

**Lumos Practice Booster: COPD**

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| **About you** |

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| Demand | **The service is too busy, and you are unable to meet demand** |
| Age cohorts | 45-64 |

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| **Consider** |

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| **Patient characteristics** | Refer to page 6 of your report |
| Gender | E.g., female patients may wish to access a service offered by a female GP/nurse |
| Cultural background | Consider if your services need to be promoted in **different languages**, need to **consider specific social norms** (community leaders, religious leaders, etc.) or offer different options (e.g., service is offered by **female GP/nurse**) |
| Socioeconomic status | E.g., if patients are from a low socio-economic background, they may wish to access **bulk-billed services** |
| Remoteness | **Remoteness**may hinder a patient's ability to access your services. There may be opportunity to refer patients to services in their community or arrange transportation services |

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| **Explore** |
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| If the GPs at your practice are the ones delivering the service, you may consider **employing or upskilling a nurse or a health assistant** to support some parts of the service  - Your **admin staff** may be trained to support the service: e.g., they can use your practice extraction tool to identify patients, GPs and/or nurses can review the identified patient list and authorise staff to initiate contact or follow up, set reminders, etc.  - Consider if other areas of your practice put **pressure on your capacity**; could there be an opportunity for improvement? For example, you may consider if some services can be offered via **telehealth**, by a **nurse** or by a **different provider** (if you are not able to or not interested in providing the service)  - **Get in contact with your PHN** for additional tips or advice on different **referral opportunities** to help you manage the high demand for your services.  Based on the analysis of your data, you may want to further explore:   * Identify patients with COPD without smoking status records, via your practice extraction tool (PENCS, Polar, other) to identify all patients who could benefit from your services and better target them. * Your practice may serve patients who display common COPD risk factors. These patients may benefit from smoking and lifestyle education and coaching, but also consider performing a periodical spirometry with them.   + When **performing or wanting to start performing spirometry**, you may consider:     - **Upskilling more members of your practice team** (e.g., nurses) so to potentially free up your GPs' time     - Initiate proactive screening activities whereby at-risk patients are referred, for example, to your practice nurse to receive a spirometry     - Use spirometry not only for diagnostic purposes, but also for monitoring purposes * Your practice serves a large 45-64 cohort.    + Is the service appropriate for this age group?  For example: the **hours of operation** of the service may need to consider that this age cohort may be employed and as such be able to access services outside working hours, over the weekend or via telehealth.   + Are you engaging with your patients through the right channels? A combination of **digital and traditional channels** may be more appropriate and palatable for this group; consider offering online appointments via your website, a third-party website, or an app, sending notifications via SMS or via mail. * If your COPD patients appear to be more acute than the ones in other practices, they may require more interactions with your practice or other services.   If your COPD patients appear to have less interactions with your practice (see GP visits) but are more acute than the ones in other practices (based on the hospitalisation data), they may be an opportunity to interact more with these patients.  Alternatively, your COPD patients may appear to have many interactions with your practice (see GP visits), and potentially be more/less acute than the ones in other practices (based on the hospitalisation data)  Explore **recall systems, telehealth-based follow ups**, **disease management resources or education.** These opportunities may help you support these patients while also helping you manage patient flow into your clinic.   * Investigate the Lumos data and ascertain the reason for admission to hospital and ED, but also use your practice data extraction tool to identify patients with additional co-morbidities. These patients may benefit from additional support.  You may:   + Upskill and **involve the wider practice team** (nurses, admin staff, etc.) in identifying patients for post hospital discharge follow up.   + Investigate the data to understand how long after discharge these patients seem to be visiting your practice (similar to page 18 of your practice report) and make an informed decision on the need for more proactive follow up.   + Initiate a **multidisciplinary management plan** (e.g., shared care plan) Would any COPD patient benefit from a **mental health plan** or other coping advice and could they be referred to an on-site or external psychologist experienced in managing anxiety in respiratory patients?   + **Refer to other support services** (e.g., hydrotherapy, exercise physiologist, etc.) * Consider if referral to **pulmonary rehab services or other outpatient services** is appropriate for your patients. |
| **Implement** |
| * Access tools from your PHN to help you start on a project: [*https://www.nbmphn.com.au/Health-Professionals/Services/COPD*](https://www.nbmphn.com.au/Health-Professionals/Services/COPD) * Contact your General Practice Support Officer: 02 4708 8100 |

**Useful links**

1. [*https://www.nps.org.au/news/the-value-of-spirometry-in-clinical-practice*](https://www.nps.org.au/news/the-value-of-spirometry-in-clinical-practice)
2. [*http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-RespiratoryFunctionTests*](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-RespiratoryFunctionTests)
3. [*https://copdx.org.au/copd-x-plan/key-recommendations-of-the-copd-x-guidelines/*](https://copdx.org.au/copd-x-plan/key-recommendations-of-the-copd-x-guidelines/)
4. [*https://lungfoundation.com.au/resources/?condition=9&user\_category=31*](https://lungfoundation.com.au/resources/?condition=9&user_category=31)
5. [*https://pubmed.ncbi.nlm.nih.gov/25478202/*](https://pubmed.ncbi.nlm.nih.gov/25478202/)
6. [*https://www.racgp.org.au/clinical-resources/clinical-guidelines/handi/conditions/musculoskeletal/pulmonary-rehabilitation-for-copd*](https://www.racgp.org.au/clinical-resources/clinical-guidelines/handi/conditions/musculoskeletal/pulmonary-rehabilitation-for-copd)
7. [*https://www.sjog.org.au/our-locations/hawkesbury-district-health-service/news/news/2018/11/15/03/20/new-pulmonary-rehabilitation-service-in-the-hawkesbury*](https://www.sjog.org.au/our-locations/hawkesbury-district-health-service/news/news/2018/11/15/03/20/new-pulmonary-rehabilitation-service-in-the-hawkesbury)
8. [*https://lungfoundation.com.au/health-professionals/clinical-information/pulmonary-rehabilitation/lungs-in-action/*](https://lungfoundation.com.au/health-professionals/clinical-information/pulmonary-rehabilitation/lungs-in-action/)
9. [*https://www.nbmphn.com.au/Health-Professionals/Services/COPD/COPD-Collaborative*](https://www.nbmphn.com.au/Health-Professionals/Services/COPD/COPD-Collaborative)
10. [*https://www.nbmlhd.health.nsw.gov.au/ArticleDocuments/619/GP\_INtegrated\_COPD\_Respiratory\_Service\_InfoSheet.pdf*](https://www.nbmlhd.health.nsw.gov.au/ArticleDocuments/619/GP_INtegrated_COPD_Respiratory_Service_InfoSheet.pdf)
11. [*http://www.catestonline.org/*](http://www.catestonline.org/)
12. [*http://goldcopd.org/wp-content/uploads/2016/12/wms-GOLD-2017-Pocket-Guide.pdf*](http://goldcopd.org/wp-content/uploads/2016/12/wms-GOLD-2017-Pocket-Guide.pdf)
13. [*https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation*](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation)