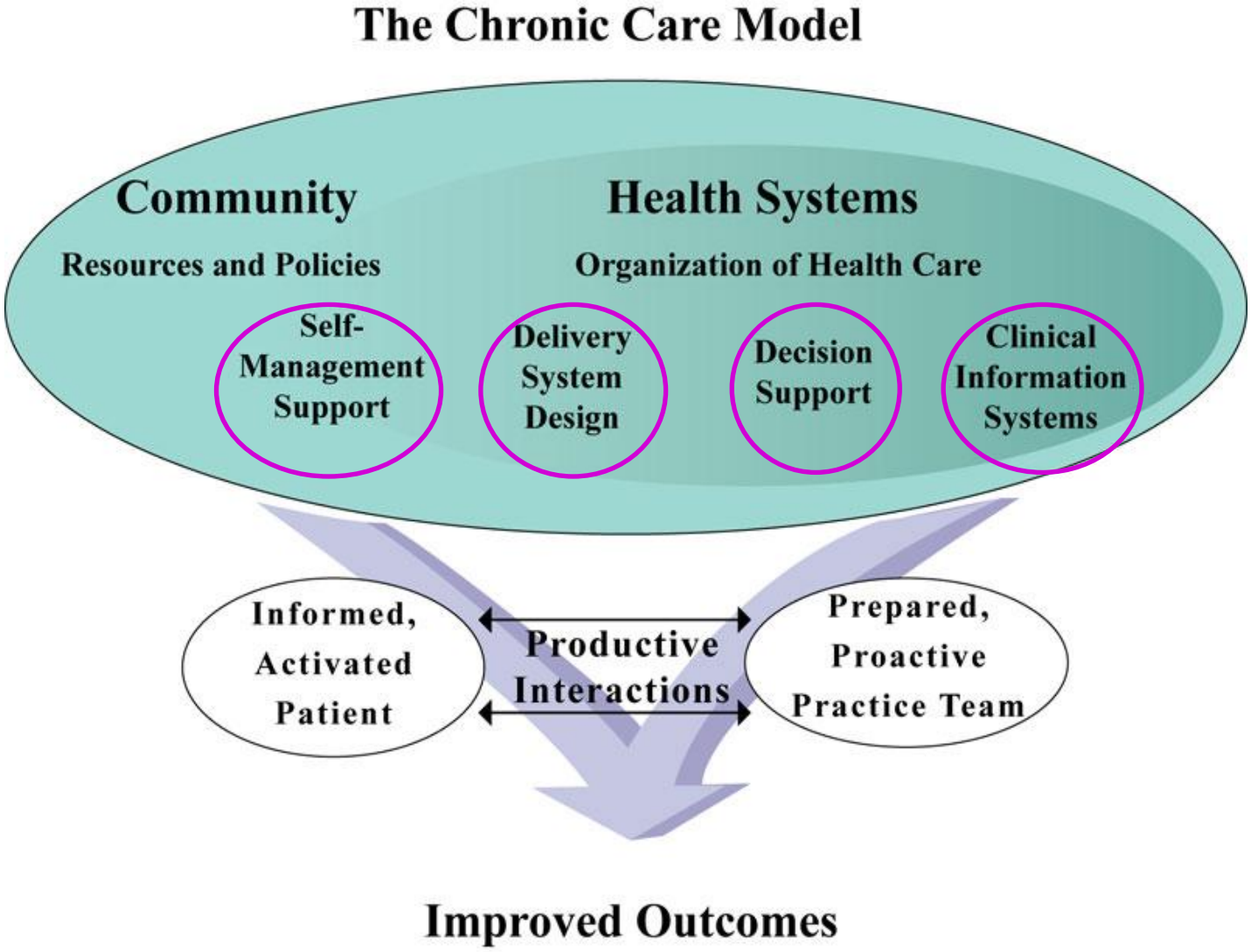
- The program was first conceptualized since 1997, led by Dr. Sean Bourbeau and his team, with the following clinical situations:

