COPD pathway connects patients, clinicians, and community for continuity of care

Chronic obstructive pulmonary disease (COPD) accounts for the highest rate of hospital admission among major chronic illnesses in Canada. Patients with this debilitating, progressive lung disease also have much higher hospital readmission rates than those with other chronic illnesses (18% are readmitted once within the year and 14% twice within the year).[1]

Respirologists at Penticton Regional Hospital were encountering the impact firsthand, particularly with patients experiencing acute exacerbations of COPD (AECOPD) frequently having to be readmitted through the emergency department.

To address the problem, respirologists connected with other physicians, nurses, pharmacists, patients, respiratory therapists, and administration staff to create a trial project (funded by the Doctors of BC/Ministry of Health Shared Care Committee) to identify gaps in the current system. Together, the team conducted chart reviews, researched best practice, developed patient pathway maps, and tested clinician tools. The result was the creation of an innovative pathway for COPD patient care that has attracted local and international attention, including a presentation at the Institute for Healthcare Improvement's 25th Annual National Forum on Quality Improvement in Health Care in December 2013.

The new pathway was trialed for 3 months in early 2013 and implemented in June.

Prior to the pathway there was no process to transition COPD patients discharged from the hospital back to community care. Now, when patients enter the hospital (either through the emergency department or admitting), they benefit from a predictable and comprehensive process used by doctors and nurses, in collaboration with respiratory therapists, to better identify and treat patients with an acute exacerbation of COPD. The pathway reflects the Canadian Thoracic Society's clinical practice guidelines for COPD and spans multiple care providers to ensure patients receive:

- COPD education in hospital.
- Standardized medical treatment for acute treatment and preventive therapy of AECOPD.
- In-home and telephone follow-up.
- Timely family physician follow-up.
- Links to community respiratory programs.

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Preprinted AECOPD order sets are an integral part of the standardized in-hospital care. The order sets, which include a referral function, help ensure patient information is communicated effectively. The discharge orders contain information about recommended medications and can double as a valid prescription.

Education is a critical component of the pathway for patients, many of whom have limited knowledge about COPD, to help manage their own care, including basics such as how to optimize their medications and use an inhaler properly. Many patients were unaware they were using their medication incorrectly until they attended an education session. The pathway also allows specialists and family physicians to feel more confident that patients will connect with support in the community, and that the family doctor will be an integral part of the care pathway.

A combination of extensive, ongoing communication and in-service training, in addition to a broadly inclusive working group, has been essential for the project's success and adoption of the new pathway, with initial results indicating strong uptake by local physicians and care providers.

Further data are being collated on the project in partnership with the health authority, and adapting the tools for neighboring regions is currently in discussion.

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This article is the opinion of the Shared Care Committee and has not been peer reviewed by the BCMJ *Editorial Board.*

Reference

1. Canadian Institute of Health Information. Health Indicators 2008. Accessed 23 May 2014. https://secure.cihi.ca/free_products/HealthIndicators2008_ENGweb.pdf.