Collaborative Commissioning:

Development of a COPD Care Pathway for South Eastern NSW

Summary report

17 February 2023

Contents

Introduction

Context

COPD is the single biggest contributor to the total health services burden due to potentially preventable hospitalisations, and represents the fifth leading cause of death in the region from chronic conditions.[1] For Aboriginal and Torres Strait Islander people, chronic lower respiratory disease is one of the leading causes of death in the region.[2]

Coordinare (the South Eastern NSW Primary Health Network), Illawarra Shoalhaven Local Health District (ISLHD) and Southern NSW Local Health District (SNSWLHD) have partnered together through the Collaborative Commissioning Program to jointly develop and implement a care pathway for Chronic Obstructive Pulmonary Disease (COPD). The care pathway aims to improve outcomes for people with COPD and to improve healthcare system sustainability, including through reducing preventable hospitalisations. The care pathway is also intended to be broadly applicable to other chronic health conditions.

Methodology

The care pathway outlined in this document was developed through a co-design process, which included:

- A literature scan, including the latest COPD-X guidelines developed by the Lung Foundation and Leading Better Value Care NSW Chronic Obstructive Pulmonary Disease Clinical Priorities.
- Development of an initial high-level care pathway
- Five co-design workshops to explore each stage of the care pathway in detail
- An additional three co-design workshops to test the initial care pathway in full, and explore enablers of the care pathway
- Three additional Interviews to enable input from stakeholders unable to attend the workshops.

Workshops were held during November and early December 2022, and included both online and face-to-face sessions. The process was designed to enable a broad range of stakeholders to shape and refine the initial care pathway in line with local needs, capacity and opportunities.

The co-design process engaged the following stakeholder groups:

- Consumers
- General Practitioners
- General practice staff
- Non-GP specialists
- Nurses
- Pharmacy
- Allied health
- LHD staff
- Community health providers
- Aboriginal Health Workers
- Residential Aged Care Facilities

While a broad range of stakeholders participated in the workshops, there were some stakeholder groups that were underrepresented. These included Aboriginal Community Controlled Health Organisations (ACCHOs), and Aboriginal and Torres Strait Islander consumers and/or carers. Ongoing consultation will occur as the opportunities for implementation are further developed as part of the joint development phase of the Collaborative Commissioning Program.