☹ Evidence ⇨ standard care fails to meet needs of patients with chronic disease

☺ Self-management education ⇨ effective in chronic diseases such as DM, CHF

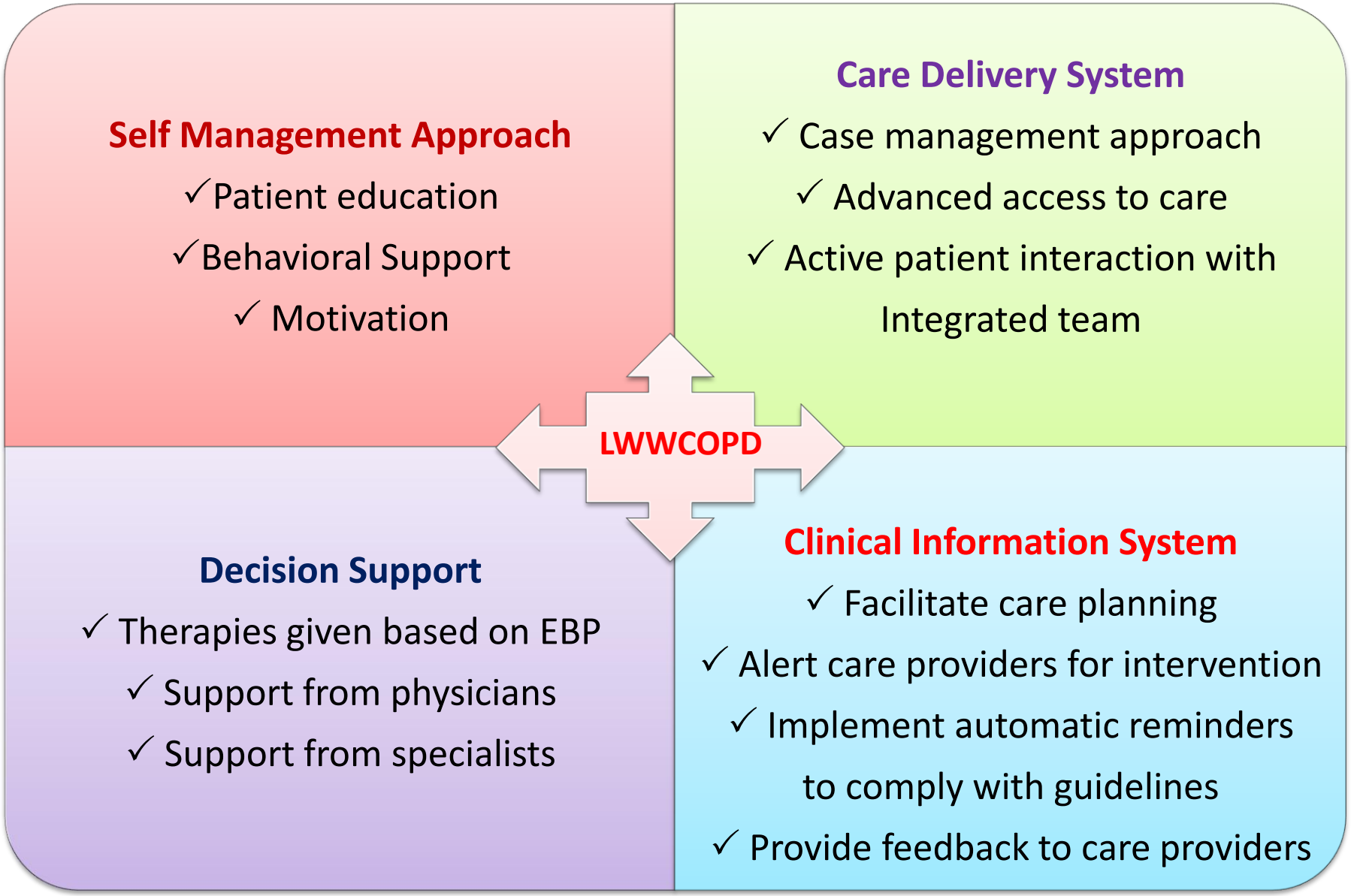
☹ No self-management program ⇨COPD

Theoretical base for delivery of care:



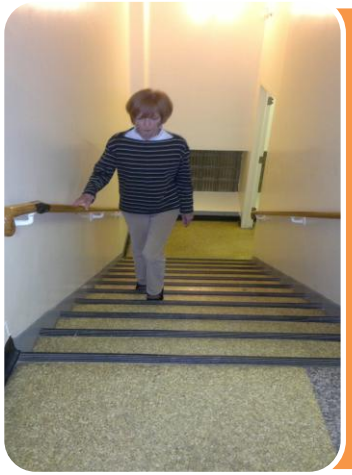
Wagner EH. http://www.improvingchroniccare.org

