Project Spread Profile:

SOS AECOPD Transitions in Care Project

Home Division	South Okanagan SImilkameen Division of Family Practice
Division Membership	Respirologists, Family Physicians, and ER Physicians
Project Scope (community(s))	South Okanagan Similkameen (Penticton Regional Hospital)
Timeline (months)	July 2012 - March 2013
Health Authority	Interior Health Authority

PROJECT BACKGROUND

COPD prevalence of Interior Health residents continues to grow annually and is increasing at a faster pace than the provincial rate. The South Okanagan Similkameen Division of Family Practice, in collaboration with Respirologists, Interior Health and the Shared Care Committee, worked together in a structured collaborative to improve the health and quality of life of patients with COPD.

PROJECT GOAL

To improve the health and quality of life of patients experiencing COPD and to reduce the burden of COPD on the healthcare system through a multi-disciplinary care pathway that is patient-centered.

BENEFIT FOR PHYSICIANS

- Improved processes, knowledge transfer, and relationships between specialists, family physicians, health-care providers, and patients.
- An inpatient admission and discharge pathway was developed for patients experiencing an acute admission of COPD.
- Supported timely and meaningful exchange of clinical information between handoffs.
- Provided a resource for family physicians to optimize transitions in care, manage, and address the acute health needs of this multi-faceted disease.

BENEFIT FOR PATIENTS

- Integrated discharge plans supported collaboration and continuity of care between providers and patients where appropriate.
- An information package and communications plan was developed to increase patient awareness and understanding of COPD symptoms.
- Effective patient and caregiver education and self-management training was provided during hospitalization and following discharge.

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GAPS AND DELIVERABLES

The working group mapped the process for a COPD patient moving through the hospital and back to the community. The maps illustrated the interaction between the patient and various care providers (emergency physician, family physician, Respirologists, respiratory therapist, nurse, clerk, MOA). They also identified opportunities for improvements and ways to ensure standardized care.

Key Deliverables are numbered and further indicated with an asterisk (*)

Problem Identified	Baseline Data – start	Strategies and *Deliverables	Success Indicator
What was the specific problem identified	**List any data collected at the start of the project if applicable**	**How did you approach the problem? What was the identified solution/deliverable?**	**How did you measure your access in completing this deliverable?**
CLICK HERE FOR EXAMPLE			
COPD patients experience multiple visits to emergency between admissions	Patients experienced 2-9 visits to emergency or a clinic between COPD admissions. Readmission rates are highest in the 2 weeks following discharge.	• The care model was designed to connect patients to community respiratory services through their family physician (not just through an emergency visit or hospital admission) • 83% of patients received an RT phone call within 72 hours of hospital discharge.	IH re-admission data showed that the number of readmissions dropped from 278 in 2012/13 to 195 in 2013/14.

No in-hospital patient education	Patients did not receive any in-hospital COPD education or contact with a respiratory therapist.	• A main component of the AECOPD care model was the COPD Care Liaison who identifies AECOPD patients, provides in-hospital education assessments and connects patients to community respiratory services. • 100% of patients with clinically confirmed COPD received COPD education in-hospital	Weekly reports from the Pathway Coordinator detailed the experience of each COPD patient who visited the emergency department or was admitted to hospital during the trial. These reports were distributed to all members of the working group and prompted refinements to the pathway and the tools as required. A pathway compliance report card was also published during the trial. It demonstrated the level of compliance of each care provider group.

Many patients did not book a follow-up appointment with their family physician prior to discharge	There was no identifiable community pathway for COPD patients following discharge, leading to high hospital readmission rates	• An information folder was distributed to family physicians in the South Okanagan Similkameen containing all of the AECOPD pathway tools • Reminder cards were developed for MOAs to book an appointment within two weeks of discharge for an AECOPD admission.	The pathway compliance report card indicated that 83% of COPD patients evaluated during the trial visited their family physician within 2 weeks of discharge.

RECOMMENDATIONS TO SPREAD COMMUNITIES

General Lessons Learned

The initial focus of the project was on AECOPD transitions in care; however, it soon became apparent that the best way to facilitate transitions was to provide the patient with quality in-hospital and community education and support. As a result, the working group developed an optimal COPD care model in addition to an AECOPD acute pathway to address the gaps in care.

Stakeholder Perspectives

In the table below, record specific lessons from different stakeholder perspectives

Title	Notes
Physician Champion(s)	The overarching lesson learned, which may well have been apparent before the Project began, is that SOS Shared Care and IHA are still learning how to work with and trust one another.
Health Authority	Local IHA leaders were included in the SOS CSC, Steering Committee and WG, but were not able to attend as many meetings as members from other groups.

PLANNING

The SOS Collaborative Services Committee (CSC) started as the steering committee for this project. However, by the fall of 2012 a SOS Shared Care Steering Committee and COPD Working Group had been established and the CSC agreed that it was more appropriate for those groups to direct the project. Both the steering committee and the working group have strong physician and Interior Health representation. The project delivered regular reports to the CSC, which were discussed and endorsed at CSC meetings.

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ENGAGEMENT & IMPLEMENTATION

From the beginning, the AECOPD project team sought opportunities for alignment with other COPD initiatives within Interior Health and the province. These partnerships included engagement with the Practice Support Program (PSP), the Integrated Practice Support Initiative (IPSI), and the Interior Health 'Breathe Well' initiative. One of the key elements of the care model is a COPD Care Liaison (formerly called Pathway Coordinator) who identifies AECOPD patients, provides in-hospital education and assessments and connects patients to community respiratory services.

Several communication tools were also developed including the information folder for family physicians which included a step-by-step pathway tool connecting COPD patients to community care.

EVALUATION

The AECOPD acute pathway and its tools were trialed from March to May 2013. An Interior Health respiratory therapist was seconded .49 FTE to serve in the role of COPD Care Liaison (formerly Pathway Coordinator). Weekly reports from the Pathway Coordinator detailed the experience of each AECOPD patient visiting emergency or admitted to hospital during the trial. These reports were distributed to all members of the working group and prompted refinements to the pathway and the tools as required. A pathway compliance report card was also published during the trial. It showed the level of compliance of each care provider group.
Results from the trial showed excellent compliance with the pathway once initiated but indicated potential gaps in AECOPD case identification through the Emergency Department.

SUSTAINABILITY

Commenting on the project's sustainability, an evaluation expert noted that in the long term, the project needed support from Interior Health in order to remain operational. Specifically, the health authority would have to provide support of the COPD Pathway Coordinator (known as COPD Care Liaison) role and adequate community respiratory program capacity. Further, the project would need to ensure that the pathway continues to have uptake through ongoing in-service. Many of the Working Group members suggested that the way this work was done could be (and is being) used as a model for other similar quality improvement projects.

BUDGET SUMMARY

Planning	
Engagement & Implementation	
Evaluation	
Sustainability and Spread	
TOTAL	$134,513.00

SUPPORTING SPREAD

A detailed final report and project charter for this project are available upon request.

For more information contact:

Home Division Executive Director:
Tracy St. Claire, SOS Division of Family Practice
tracy.stclaire@sosdivision.ca

Project Manager:
Kathleen Jagger, SOS Division of Family Practice
Kathleen.jagger@sosdivision.ca

Regional Shared Care Liaison:
Sarah Forster, Shared Care
SForster@doctorsofbc.ca

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