New Shared Care COPD module already showing results

General practitioners and specialist physicians are working together to develop a new Practice Support Program (PSP) learning module on coordination of care for patients with chronic obstructive pulmonary disease.

Respirologist Dr Mark FitzGerald says COPD is underdiagnosed and exacerbations are the number one cause of hospitalization in Canada. He says working with GPs to develop a systematic way to treat patients at risk of or diagnosed with COPD will benefit not only family doctors and specialists but, more importantly, patients.

The Shared System of Care for Patients with COPD (Shared Care COPD) module is one of a number of new PSP modules under development. The goals of the PSP are to improve care for patients throughout the province and to increase job satisfaction among BC's general practitioners. The PSP offers focused training sessions for doctors and their MOAs to improve efficiency and to support enhanced delivery of patient care.

"The working group for the Shared Care COPD module is developing a shared care referral, consult, and communication process for family and specialist physicians treating patients with COPD that could provide a template for the shared care of patients with other chronic diseases," says Liza Kallstrom, lead for content and implementation for the PSP. "We've been developing the module over the past year and a half and began prototyping it this year. We'll expand the prototype to more GPs this fall and hope to roll out the Shared Care COPD module early next year."

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The PSP program provides training, tools, and guidelines to family physicians to help them improve practice efficiency and delivery of patient care. Each PSP learning module involves three paid half-day group learning sessions, followed by an action period of 6 to 8 weeks during which PSP participants try out what they've learned in their own practice.

Other PSP modules include advanced access, mental health, chronic disease management, end-of-life care, and group medical visits (including patient self-management and health literacy). A module is also in development for child and youth mental health. The Shared Care COPD module is the first to involve specialists in its development to this degree.

Dr Philip White runs a busy family practice in Kelowna. He is a big fan of the PSP and has been helping to develop the Shared Care COPD module. "All PSP modules are about managing patients in the community and avoiding hospital admissions and other interventions where possible," he says. "All those elements are in here. COPD can be managed to the guidelines, and by working with specialists in developing the module, we get agreement on what the specialist and the GP require from each other to give the best care to patients."

The module will provide GPs with guidelines and flowcharts to help keep track of patients at risk for or diagnosed with COPD. Dr White says by using these forms he can see what steps to take at a glance. "I can see in a flash what's been done and what needs to be done. I can see at a glance what elements of care are required, what medications my patients have or need, their spirometry results, whether they've had their pneumonia or flu shots, et cetera," he says. "It makes the care much simpler from our perspective. You can see what's been done and you don't miss anything because it's on the list."

Dr White has been working with the prototypes for the PSP module for some time and has already seen significant results. Smoking cessation has seen a renaissance through this prototype process, and he hasn't had a COPD patient admitted to hospital for 2 years for an exacerbation or flare-up.

"I have been able to access a specialist to ask questions and have been able to make better referrals to specialists when needed," says Dr White. "I can even send a copy of the patient's flowsheet with my referral. And because I'm working to guidelines specialists helped develop, they can have more faith in my call of whether or not the patient needs to be seen acutely."

Dr FitzGerald agrees that the prototype module is offering better communication between specialists and family doctors. "Often a patient can come to the specialist with very little background provided," he notes. "If the referral is improved and I know more about what's been tried, I can create a care plan for the GP to help the patient when they are discharged into the community, which can lead to better communication, fewer errors, and fewer complications."

Ms Kallstrom adds that physicians are expressing the desire to expand the PSP shared care process for other diseases such as congestive heart failure. "We are considering expanding the module down the road to include how to deal with patients with comorbid diseases," she says.

For more information on the Practice Support Program, visit www.pspbc.ca.

—Clay Barber, Executive Lead, Shared Care Committee