Integrating the components of chronic care model



Group + individual Self Management Education sessions

- COPD knowledge
- COPD medication & use
- Energy conservation, self care skills, healthy lifestyle
- Breathing
- Stress management
- Better nutrition
- Plan of action: managing exacerbation & respiratory infections



3 x /wk for 6 wks (18 sessions) active supervised exercise program

- 60-70% predicted max HR
- RPD & RPE (Borg) 3-5
- Oxygen saturation > 90% (85%)

Written Action Plan

Case Management Approach

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- The pivotal objective of SM programs is to change patient's behavior
- Acquire key SM skills in decision making, problem solving, early symptom recognition, taking action
- Acquire self-health behaviors such as maintaining comfortable breathing, implementing an action plan, faclilitating exercise maintenance, adopting healthy lifestyle
- When patients can perform self-health behaviors with confidence, they will have improved self efficacy in managing own diseases and will have less reliance on the healthcare system in long run

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Partnership

Prepared Practice Team

- **Patient** : active participation in disease management
- **Physician:** prescribe overall optimal treatment
- **Case manager:** the resource person for the patient
- **Other health professionals**: consultants, support

Activated Patients

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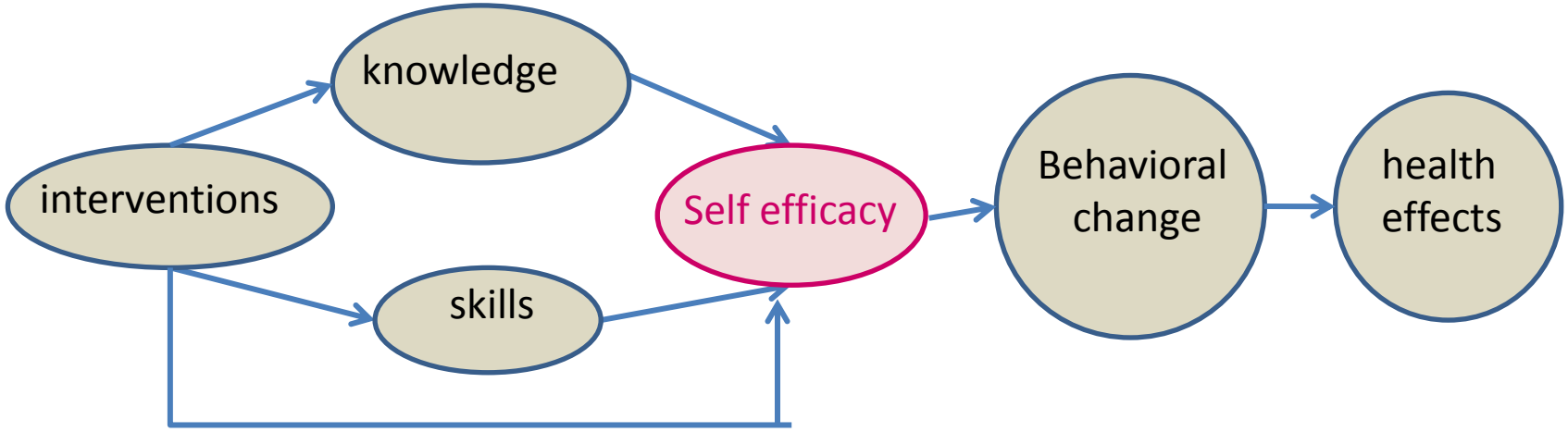

Self-management model

Emphasis on the needs of patients suffering from a chronic disease to maintain, adjust or change roles, deal with the emotional aspects of their disease and successfully manage their daily lives