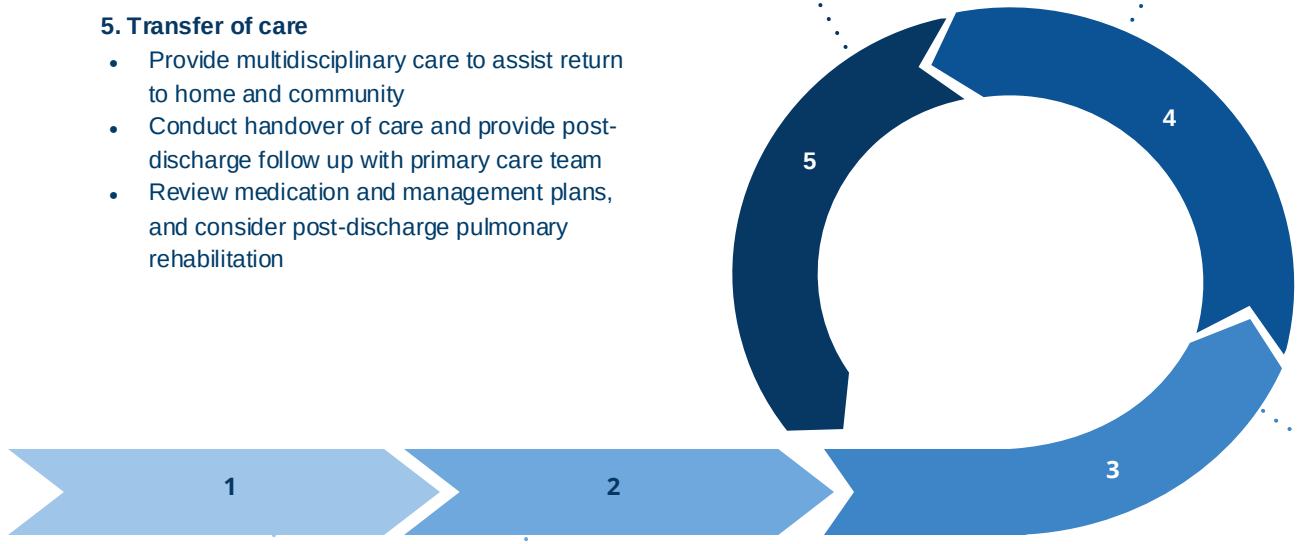
Purpose of this document and next steps

The purpose of this report is to outline the proposed care pathway, which has been developed through a co-design process. It includes recommendations for the Patient Centred Co-commissioning Group (PCCG), to support the next step of the Joint Development Phase. This will include budget and sustainability modelling, through which the pathway will continue to be refined, ahead of the initial feasibility implementation phase. More detailed information on the co-design findings is available in the accompanying *'Summary report on co-design workshops'*.

[1]Dabscheck. E, "COPD-x Australian Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease: 2022 Update." The MedicalJournal of Australia, September 19, 2022. https://www.mja.com.au/journal/2022/217/8/copd-x-australian-guidelines-diagnosis-and-management-chronic-obstructive.
[2]Australian Institute of Health and Welfare (2014) Coronary heart disease and chronic obstructive pulmonary disease in Indigenous Australians, AIHW, Australian Government, accessed 25 November 2022.
[3]. Chronic obstructive pulmonary disease - aci.health.nsw.gov.au (2022) Leading Better Value Care - Chronic obstructive pulmonary disease Clinical priorities. NSW Health. Available at: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0003/508602/COPD-Clinical-Priorities.pdf (Accessed: November 25, 2022).

Overview of the Care Pathway

An overview of the proposed Care Pathway is depicted in the figure below. It illustrates the five pathway stages, and the key objectives of each stage. More detailed information on each pathway stage, including its key features and considerations for change are included in the following section.



5. Transfer of care

- Provide multidisciplinary care to assist return to home and community
- Conduct handover of care and provide post-discharge follow up with primary care team
- Review medication and management plans, and consider post-discharge pulmonary rehabilitation

4. Managing exacerbations

- Support patients to manage exacerbations at home, while recognising the signs and symptoms to escalate care
- Provide safe alternatives to ED and hospital admission where appropriate

3. Care planning and coordination

- Enable effective management of COPD and other comorbidities, including referral to pulmonary rehabilitation where appropriate
- Support self-management and regular review in line with care plan
- Provide support to coordinate services and navigate the system, where needed

1. Awareness, prevention and screening

- Promote community awareness of risk factors and lifestyle changes to prevent COPD
- Support early detection and diagnosis of COPD

2. Diagnosis and early intervention

- Early and accurate diagnosis
- Early engagement with services to encourage timely lifestyle interventions

Recommendations

In order to support the implementation of this care pathway for COPD, and broader chronic conditions in future, there are a number of recommendations that should be considered at each stage of the pathway. These recommendations have been identified through co-design and evidence review, and aim to help address existing service and capability gaps, and increase accessibility of the pathway to consumers across the South Eastern NSW region.

Recommendations will require further consideration and exploration, including assessment of costs and value, through the joint development phase of the Collaborative Commissioning program.

Stage	Recommendations
1. Awareness, prevention and screening	1.1 Encourage health professionals (including allied health, community pharmacy and Practice Nurses) to participate in screening through engagement and capacity building
	1.2 Provide capability building support and/or guidance to general practitioners, allied health and Practice Nurses on how to approach and support consumers to make preventative lifestyle changes
	1.3 Integrate existing exercise and smoking cessation programs into the pathway, alongside raising health professional and consumer awareness of them to encourage access to these programs
	1.4 Support promotional campaigns for signs and symptoms of COPD, in pharmacies and general practice through targeted health messaging
	1.5 Consider opportunities to expand the accessibility of prevention initiatives, including exercise and smoking cessation programs, potentially through transportation support, online options, and/or services outside of business hours
	1.6 Encourage general practices to sign up to the use of Lumos to support the planning, monitoring and evaluation of value based healthcare
2. Diagnosis and early intervention	2.1 Support GPs and Practice Nurses to upskill in diagnosis so that consumers can access affordable diagnostic tests without referral to a non-GP specialist where possible
	2.2 Drive increased access to affordable and timely spirometry tests, including considering provision of free tests through primary care and public outreach services
	2.3 Consider specialist outreach clinics for higher risk populations, particularly for Aboriginal and Torres Strait Islander communities
3. Care planning and coordination	3.1 Upskill and support Practice Nurses to work at ‘top of scope’ and provide care planning and coordination support to consumers, without reliance on having a Chronic Disease Management Plan in place
	3.2 Support general practice to strengthen operating models to maximise Medicare Benefits Schedule (MBS) claiming and enable quality team-based care
	3.3 Facilitate access to pulmonary rehabilitation, including through funding additional services and driving increased awareness of available services
	3.4 Increase availability of community-based exercise classes to encourage self-management and lifestyle changes
	3.5 Integrate care coordination supports into the pathway, including existing LHD and PHN-funded services, and consider commissioning additional care coordination services to fill gaps
	3.6 Drive increased consistency in quality and completion of care plans (COPD Actions Plans and GP Management Plans) and involvement of consumers and carers in the care planning process
	3.7 Encourage consideration of social and emotional wellbeing following diagnosis, and referrals to exercise and social groups as part of care planning

