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December 10, 2015

BreatheWELL /COPD Services Condensed Implementation Plan

BreatheWELL/Chronic Obstructive Pulmonary Disease (BW/COPD) is a result of Fraser Health (FH) collaboration between acute, home health (HH), residential care (RC), and community respiratory services (CRS). The aim is to help patients avoid hospital, stay at home safely, lead an active lifestyle, and help them self-manage their chronic conditions, resulting in better health and quality of life.
The intention of the plan is to:

- Implementation into the remaining 31 Residential Care Sites in Fraser Health.
- Identify improvement opportunities in the community service.
- Availability of BW/COPD in all FH Communities

BW/COPD Integration:
Currently BW/COPD is delivered in two components:

- Community Based BW/COPD Services
- Residential Care BW/COPD Services

An integration of BW/COPD Services with existing resources in HH, RC, and CRS will minimize service duplications; achieve cost-effectiveness while offering a support for all levels of COPD acuity and ensuring sustainability of BW/COPD Services.

BW/COPD Services Components:
BW/COPD services will continue to be delivered collaboratively by HH, RC, and CRS. The intent of the redesign is to expand to all FH communities to ensure equitable access for patients. Sustainability of the approach will be accomplished through education and training with key stakeholders. This education will be tailored based on the various clinical roles, responsibilities and competencies.
Key components of BWCOPD Services:

- BW/COPD Services will be available across FH aligned with the Health Services Areas (HSAs)
- Redesigned service delivery model to integrate BW/COPD services into all staff competencies based on respective clinical expertise/role.
- Update existing COPD PSP training module for physicians of the BW/COPD Services
- Provide HH Nursing and RC staff with basic COPD training (one-time, in-person).
- Utilize On-line COPD training modules (new hires, orientation, and sustainment).
- Maintain Certified Respiratory Educator designation for RTs.
- RTs will consult/ support RC staff in their communities

Identified Opportunities:
Increase the awareness of the BW/COPD services in the acute care setting by offering space for acute care clinical nurse educators (CNE) during the HH and RC Education sessions during the roll out to the remaining HH communities and RC sites, for the purpose of sharing information only.
Gains:

- Baseline knowledge for clinical nurse educations on COPD
- Awareness of the BW/COPD services
- Ability to share this information to frontline staff as questions arise on COPD

Evaluation Framework

Review and revise current metrics - quantitative and qualitative indicators to measure program performance and utilization, client and provider experience, and patient health outcomes.

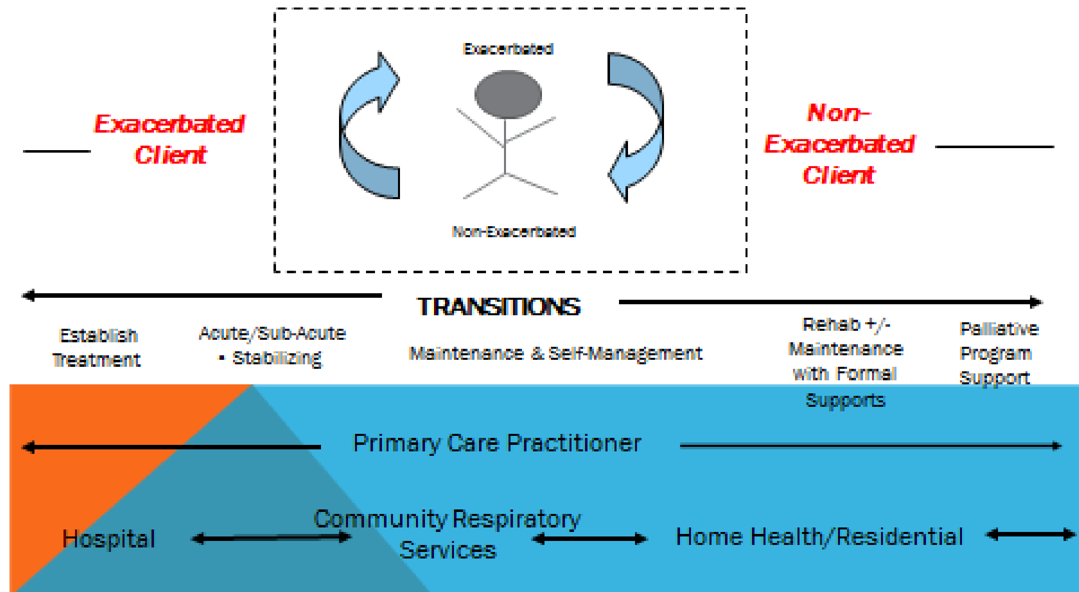
BreatheWELL/COPD Clinical Service Model (Draft)

Client Needs:

- Knowledge related to COPD, flare up plan, medications, mental health, non-medicated treatments
- Timely clinical intervention for flare up or progression of COPD
- Obtain Flare up Action Plan medications
- Access to other health professionals

Client Needs:

- Coaching related to self-identified goals to build confidence
- Ability to enact health improvement plan and action plans independently
- Review of knowledge related to COPD, flare up plan, non- medicated treatments



Right care, Right time, Right provider, and Right location.

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Project Time Line:

Fall 2011 – Fall 2013	• Implementation of BW into communities of: Burnaby, New Westminster, North Surrey/ North Delta, Langley, Chilliwack • Creation and implementation of residential care and acute COPD PPO throughout FH
September 2015	• Current clients in BW/COPD transferred to Community Respiratory Services • Combined COPD referral intake for BW/COPD and Community Respiratory Services by order entry, fax and phone
October 2015	• Communique on new delivery model sent to current providers in HH and RC • Communications sent to Acute Care Facilities: Respiratory Therapists, medicine managers and physicians involved in COPD patient care
December 2015	• Process mapping completed to support the Clinical Service Model • Planning for Education in RC and HH in the communities without formal implementation of services: Abbotsford/Mission, South Surrey/ White Rock, Ridge Meadows/ Pitt Meadows, Tri Cities • Communications sent to 1. FH Leaders, Executive Directors FYI to share with their Health Service Area X 2 2. Residential Care Homes (O & O) 3. Residential Care Homes (Contracted as an FYI in 2016) 4. The Beat Newsletter 5. Posted on Intranet Beat Share point site • Communications to inform Division of Family Practice sent: 1. to the Divisions Executive directors, by e-mail and 2. by mail to individual GP's in new communities 3. Referral forms requested to be placed on Pathways
January – March 2016	• Education & implementation to be offered and provided in 5 - OO RC sites in above HSAs • Education & implementation to be offered and provided in HH communities of above HSAs
March – Dec. 2016	• Education & implementation to be offered and provided in remaining contracted RC Homes

Created by communications Team, BW/COPD

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