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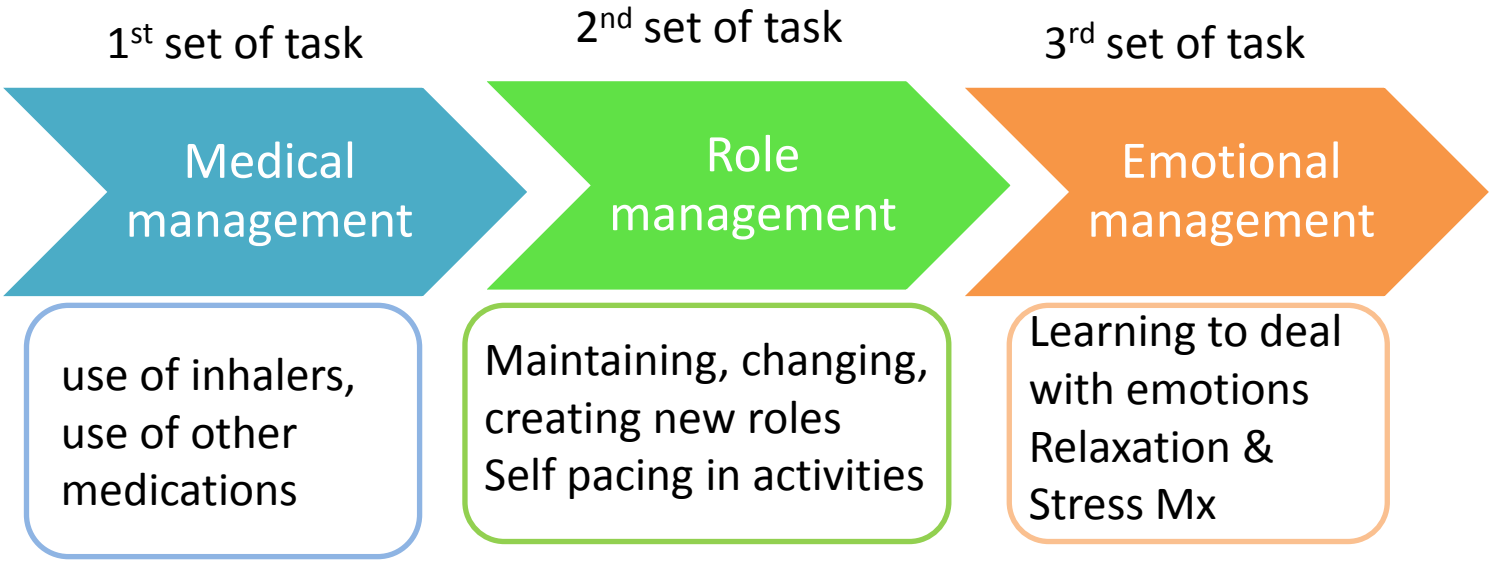
- To enable a shift towards increased self-management, patients have to:

✓ be provided with necessary tools

✓ gain confidence

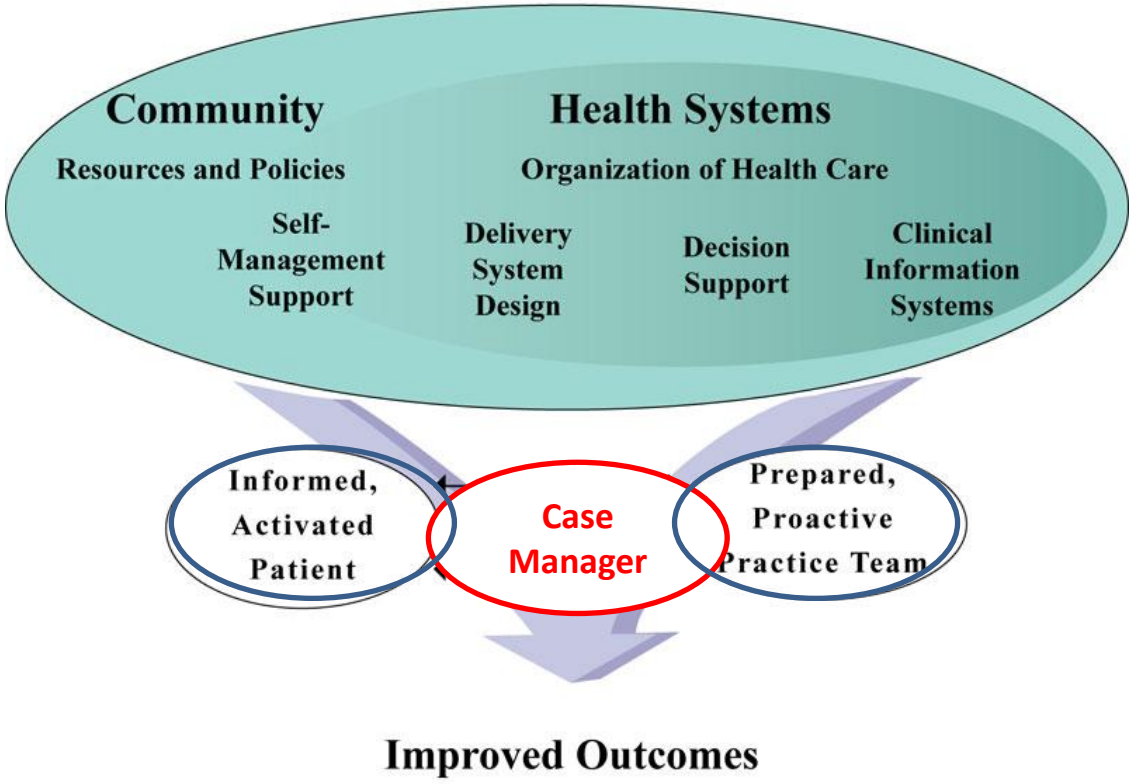
✓ gain self efficacy

✓ apply the acquired skills on a daily basis



Case Management Approach (CM - an designated healthcare professional)

- regular progress and problem assessments
- goal setting
- motivation and confidence building
- problem solving support



Developed by The MacColl Institute
® ACP-ASIM Journals and Books

CM also provides:

- Regular follow-up
- Coordination of care with
  : the practice team,
  : the health system,
  : the community
  : the patient

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In an Action Plan Session:

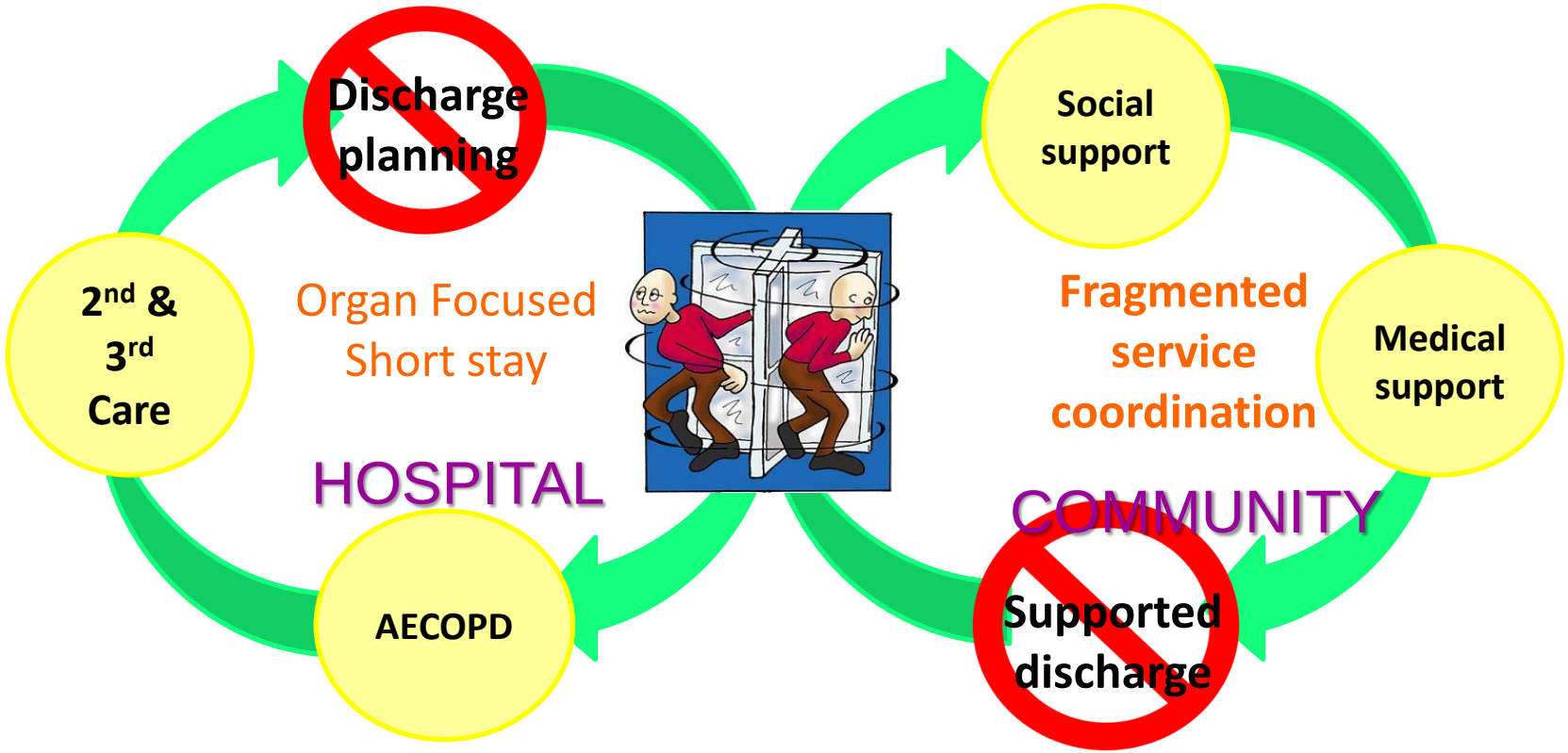
The health care professionals (Case Managers) coach the patients :