Recommendations

Stage	Recommendations
4. Managing exacerbations	4.1 Drive increased awareness and uptake of Virtually Enhanced Community Care (VeCC) as a key feature of the care pathway, including encouraging increased referrals from primary care
	4.2 Explore models to strengthen access to non-GP specialist services to support management in the community and hospital avoidance. This could include facilitating non-GP specialist outreach in the primary care setting.
	4.3 Consider options to expand the availability of primary care services after hours, including considering leveraging existing services and practitioners (such as pharmacists) to reduce avoidable hospital presentations
	4.4 Explore opportunities to provide out of hours information to consumers, potentially using digital methods and leveraging existing after hours triage services (such as Healthdirect)
5. Transfer of care	5.1 Increase the timeliness of follow up appointments for consumers upon discharge by encouraging appointments to be scheduled while in hospital and encouraging general practices to prioritise consumers being discharged
	5.2 Increase the timeliness of follow up appointments for consumers upon discharge by encouraging general practices to prioritise consumers being discharged
	5.3 Drive early engagement with community care coordination services through inpatient services to encourage early referrals and facilitate transfer of care, leveraging existing LHD services

Stage	Recommendations
5. Transfer of care (cont'd)	5.4 Encourage and facilitate case conferencing, multidisciplinary team meetings and shared care planning between the care team (including primary care and non-GP specialists) to strengthen care handover points
	5.5 Drive increased quality and timeliness of discharge summaries to the primary care team to facilitate care handover, including exploring opportunities to enhance communications through digital improvements
	5.6 Explore options to increase access to respiratory clinics, including considering establishing new clinics to address service gaps. All respiratory clinics should be multidisciplinary including non-GP specialist, hospital and primary care teams to facilitate handover, follow up and hospital avoidance
6. Overall recommendations	6.1 The pathway should be able to be delivered at no additional cost to consumers
	6.2 While focused on COPD initially, the pathway should support the establishment of models of care for other chronic conditions
	6.3 Initiatives should deliver sustainable improvements to the health system in the South Eastern NSW region
	6.4 Promote the use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to measure and understand the impact of the pathway
	6.5 The pathway should aim to increase community access to non-GP specialists through increased outreach clinic capacity, telehealth options and encouraging non-GP specialist workforce to rural areas

Stage 1: Awareness, prevention and screening

Objectives

The objectives of this stage are to:

- Promote community awareness of COPD risk factors
- Encourage lifestyle changes to prevent COPD
- Support early detection and diagnosis of COPD.

