NSW Health

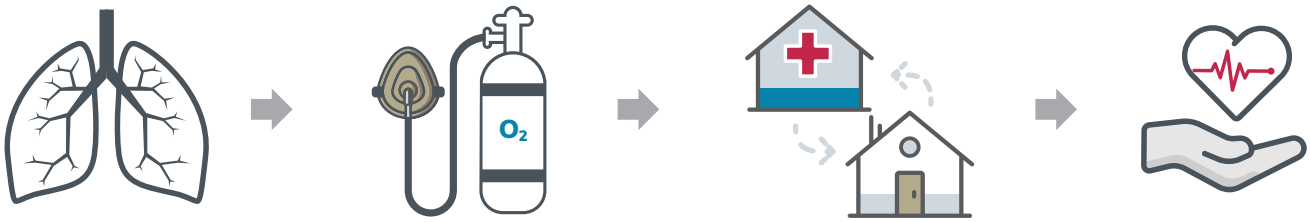
Leading Better Value Care

Chronic obstructive pulmonary disease

Organisational models

This document provides decision-makers with options to improve care in different service delivery settings. Building on *Chronic obstructive pulmonary disease: Clinical priorities* (2017) which described *what* to improve, the focus here is on *how* to improve care. Together these documents are informed by: research evidence about best clinical care and the effectiveness of different delivery models; empirical evidence about current service delivery levels; experiential evidence from clinicians and patients.

IMPROVING KEY PRIORITY AREAS



Diagnostic testing

Establish local policies and procedures for spirometry including:

- Training and capability building
- Correct operator technique
- Incorporation into patient flow processes
- Establish a 'spirometry champion'
- Bluetooth and Cerner interface capability in new purchases
- Automated integration of results into the eMR

Exacerbation management

- Perform arterial blood gases to assess acute respiratory failure
- Educate staff about local policies and procedures to ensure appropriate non-invasive ventilation (NIV) and oxygen (O_2)
- Use NIV and O_2 prescription modules in eMR
- Establish an 'O_2 champion'
- Build medication device technique checks into patient flow processes

Ongoing care

- Hold regular multidisciplinary meetings to review and refer high risk patients to chronic disease management services supporting discharge
- Ensure patient flow processes include assessment and referral to pulmonary rehabilitation
- Build discharge communication with GP into patient flow processes

Last year of life

- Establish breathlessness clinics
- Prevent presentations to emergency departments (EDs) and unnecessary admissions through the use of rapid review clinics
- Enhance quality of life through early referral to palliative care and extended symptom management
- Establish joint respiratory/palliative care treatment models to optimise management

IMPROVING THE OVERALL PATIENT JOURNEY

- Consider the continuum of care for patients with COPD and plan for other determinants of health that impact on patient outcomes
- Support health literacy and provide education to patients, enabling self-management
- Coordinate care, reducing fragmentation of services (particularly for patients with comorbid conditions)
- Incorporate the general practitioner (GP) as an integral part of the patient's care journey
- Establish data collection and monitoring through audit and feedback processes
- Measure and act upon patient reported experience and outcome measures (PROMIS-29 and COPD Assessment Test (CAT))

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● Potential location(s) for implementation

OPTIONS FOR ORGANISATIONAL CONFIGURATIONS

A coordinated multidisciplinary team-based approach delivers core components of care. The options below outline different organisational models which sites can use to tailor their clinical services to fit with local requirements. Larger hospitals may have both models in use, smaller hospitals require ED protocols that ensure evidence based diagnostic testing, and appropriate transfers for more severe cases.

Option 1: Respiratory coordinated care program

Hospital-based community programs that span hospital and community care. A specialised hospital-based community program, it also assists people with end-stage lung disease to stay in their homes. Its goal is to coordinate care, reduce unplanned admissions and strengthen transition of care from hospital to community. This model is suitable for adoption in metropolitan and regional facilities.

	Emergency department	Early admission	Late admission	Transition to discharge	Community
Referral to respiratory coordinated care program (RCCP)		●	●	●	●
Case finding	●		●	●	
Refer to multidisciplinary team		●	●	●	●
Ensure correct inpatient management	●	●	●	●	
Immunise				●	●
Home medicine review				●	●
Discuss advance care plan	●	●	●	●	●
Discuss resuscitation plan	●	●	●	●	●
Communication with GP	●	●	●	●	●

Option 2: Nurse-led models of care

Nurse-led models of care, or nurse navigators, provide services for patients with complex health conditions who require coordinated, comprehensive care. The nurses are highly experienced. Nurse navigators work across system boundaries in close partnership with patients, multiple health specialists and health service stakeholders. Patients with very low health literacy, comorbid conditions and multiple returns to acute care benefit most from these services, which focus on hospital avoidance. This model is suitable for adoption in all facilities across NSW.

	Emergency department	Admit to ward	Community
Promote awareness of service, location, referral criteria, hours and objectives to GPs and acute care staff	●	●	●
Enrol in nurse navigation program	●	●	
Medication review		●	●
Communication with GP	●	●	●
Support for self-management			●
Communication with GP	●	●	●

Option 3: Virtual health model

Models of care that use virtual wards, hospital in the home (HITH) and remote telemonitoring. Can be combined with either of the above models of care. This model is suitable for adoption in all facilities across NSW.

	Emergency department	Early admission	Late admission	Transition to discharge	Community
Telehealth	●	●	●	●	●
Remote monitoring				●	●
Telephone support	●	●	●	●	●
Support for self-management	●	●	●	●	●

Brief vignettes, describing how various organisational models have been implemented locally, are housed on the LBVC hub or website.

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