Respiratory disease management clinic

Nurse-led and proactive chronic disease patient care

What?

Within a nurse-led clinic, the practice nurse is the main care provider for the patient. The role of the practice nurse can include disease identification and tracking, health promotion and symptom exacerbation prevention activities. By undertaking these activities, nurse-led clinics have the potential to proactively address chronic disease and support the complex care required for Australia's ageing population.

Sharing care responsibilities throughout a clinical team and encouraging practice nurses to work to top of scope, can reduce the demand on GPs, and provide a more comprehensive and integrated service for patients. Utilising nursing expertise in the general practice setting strongly aligns with the principles of the Patient Centred Medical Home (PCMH) model of care. This team-based approach is rapidly evolving to become the future of primary health care in Australia and internationally.

Why?

South Eastern NSW has higher rates of potentially preventative hospitalisations than the state average. Multiple factors contribute to this issue, including a high burden of chronic disease. In the Shellharbour region, the rates of chronic obstructive pulmonary disease (COPD) and asthma are above average.

Proactive nurse-led clinics targeting chronic disease management can help ensure patients get the right care, at the right time and in the right place. The benefits of a nurse-led respiratory clinic in a general practice setting, include:

- patients develop an improved understanding of how their respiratory disease affects them physiologically, the preventative role of medication and how to recognise the worsening of symptoms
- GPs have more time to focus on patients with more complex care needs that require high level intervention
- practices are able to provide targeted and comprehensive care without increasing their GPs' workload; and increased patient satisfaction from the higher level of personal care.

How?

The nurse-led respiratory management clinic was one of 13 initiatives supported by COORDINARE. It was part of a project designed to build the capacity and capability of our region's general practices to move towards a PCMH model of care.

With funding from COORDINARE, Dr Chandran's surgery in Albion Park implemented clinics to manage the increase in patients presenting with exacerbation of COPD and asthma during the winter months.

Before the clinic started, the practice reviewed their current systems, upskilled their practice nurse in spirometry and established new workflows. High-risk patients were then identified and contacted by reception staff to attend the clinic.

During the six month trial implementation, the practice nurse undertook patient assessments which included spirometry testing, medication technique and compliance, as well as self-management education. High-risk patients were seen by the GP or referred to a specialist. Patients were then followed up at six months to assess their progress and the effectiveness of their management plan.

This project has proven sustainable for the long term, and has now become part of everyday workflow for the practice nurse and GP.

"As the GP, I am more than happy with our new patient workflow, it involves our whole practice team and highlights the value of management plans in re-educating patients." *- Dr Chandran, General Practitioner.*

Want to get involved?

At different times COORDINARE offers funding to support initiatives such as this. Practices which do not apply or are not selected for funding can still work with us and explore other opportunities. If we are outside of a funding round, we have resources to support practices on their change journey.

For further details on the steps involved to implement this model of care, visit http://bit.ly/MOCrespiratorydisease. For more information or support contact your Health Coordination Consultant, or phone 1300 069 002.

This initiative is supported by funding from COORDINARE – South Eastern NSW PHN through the Australian Government's PHN Program.

Outcomes

Figures sourced from Dr Chandran surgery PCMH final report.

Systematic identification of target patients

Increased accurate diagnosis and high-risk patient identification

87% participation rate of the initial target patient cohort

54% participation rate in the patient follow-up group

Improved patient education and self-efficacy

100% of patients clearly understood respiratory medications, beneficial lifestyle changes and value of repeat spirometry

97% of patients reported a good experience attending the clinic

Increased patient confidence in managing own respiratory health

Improved chronic disease management

88% of target patients have a chronic disease management plan in place

72% achieved good medication compliance

100% of patients seen by the nurse at six-month follow-up had avoided hospital admission that winter

The practice nurse perspective

- Kristen Mawbey

"If you didn't know what month winter started, you could just look at our books and be able to pinpoint every winter month from the increased number of patients making an appointment to see Dr Chandran for respiratory distress. And that's not including the patients we don't see because they go to hospital emergency instead. We all knew there had to be a more effective way."

Kristin Mawbey felt that, compared to their past practice, the new nurse-led model allowed for targeted and effective respiratory care to be provided.

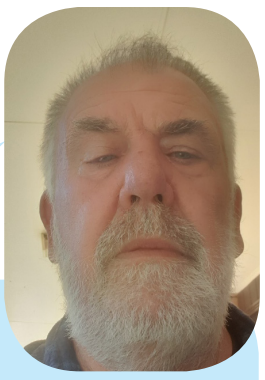
"Our patients with COPD and asthma who we saw through the respiratory clinic, now have an appropriate action plan and chronic disease management plan. Their care is now more formalised and targeted, especially where most of our elderly patients have multiple chronic diseases. Action plans help to reiterate what patients need to do in black and white and therefore mean that patients are more skilled in an emergency."

Kristin saw a difference in those patients who had previously not had an action plan; they were keen to have one and return to see the nurse because they felt they were being well looked after.

"I actually had two gentlemen, who were very excited to return to see me because they felt like someone was there for them, they weren't rushed and could ask questions. It has been great for our nurse-patient relationships."

The patient perspective

- Norman Ockroyd
(age 64 years)



"I have nothing but praise for this clinic. It has literally transformed my fear into empowerment and confidence. I was a coal miner for 28 years and whilst I can't change the past or change my diagnosis, I now understand what COPD really means - the signs to monitor and the medications to take accordingly.

I am no longer anxious, especially when winter is approaching, it's just part of my life.

Kristen, the nurse, is so easy to talk to and she continues to go out of her way whenever I have an appointment for a non-related concern. When I do see Dr Chandran for another problem, he still asks me about my COPD action plan - there is always someone watching me - it's personal health care but from the entire team. They don't usher me in and out.

Everyone should be involved in a clinic like this."

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