AB1039: Demonstration of a combination of patient management software for COPD (DiseaseControl) and implementation support (*Prim Care Respir* 2002 **11**(2) 68)

Author(s): P. Pijman, Medical Advisor Diagnosis4Health, The Netherlands

In The Netherlands (local) experiments to improve the healthcare system have been numerous, but most of these experiments have remained local, due either to the original customisation or to its complexity. Therefore the distribution of improvements has been poor and patchy and the effects of the learning curve have been limited.

Following a number of pilot experiments in many indications during 1999-2001, Diagnosis4Health introduced in early 2002 the latest release of DiseaseControl, its patient management software supporting transmural care for COPD patients. Accompanying the patient management software Diagnosis4Health provides practice organisation and implementation support. This comprehensive package provides the following features:

1. Implementation of a protocolised electronic COPD patient record (DiseaseControl© by Diagnosis4Health), shared between GP and pulmonologist, enabling TeleAdvice by the pulmonologist
2. COPD care - comprised of diagnosis, treatment and follow-up - based upon national clinical COPD guidelines (NHG, LTA)
3. Implementation of a categorical COPD surgery in the participating GP practices to concentrate all routine care, enabling the delegation of this routine care to the practice assistant or nurse practitioner

This approach yields benefits for all stakeholders:

1. Better care for patients resulting in preservation of pulmonary function and quality of life
2. Better quality of care by the GP without the burden of elevated work pressure
3. More efficient and effective practice organisation
4. Well-defined responsibility and contribution by the practice assistant or nurse practitioner
5. Mutually beneficial co-operation between GP and pulmonologists

In summary this approach to the management of COPD delivers:

1. Comprehensive package of patient management software plus its successful implementation
2. Controlled delegation from GP of routine care, including spirometry, to practice assistant or nurse practitioner
3. Implementation of the best possible care through the execution of the national guidelines
4. Supervision and support by the pulmonologist through electronic TeleAdvice
5. Communication from crucial COPD data into the GP's clinical system
6. Mirror information and benchmarking for self-education and improvements

The COPD software and its implementation will be presented, demonstrated and discussed.

KB040: A pilot study to evaluate the feasibility of undertaking an acute asthma professional development plan in three different primary care settings (*Prim Care Respir* 2002 **11**(2) 68)

Author(s): Pinnock ¹, Hoskins ², Smith ², Weller ³, Price ¹; ¹University of Aberdeen, Department of General Practice Primary Care, Foresterhill Health Centre, Aberdeen UK; ²University of Dundee, Tayside Centre for General Practice, Dundee, UK; ³National Respiratory Training Centre, The Athenaeum, 10 Church Street, Warwick U

Background Asthma attacks are common, potentially fatal acute medical emergencies. The General Practice Airways Group (GPIAG) designed a Professional Development Plan (PDP) to promote the evidence-based management of acute asthma in line with current national Guidelines.

Methods 4 GP practices, 2 Out-of-Hours services and 2 nurse-run Walk-In Centres were recruited to this pilot study. Participant identified all attacks occurring to asthmatics (excluding children <5yrs) over a 3-month period. Data was collected from the patient's written/computer records and a data sheet completed for each episode. Organisational information was also collected about the centres. Data was analysed and fed back to the centres before they attended educational sessions at the GPIAG Congress 2001. Six months after the programme organisation and clinical practice was reassessed.

Results 7 centres provided organisational data and baseline data on 160 incidents (47% male). Contrary to recommendations 2(29%) centres did not have oxygen available, 4(57%) had no soluble prednisolone, 10% of consulting rooms did not have a peak flow meter and 4(57%) centres did not have a management protocol. A peak flow was recorded in 77(48%) and compared with best/predicted in 33(21%) of episodes. 48(30%) were given emergency bronchodilation, 61(38%) were given or prescribed systemic steroids and 15(9%) were referred to hospital. Despite illness preventing 2 of the delegates attending the Congress, all 7 of the centres are intending to participate in the follow up audit.

Conclusion This pilot study has provided useful experience for informing the future development of PDPs to improve the management of acute asthma. Baseline data suggest that recommended management guidelines are not being adhered to and establishes the need for an educational programme. The programme was well received by the GP practices, Out of Hours services and Walk In Centres. The audit tools proved to be practical within all three settings.

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