Implementing Respiratory Integrated Care (RIC): the future for COPD diagnosis and management?

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Introduction

Why do we need Respiratory Integrated Care?

Ireland has the highest rate of admissions for COPD in the Organisation for Economic Co-operation and Development (OECD) countries.1

Part of the explanation for this may reside in lack of resources for diagnosis and management in the community.

What is Respiratory Integrated Care?

An integrated model of care based within Primary Care was developed as part of the Clinical Care programme for chronic disease management.

The first Respiratory integrated care post commenced in April 2016. This programme provides the services of a Clinical Nurse Specialist (CNSp) to both primary and secondary care.

Aims of RIC

• To provide expert diagnosis and care in an integrated manner
• To improve access to spirometry in the community for diagnosis and accurate staging of disease
• To foster the ethos of self-management in the patient and the GP team
• To share expert knowledge and skills with general practice staff
• To maximise patient quality and quantity of life
• To reduce emergency attendance at GP OOH, ED and Hospital admissions

Method

The first Respiratory CNSp commenced post on the 11th of April 2016 and first clinics commenced on the 19th of July. Three G.P practices in a Primary Health Care centre in Wicklow were selected as the initial sites for commencement. Selection was based on:

• Improving access for patients to specialist care
• Potential site for future Pulmonary Rehab
• Available space for CNSp to work
• Good access to multidisciplinary team

Method Cont..

Challenges encountered

• Transferring equipment to clinics
• No specific templates available on G.P.I.T systems for RIC.
• Limited IT links between primary/secondary care that would facilitate RIC
• Data collection difficult
• No model of care for programme

Benefits of working within the G.P practice

• Instant access to patients past interventions, letters, radiology reports and a view of exacerbation history.
• Ability to liaise with G.Ps instantly
• Being visible and a part of the primary care team generates referrals and discussion around Respiratory disease.
• Patients expressing appreciation at ease of access and closer proximity to home.

Results

Patients statistics from first clinic July 19th to 30th of September 2016 were collated on excel.

Target population for RIC are patients with OOPG, Inpatient or Emergency Dept. Attendances in previous year:

► Out of the 45 new patients seen only 22% meet this target.
► 17% were current smokers
► 29% Had a BMI 30 – 40
► 31% Had a BMI 25 – 29
► 35% were provided with written Action Plans by the Resp CNSp (No previous action plans had been provided)
► 4% had Respiratory disease ruled out

Components of RIC intervention

• Spirometry with reversibility
• Inhaler optimisation
• Diet & Exercise advice
• Airway clearance/breathing techniques
• Exacerbation action plans
• Brief intervention for smoking cessation
• Disease process education
• Referral to MDT or Resp OPD as appropriate
• Caseload for the clinics comprise of patients with both COPD & Asthma, selected and booked in by the G.Ps and practice staff.

Conclusion

Respiratory Integrated Care (RIC) provides for accurate diagnosis, with evidence based cohesive management in primary care.

Continued collaboration and communication is required to streamline and expand the service further.

Further Integrated Care posts are expected to commence next year.

Learning from this current programme can be utilised in upcoming programmes and to help shape a model of care.

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