CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) SERVICE MAP

Objective

Clinician tool to support patient care through lifestyle behaviour modification so patients can self-manage their condition

Refer

Family Physician (FP) refers a diagnosed COPD patient to Neighbourhood Nurse (NN) or Nurse in Practice (NIP)

Assess

Clinician contacts the patient to arrange initial in-person appointment

Conducts Assessment:
- COPD Checklist (supporting tool)

Initial Appointment (in-person)

Newly Diagnosed

During appointment, clinician can:
- Review COPD diagnosis with patient
- Consult patient to determine their needs
- Co-develop a self-management plan with patient
- Discuss & review Flare-up Action Plan ☑ with patient
- Complete referrals, if required
- Provide patient with self-directed resources, if required
- Communicate back with FP regarding visit

Mild / Moderate

During appointment, clinician can:
- Consult patient to determine their needs
- Co-develop a self-management plan with patient
- Discuss & review Flare-up Action Plan ☑ with patient
- Complete referrals, if required
- Provide patient with self-directed resources, if required
- Communicate back with FP regarding visit

Acute

Clinician to contact patient to set up initial appointment within **48-76 hours**

During appointment, clinician can:
- Adjust oxygen (if needed) and/or contact Community Respiratory Services (CRS) (604-514-6106) if patient is on oxygen
- Set a self-management plan
- Review Flare-up Action Plan ☑
- Educate patients on importance of movement during an exacerbation
- If patient is not exercising:
  - Refer to Pulmonary Rehabilitation Program AND/OR
  - Provide exercise resources
- Provide patient with self-directed resources, as required
- Communicate back with FP regarding visit
- Book follow-up visit with FP within 1-2 weeks, unless more urgent, phone/text FP first prior to booking

Follow-up Appointments (virtual/phone)

During follow-up appointment(s), clinician can:
- Follow up to see if patient has been contacted from referral site (RRP ~ 4 wks if has Respirologist; CRS ~21 days), if applicable
- Follow up after service completion (i.e. RRP 6 wks and/or initial apt with CRS ongoing)
- Review the self-directed material sent, and address any questions
- Check in on patient's compliance with self-management plan
- Discuss next steps in their self-management plan
- Make any additional referrals, if necessary

Communicate back with FP regarding visit(s)

Appointment will take approximately 15 minutes

Number of follow up visits at discretion of clinician (Suggested 3 max.)

Let patient know during last visit if any new concerns or needs come up to connect with their FP.

Other PCN & Indigenous Referrals

If there are *mild* mental health and/or psychosocial issues raised during assessment, refer to Mental Health Service Maps (Anxiety Service Map / Depression Service Map), or consider Sources referral for counselling, and commincate back to FP.

If there are *significant* mental health and/or psychosocial issues raised during assessment, refer to Mental Health Service Maps (Anxiety Service Map / Depression Service Map), discuss case with Neighbourhood Social Worker (NSW), and communicate back to FP (faciliate a follow-up with FP as appropriate).

If the patient is facing significant financial concerns, and is a potential candiate for support, discuss case with NSW.

Consider Pharmacist referral in the following cases (after discussion with FP):
- Patient is on 8+ medications
- Patient is on opioid/benzodiazapine combination
- Experiencing side effects

*Before referral to Pharmacist, check if patient has recently been reviewd by Specialized Seniors Service

For Indigenous specific services, contact the Aboriginal Health Liaison (1-866-766-6960)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) SERVICE MAP
CLINICIAN RESOURCES

Self Management Resources

EDUCATION RESOURCES:

Required Education Handbook:
COPD handbook ☑
(emailed or printed for patient)

Self Management of COPD (Videos)

Inhaler Techniques
Video & Handout (English only)

Breathing Techniques
Video

Airway Irritants

COPD Flare-up Action Plan
Video
Handout ☑

Energy Conservation Video

Coughing and Mucous Clearing
Video

Nutrition and COPD
Video
Handout

Relaxation Positions

Tips to Reduce Stress

Tips to Improve Sleep

Benefits of Physical Activity

COPD & Physical Activity (exercises handout)

Virtual Exercise Classes
(can register for virtual exercise classes lead by kinesiologist, or watch uploaded recordings)

PEER GROUP SUPPORTS:

Better Breathers in-person support community

Better Breathers online support community ☑

SERVICES:

Respiratory Rehabilitation Program (group based)
- Provides educaton and exercise programs designed specifically for people who are living with chronic lung disease
- Brochure ☑
- *Eligibility:* Suspected or diagnosed lung condition
- Referral to be completed by FP/NP
- *Wait:* ~ 4 weeks

Community Respiratory Services (CRS)
- Respiratory Therapist (RT) visits the client in their home to provide coaching of self-management skills related to respiratory conditions including education on the use of prescribed medications, identification of the signs and symptoms and mangement of flare ups. Goals are set to identify strategies for the mangement of activities of daily living, diet and exercise, and improve quality of life. Services are based on the patient's needs.
- *Eligibility:* Diagnosed with a respiratory condition. If you are referring a respiratory patient other than COPD or Tracheostomy, please describe this patient's needs in the comments section of the referral form.
- Referral can be completed by any Health Care Professional
- *Wait:* Patients are triaged to determine how quickly they are seen by the therapist
    - If recently discharged from hospital with COPD flare up, will be seen within few days
    - If referred from a FP office with no recent admission to acute care, will be seen within 4 weeks

Smoking Cessation

Smoking Cessation Clinic at JPOCSC
- Free comprehensive 12 week group program that guides patients to become smoke-free through education, behavioural support and counselling
- *Eligibility:* Patient looking to quit or reduce tobacco
- Referral to be completed by FP
- *Wait:* Runs quarterly

QuitNow BC ☑
- Free program for individuals looking to quit or reduce tobacco and e-cigarette use. Offers personlized quit-smoking plans; one-on-one coaching and group support by phone, chat, email and video conferencing; and an online discussion form.
- *Eligibility:* Patient looking to quit or reduce tobacco and/or e-cigarette use
- *Referral:* Self-refer AND Health Care Professional can refer
    - Online OR fax the referral form to 1-888-857-6555
- *Wait:* None

NN to connect with GPs MOA to book a personal risk assessment

Clinician Resources

CLINICIAN EDUCATION:

COPD Management LH Course #14421

PATIENT ASSESSMENT TOOLS:

MRC breathless scale ☑

CAT questionnaire

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