Chronic Obstructive Pulmonary Disease (COPD)

Initiative Type

Model of Care

Status

Close

Added

11 September 2017

Last updated

25 June 2020

URL

https://cnxp3cuvtvrn68yjaibaht5ywrxspj7m.clinicalexcellence.qld.gov.au/improvement-exchange/copd

Summary

The aim for the initiative is that a discrete population of patients with COPD are managed with a different model of care such that they incur lower costs and enjoy better health outcomes. Changes to the model of care should be acceptable to providers and patients and factors that hindered and promoted adoption should be revealed so the innovation can be implemented successfully and sustained with fidelity in other settings.

Key dates

Jan 2016

Sep 2017

Implementation sites

Metro North Hospital and Health Service

Partnerships

Healthcare Improvement Unit, Brisbane North PHN

Key Contacts

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Aim

Implement sustainable practices to improve disease screening and diagnosis for patients with or at risk of COPD.

Benefits

- Primary care screening and case identification improvement
- Post hospital rehabilitation access and care planning improvement

Background

COPD is a progressive long-term disease of the lungs that causes shortness of breath. It is prevalent among populations in Metro North and when poorly managed is likely to incur greater cost and worse mental and physical health. Current management of these patients in MN HHS could be improved and evidence based practice is:

- early disease identification, to slow progression
- appropriate therapy using a stepped approach based on disease severity
- patient-centred care plans in partnership with a health professionals and other carers
- early intervention to reduce the severity of exacerbations
- access to pulmonary rehabilitation, particularly following an exacerbation

The challenge for health services is to implement these by working with general practices, PHN leadership, the Lung Foundation and primary care services. There is a need to improve early identification and diagnosis of patients with COPD in a primary care setting, and then proactively plan for care and optimise management of the condition in primary care. The Integrated Care Innovation Fund provides financial support to innovative projects that deliver better integration of care, address fragmentation in services and provide high-value healthcare. Funded projects also demonstrate a willingness to embrace and encourage the uptake of new technology alongside the benefits of integrating care and improving communication between health care sectors.

Solutions Implemented

Four strategies were implemented:

1. Targeted quality improvement activities: GP training; education; support in line with best practice screening and assessment (e.g. COPDX). The PHN will work with the GP practice liaison officer/educator.
2. Support the implementation of best practice guidelines by using the COPDX assessment tool, through GP practice software.

3. Monitoring rates of case identification and adherence with evidence based treatment for patients at different disease stages being treated in primary care.
4. To improve ongoing management of patients discharged from hospital for COPD they will be given better access to pulmonary rehabilitation, and offered group rehabilitation and/or access to a mobile device application. In receiving rehabilitation, care plans will be developed with patients to align with standardised assessment findings and best practice guidelines.

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