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Selwyn Street Nurses
Christchurch

Friday, August 12, 2016

(Plenary)

16:30 - 16:50 Primary Care Perspective

COPD Patient Journey

Primary Care Perspective

Selwyn Village HealthCare

- 2013, started considering how to better manage COPD within the practice
- Some ‘Frequent flyers’ requiring high input, feeling we’re perpetuating reliance and ‘fire fighting’ not ‘managing’ or ‘empowering’
- Anecdotally under-diagnosing or miss- diagnosing
- Coding variance

Visit from Respiratory Team CPH December 2013

- Focus on case finding – likely under or miss diagnosing COPD. Data Provided included;
- Smoking rates, Coding, Spirometry, Admissions, Pulmonary rehab rates and Dispensing
- Coincided with the introduction of Acute Plans for patients at risk of admission

The Practice chose to take this further with a two pronged approach;

- Develop a practice wide protocol for managing known COPD

And

- Case finding for undiagnosed COPD
- Quality focus and best practice principles

Protocol

Known COPD

- QB and search to find current patients
- Review lists Nurse/GP team – frequent attendees, complex, symptomatic, admissions and exacerbations invited in

Case Finding

- QB to find smokers over 40, on a reliever
- Review notes and post out an offer letter and flyer

Known COPD

- Nurse previews notes and prepares, requests repeat Spirometry if appropriate to confirm diagnosis and severity
- 30 min nurse, 15 min GP appt
- Nurse does physical exam, CAT and mMRC score, checks inhaler technique and changes spacers, and...
- education, smoking cessation, vaccines, BMI & dietary advice, falls risk, offers pulmonary rehab, medicines management, accessible parking
- establishes Gold severity group

- GP reviews diagnosis, co-morbidities and medications action plan agreed between all parties and scripted separately
- Nurse gives patient/Family home action plan and also enters into CCMS for view by ED/After Hours
- Recall on to repeat in 12 months – usually pre winter
- Patient centred approach

Enablers & what went well

- Enthusiastic drivers within staff
- IT Tools – ERMS, ePortal, screening terms, HealthPathways, recurring tasks, QB
- Acute Plan funding
- GP Nurse Team approach with specialist support
- High level of awareness and opportunistic screening, education and intervention

- Roll on effect to managing other conditions
- Patient and family satisfaction - confidence!
- Better, and innovative use of other PHC services – physio, dietician, resp nurses, PCW, Pharmacy and MMS, falls prevention, CREST, age concern
- Patients prepared to advocate and mentor others
- Potential whanau and generational benefit

Barriers, Issues and opportunities

- Complexity – high level of co-morbidities
- Dangers of a disease centric approach
- Patient reluctance – ‘unwanted’ diagnosis
- Variance of coding and managing
- Uneven rollout – acute plan
- Cultural and language issues not addressed – ethnicity, age, gender
- Staff training and working up to scope

Funding

- We’re quite good at funding interventions e.g. acute plans
- Not good at funding prevention e.g. case finding
- A group of patients need the education and intervention but not an acute plan – therefore no funding
- New funded COPD meds aren’t helping reduce complexity

Results?

- Stats a Little better - still not up to predicted rates
- Big increase in referrals for spirometry and pulmonary rehab
- Smoking cessation advice up+
- GP Nurse team spin offs
- A platform to launch other disease management – CHF, CRF
- Raised level of awareness – lots of opportunistic testing and discussions e.g. at triage

Summary

Like the rest of general practice;

- ‘Its all about people and relationships’
- ‘More than one bite of the apple’
- Team approach is key – all LTC
- Cleverness with funding and services