- active participation
- practicing
- feedback
- role models
- sharing experiences
- building positive experiences

Integrating the self management skills into "Plan of Action"

Components	Required self-management skills
Maintenance & Prevention	Knowing baseline symptoms Adherence to medication Maintenance of healthy behaviors Identify & avoid aggravating factors
Early Intervention for exacerbation	Recognize symptoms deterioration Knowing contact resources (CM) When & how to add specific medication (antibiotics & steroids) Use of specific non-pharmalogical technique to control symptoms
Recognize & Manage Non-improvement	Recognize non-improvement or worsening within expected delay Contact resources for advanced care (CM, treating physician, ER)
Manage emergency situation	Recognize of life-threatening symptoms Contact resources for emergency

Challenges faced by patients & local health care system



Patient Factors:
- inadequate self Mx
- poor social support
- poor drug Mx skill

Clinical Factors:
- disease progression/relapse
- develop new problems
- complications of condition
- need for terminal care

System Factors:
- lack of unified approach of care
- fragmented pathway
- lack of continuity of care
- inadequate connectivity with community

Where are we now?

- Organized trainings to promote Self Management Approach to staff & patients/families
- Utilized resources from LWWCOPD program to improve patient education in local settings
- Adopting evidence-based practice in use of “E-kit” in managing AECOPD in some local settings & programs
- Enforcing multi-disciplinary approach in managing COPD in some hospitals & clinics
- Special programs for COPD management in some local settings, incorporating Case Management Approach, developed
- Patient empowerment programs with support from hospitals strengthened

Ways forward

- Change the way of thinking
- drive the shift of models of care from acute to chronic conditions
- endorsement, engagement and support from stakeholders, including the physicians, nursing staff, other allied health professionals, the patients and the families
- Readiness of organizational change is imperative
- necessary change in infrastructure in the healthcare system, better delivery of service & collaboration with the community is demanded
- implement effective intervention for chronic diseases

Ways forward

- Effective delivery of program is enhanced by case management approach
- Case managers with effective clinical & psychosocial skills can support patients in building self efficacy in disease management

- Self management program is not only education
- not an one-off intervention
- provider-patient partnership, reinforcement, follow-up are essential

Ways forward

- Do it for the right reason
- achieve change in self-health behaviors
- improved health outcomes will only come after this change is achieved

- Training is essential
- The practice team should possess effective pharmacological & non-pharmacological skills in COPD management, e.g. psychosocial skills, COPD related evidence-based practice

Self management program for COPD

Patients using Action Plans

✓Recognize symptom changes

✓ Implement self care

✓ Self-initiate a customized prescription in the event of exacerbation

Improved Outcomes

Supported by a prepared practice team & CM

✓ to optimize disease control

✓ to provide regular follow-up

Organization & Practice

✓ accurate self management strategies

✓enhance patients' self-efficacy & specific skills in disease management