Key Features

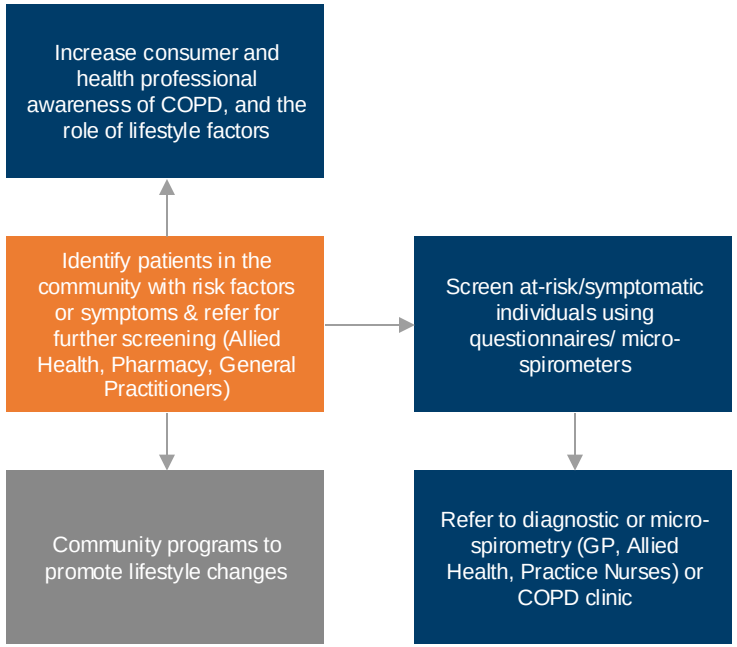
Co-design and the evidence base have emphasised the following activities as the ideal key features of this stage of the care pathway for COPD:

- Promoting consumer awareness of COPD and its risk factors through targeted health promotion campaigns - messaging should be tailored for different cohorts, including culturally and linguistically diverse groups, lower socioeconomic cohorts and younger people (particularly in relation to vaping)
- Promoting health professional awareness of COPD risk factors and the local availability of prevention programs, through targeted messaging with a focus on non-GP specialists, Practice Nurses and Allied Health
- Identifying patients with risk factors or symptoms in the community and in residential aged care, and conducting screening using questionnaires, thorough histories and/or micro-spirometry (followed by referrals for spirometry where appropriate)
- Supporting consumers to make necessary lifestyle changes, through smoking cessation (including e-cigarette) initiatives, exercise programs such as Healthy and Active for Life, and programs which engage carers and families to facilitate behaviour change.

Additional learnings from co-design

- There is a perceived stigma around COPD, with consumers often feeling they may be 'blamed' for having COPD (even for non-smokers)
- Encouraging behaviour change among consumers is often a challenge for health professionals
- Access to prevention initiatives including exercise and smoking cessation programs may be limited or costly for consumers

Flowchart: Key activities at Stage 1



Target population: General public, with a focus on individuals living at home or in aged care facilities with risk factors and/or symptoms of COPD.

- Enhanced service / activity
- New service / activity
- Existing service / activity
- ····· Stages occur simultaneously

Stage 2: Diagnosis and early intervention

Objectives

The objectives of this stage are to:

- Support timely and accurate diagnosis of COPD in primary care
- Reduce misdiagnosed or undiagnosed cases of COPD
- Ensure that consumers receive the care they need at the right time, with early involvement of multidisciplinary teams as required.

Key Features

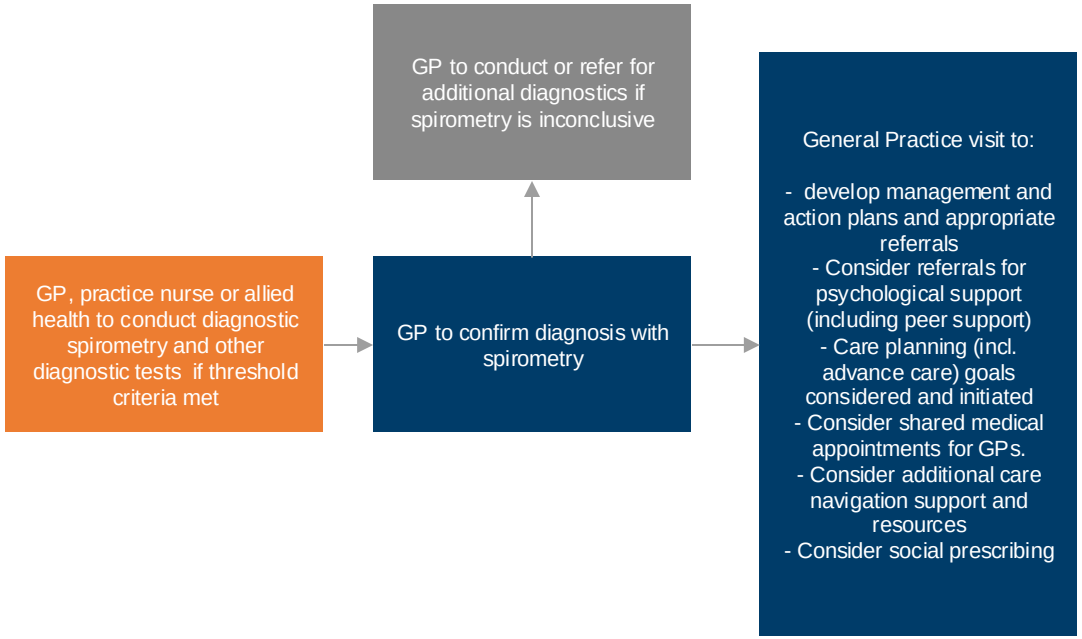
Co-design and the evidence base have emphasised the following activities as the ideal key features of this stage of the care pathway for COPD:

- Confirming COPD diagnosis in primary care using spirometry conducted by a health professional with appropriate spirometry training (Practice Nurses, GPs, exercise physiologists, occupational therapists or physiotherapists)
- Conducting additional diagnostics or referral to a non-GP specialist if spirometry results are inconclusive (for example, as a result of comorbidities with similar symptoms which may make diagnosis complex)
- Considering the need for broader wellbeing or psychosocial supports for consumers and carers at the point of initial diagnosis
- Developing a GP Management Plan and COPD action plan as soon as possible to support multidisciplinary care and early engagement with services and other lifestyle interventions.

Additional learnings from co-design

- Capability, confidence and access to equipment are barriers to use of spirometry and early diagnosis in primary care - it was noted that this was particularly the case following COVID-19
- There is limited access to affordable diagnostic services and significant wait times for diagnosis from non-GP specialists (6+ months)
- There is limited access to outreach non-GP specialists and diagnostic services across the region for complex or severe cases

Flowchart: Key activities at Stage 2



Target population: Individuals who have been screened and referred for diagnostic spirometry, requiring intervention.

- Enhanced service / activity
- New service / activity
- Existing service / activity
- Stages occur simultaneously

Stage 3: Care planning and coordination

Objectives

The objectives of this stage are to:

- Enable effective ongoing management of COPD and other comorbidities
- Provide holistic care planning
- Coordinate care for consumers who require support to access services
- Support self-management with regular review

Key Features

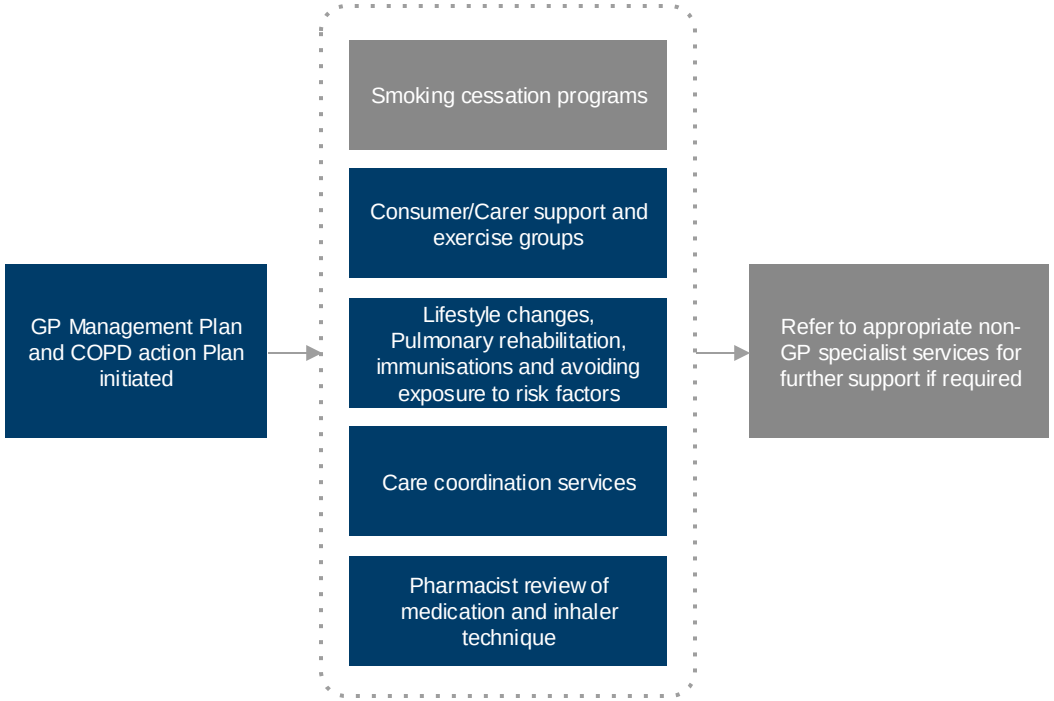
Co-design and the evidence base have emphasised the following activities as the ideal key features of this stage of the care pathway for COPD:

- Care planning and coordination provided via general practice with General Practice Management Plan and/or COPD Action Plan, with regular follow up
- Supporting consumers to coordinate access to programs and services (e.g smoking cessation programs, consumer/carer supports, exercise and nutrition programs and immunisations)
- Providing pulmonary rehabilitation that suits the needs and preferences of the consumer
- Providing access to affordable and convenient community-based exercise groups (such as Lungs in Action) - consumers emphasised the importance of options being affordable and community-based
- Reviewing medicine management and inhaler technique (by pharmacists)
- Facilitating access to consumer and carer support groups as required
- Referring to appropriate non-GP specialists as required.

Additional learnings from co-design

- There is inconsistency in the completion and quality of care plans (including GP Management Plans and COPD Action Plans) and how well they are understood and used by consumers
- Access to pulmonary rehabilitation and non-GP specialist services is challenging, particularly in rural areas - barriers include availability of services and long wait times, cost and transport
- Specific care coordination support is available for some consumers through PHN and LHD-funded services - it will be important to increase awareness of these services, and consider supplementing them

Flowchart: Key activities at Stage 3



Target population: Individuals who have been diagnosed with COPD and given a management and action plan to reduce the progression of disease and limit hospitalisation.

- Enhanced service / activity
- New service / activity
- Existing service / activity
- ····· Stages occur simultaneously

Stage 4: Managing exacerbations

Objectives

The objectives of this stage are to:

- Support patients to manage exacerbations at home, while recognising the signs and symptoms to escalate care when required
- Provide safe alternatives to ED and hospital admission where appropriate.

Key Features

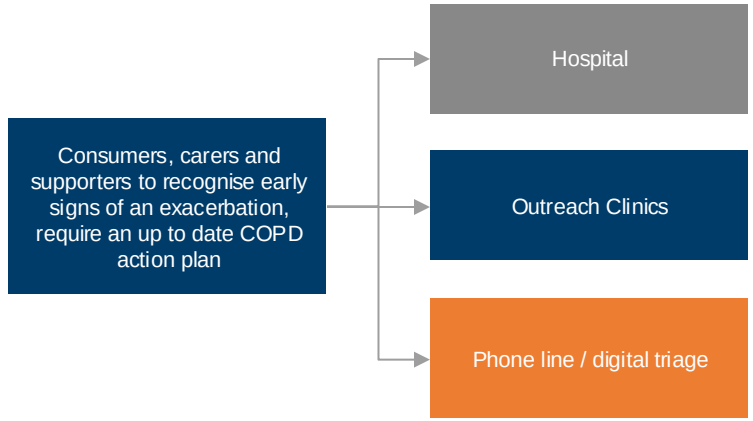
Co-design and the evidence base have emphasised the following activities as the ideal key features of this stage of the care pathway for COPD:

- COPD action plans / GP management plans should be regularly reviewed by GPs or Practice Nurses to support consumers to manage exacerbations at home when possible.
- Providing alternatives to hospital admission in the event that care needs to be escalated during an exacerbation - this may include:
  - Hospital-based COPD clinics (ISLHD) to assist with Action Plans, medication use and access to pulmonary rehabilitation programs.
  - Lung Rehabilitation services (SNLHD) can assist with preventing and managing flare ups
- Primary care may consider referral to the VeCC service or alternative care coordination and management support services
- Following an exacerbation, consumers should generally be referred to pulmonary rehabilitation and care coordination support as soon as acute instability has resolved.

Additional learnings from co-design

- It is important for consumers to receive appropriate prescriptions (including antibiotic and prednisone prescriptions) for use in case of an event
- Availability of after hours services is a challenge, with the hospital / emergency department generally the only option for escalation

Flowchart: Key activities at Stage 4



Target population: Individuals with a diagnosis of COPD and are prone to or experiencing exacerbations whilst living at home.

