A COPD Example:

SharedCare
Partners for Patients

Implementing a care pathway by changing community culture around a disease

The aim of the South Okanagan Similkameen Shared Care Acute Exacerbation (AE) of Chronic Obstructive Pulmonary Disease (COPD) project was to reduce AECOPD readmissions. This was accomplished by community adoption of an optimal COPD care model and an acute care pathway.

The following is a step-by-step guide for the implementation of a care pathway in any community. Please note that a collaborative approach, facilitated by dedicated project management, is key at every step of this implementation process.

STEP BY STEP GUIDE: Implementing a Care Pathway

1. **Identify clinical problem or gap**
   Collect data, conduct in-depth chart reviews and map the patient journey to identify current practices and gaps in service.

2. **Bring stakeholders to the table**
   Recruit champions from every discipline involved with COPD care in the community. This includes physicians in every aspect of care, nurses, allied health professionals, pharmacists, clerks and office staff. Deliberately engage a patient or family member with lived experience, if possible.

3. **Co-design care pathway**
   Together, review best practices and current patient flows to design an optimal care pathway.

4. **Assess, evaluate and make improvements**
   Test the proposed pathway. Measure pathway compliance and solicit feedback from stakeholders and patients. Re-design often based on data collected.

5. **Construct tools to implement pathway**
   Make the pathway as user-friendly as possible by giving care providers the right tools. Useful tools for COPD are patient education handouts, physician and respiratory therapy checklists, EMR templates and pre-printed orders.

6. **Engage all stakeholders**
   Project champions report out to their colleagues and solicit feedback regularly. Peer-to-peer education is more effective than a top-down approach. To facilitate engagement, create newsletters, report cards, posters, and host CMEs and other inservice events.

7. **Align with similar activities and leverage resources**
   From the outset, align with similar initiatives in the area to avoid duplication and create partnerships where possible. Identify potential allies in change.

8. **Plan for sustainability**
   Embed roles and responsibilities into workflow and job descriptions for all aspects of the care pathway.

For detailed reports and more information about this project please contact:

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PSP Practice Support Program