DEVELOPING AN INTEGRATED MODEL OF CARE FOR COPD

This is a summary; the full paper can be accessed at nursingtimes.net

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ABSTRACT Serginson, J. (2007)
Developing an integrated model of care for COPD. Nursing Times; 103: 35, 28–29. Within a Brisbane health service district, respiratory clinicians recognised a number of limitations with existing COPD services, including suboptimal communication of patient information, variability in clinical practice and limited or inequitable access to services. The ‘Strengthening the Respiratory Care Continuum’ project was undertaken to review the existing model of care and associated processes and services for people with COPD. This article describes the model and its development into a blueprint for ideal care.

Traditional models of care have been based around specialist and general medical services, with the acute care hospital episode as the focal point. A referral – usually medical – initiates the episode, which concludes with discharge to primary care. This has worked efficiently for patients without co-morbidities who experience an acute illness or injury and can expect full recovery within a short time. However, most COPD patients have some co-morbidity and many have several long-term illnesses that require ongoing monitoring and care.

The ideal features of an effective model of care for long-term conditions were identified through literature reviews, consultation with other health services, discussion with local stakeholders and the experiences of clinicians in the Prince Charles Hospital Health Service District (PCHHSD). These were:
- Patient focus in the community setting;
- Maintenance phase central to the model;
- Emphasis on self-management principles;
- Application across a wide range of care needs, disease severity and disease impact;
- Consideration of the natural course of COPD (functional decline over time with acute exacerbations);
- Linking existing evidence-based services to proposed additional services as per national guidelines;
- Defined key areas for communication between team members;
- An intuitively sensible practical model;
- Ability for the model to be implemented within available structures.

The draft model was developed as a synthesis between the COPDX guidelines (McKenzie et al, 2003) – our equivalent of NICE (2004) guidelines and chronic-disease management principles to reflect the relationship between current COPD services and new services proposed to fill existing gaps. Recommendations of the COPDX guidelines were separated into three phases (establishment, maintenance and transition) and core services associated with these

planned reviews of patients’ progress towards their goals.
- The transitional phase is when patients need more intense care due to an exacerbation of COPD. The emphasis is on recognition of early signs by the patient/carer and prompt action.
- We believe the model could be adapted to other districts or long-term conditions for which evidence-based guidelines are available.

THE DEVELOPED MODEL
The model describes our vision of ideal healthcare for all patients with COPD. Any clinician in acute or primary care can refer patients as long as the patient:
- Has a spirometry-confirmed diagnosis of COPD;
- Lives in the district and consents to the sharing of their clinical information.
Initially, most patients are likely to be identified during inpatient episodes for exacerbations or at specialist outpatient clinics. Over time, however, referrals will be encouraged and accepted from all points in the continuum, particularly primary care.

Establishment
The aim in this phase is to complete a detailed assessment of the patient’s disease severity, complications, functional status and ability to manage their condition and to enable access to all COPDX-recommended interventions as appropriate. Interventions to be considered are:
- Confirming or supporting the diagnosis;
- Assessing disease severity and complications;
Review by a respiratory physician; 
Medications and vaccination; 
Pulmonary rehabilitation or individual exercise plan; 
Smoking cessation plan; 
Individual education regarding COPD and self-management; 
Support group referral; 
Written self-management plan; 
Multidisciplinary care plan. 

The model shows the health professionals most appropriate for each intervention.

**Maintenance phase**

This phase aims for planned and integrated reviews of patients’ progress towards their goals and clear communication of assessments, interventions and outcomes to the entire care team including the patient. Aspects to be reviewed regularly include: 
Spirometry, complications, quit status of current and recent ex-smokers, and functional status; 
Actions taken by the patient as part of a care plan; 
Coping skills, knowledge, quality of life and self-management; 
Self-management plan; 
Patients’ progress towards their goals.

The impact of COPD, and resulting care needs, depend on individuals’ disease severity, coping skills, available support and other co-morbidities. All patients are expected to have a GP as their primary medical carer but some will also receive care from the community health nurse, community or acute care-based allied health professional (AHP), respiratory specialist and/or respiratory nurse.

Patients referred to the community health nurse COPD programme receive structured home visits and ongoing maintenance visits or phone support as required. For those who frequently use inpatient or emergency department services, the community-based respiratory nurse will function as care coordinator with the aim of providing regular and as-needed access to intensive support.

**Transition phase**

This is the period during which patients need more intense care due to COPD exacerbations. The emphasis is on the patient/carer recognising early signs of exacerbation and taking prompt action. Rapid access to the appropriate level of assessment, interventions and support follows patient-initiated changes to medications as per the plan. Interventions may include:

- Community care – more frequent community health nurse visits, GP review and extra medications;
- Hospital admission – usually 6–7 days;
- Hospital in the home (HitH) service – daily to second daily respiratory nurse home visits;
- Brief hospital admission of 2–3 days with supported early discharge. 

The intensity and frequency of assessment, treatment and support is stepped down as the patient improves. Patients are referred to the community health nurse COPD programme before discharge. They receive structured home visits post discharge to assess progress and reinforce the education provided in hospital. The transition phase continues until recovery, when the patient re-enters the maintenance phase after baseline care needs are reassessed and their self-management plan is re-established.

Communication of patient information between health-team members is achieved through the following strategies:

- A fax to the GP and community health nurse or AHP advising of admission;
- Nurse and AHP input into medical discharge summaries with a self-management plan;
- Discharge summaries and outpatient review letters sent to all team members as opposed to the GP alone;
- Summary from nurse’s or AHP’s home visit sent to GP and added to patient’s hospital chart;
- Teleconferences about patients with complex needs prior to their discharge;
- Follow-up appointments booked before discharge to ensure all relevant professionals are involved.

**OUTCOMES**

The model describes the ideal care towards which we are working. One of its limitations is the incorporation of such a wide range of services and organisations, with disparate funding models, aims and practices. Enabling collaboration between different groups and individuals remains a challenge.

Some aspects of the model – HitH, rapid-access outpatient clinics and community-accessible pulmonary rehabilitation – are yet to be fully implemented due to funding issues. Nonetheless, outcomes have included the implementation of a revised community health nurse COPD programme, the establishment of a community-based respiratory specialist nurse position and a common focus for community and acute care-based service planning.

**REFERENCES**