- Enhanced service / activity
- New service / activity
- Existing service / activity
- ····· Stages occur simultaneously

Stage 5: Transfer of care

Objectives

The objectives of this stage are to:

- Provide multidisciplinary care to assist return to home and community
- Conduct handover of care and provide post-discharge follow up with primary care team
- Review medication and management plans, and consider post-discharge pulmonary rehabilitation

Key features

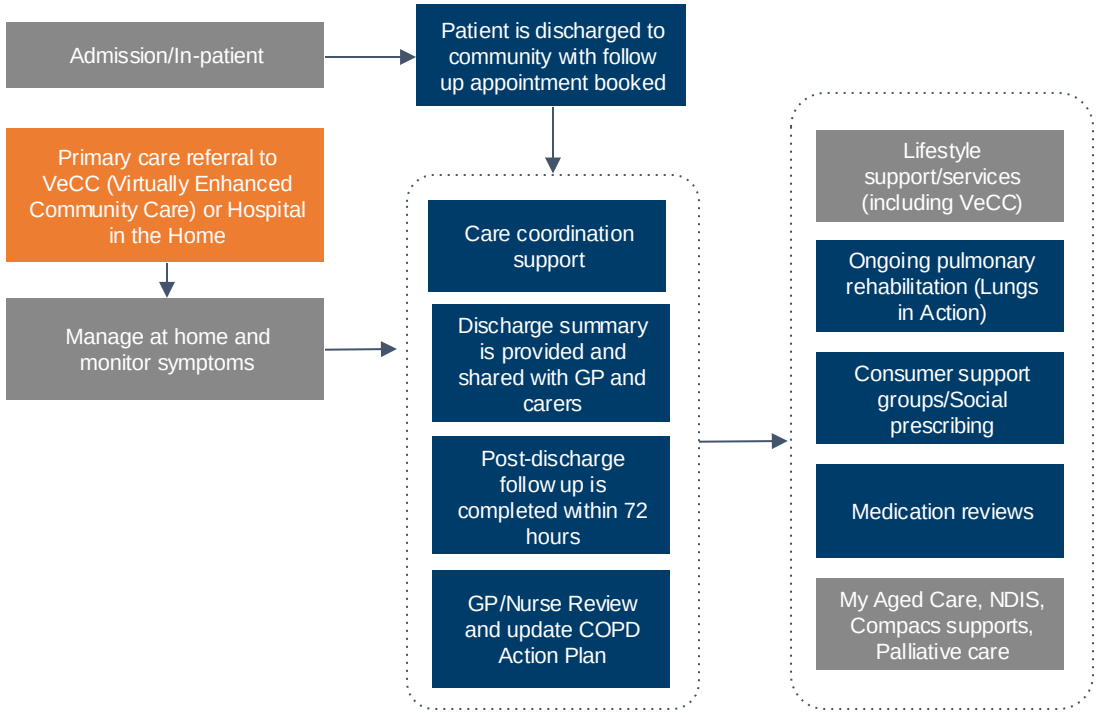
Co-design and the evidence base have emphasised the following activities as the ideal key features of this stage of the care pathway for COPD:

- Providing a comprehensive and timely summary upon discharge to support handover of care
- Providing a follow up GP visit with consumers within 72 hours of discharge
- Providing hospital in-reach services to encourage self-management and link consumers to services prior to discharge
- Updating and reviewing COPD Action Plans, reviewing medications and usage
- Referring consumers to pulmonary rehabilitation services to continue treatment in line with their care plan
- Considering the need for social prescribing and consumer groups to address broader wellbeing needs of consumers and carers
- Referring to lifestyle supports and programs to assist with ongoing maintenance and reduce likelihood of readmission.
- Considering independence needs such as NDIS, My Aged Care, ComPacks and/or palliative care

Additional learnings from co-design

- Discharge summaries are not always shared with the primary care team within 24 hours of discharge, and the quality of summaries varies
- While post-discharge follow up and reviews are critical, this does not always occur. This may be a result of barriers to accessing GPs for a follow up appointment, including the availability of appointments and financial barriers for some consumers

Flowchart: Key activities at Stage 5



Target population: Individuals Individuals who have been diagnosed with COPD and discharged from hospital.

- Enhanced service / activity
- New service / activity
- Existing service / activity
- Stages occur simultaneously