A New Model for Respiratory Care in General Practice: The CATS model for respiratory car

Woodforde Christophe
Peelhouse Lane Surgery, Widnes, Cheshir

Prim Care Respir
2001 10(3 3

Conflict of Interest
None declare

We have proposed a simple yet effective model fo the provision of respiratory care based around th current British Thoracic Society (BTS) guidelines an the current READ codes available in current medica software. This model has been termed the Compute Assisted Asthma Tracking System (CAATS) and i easily implemented in most computer systems. Thi model permits easy monitoring and subsequent audi of the provision of respiratory care in genera practice. In our practice all respiratory patients ar reviewed in the generic Chest Clinic. The mode comprises of five simple steps of care

1) **Step 1 - Recognitio**
- written invitations for patients to attend the Chest Clinic
- opportunistic health screening
- monitoring of repeat inhaler prescribing
- spirometer screening of patient with smoking histories
- monitoring of hospital discharge summaries

2) **Step 2 - Registratio**
- Attends for formal assessment by practice nurse/GP
- Defaults assessment
- Standardised medical template' collecting all the relevant asthma/COPD) data is completed;
- Therapy is evaluated; Vaccinations are offered;
- ;Written Action Management Plan (AMP) is devised in conjunction with the patient
-)Notes and computer files we labelled:(READ Codes
)Asthma stage 1 (8794)Asthma stage 2 (8795 Asthma stage 3 (8796
)Asthma stage 4 (8797)Asthma stage 5 (8798)No longer asthmatic stage 0 (8793
  Mild COPD (H36))Moderate COPD (H37 Severe COPD (H38
- Inhalers are added to repeat prescribing (so minimising possible errors in future prescribing an)permitting subsequent audit .
- A review date is agreed, documented and logged in the computer

3) **Step 3 - Revie**
- systematic review of sympto control, peak-flow/spirometry, trigger factor avoidanc
- adjustment of inhaled/oral therapie
- the setting of a further date for reassessmen

4) **Step 4 - Reassessment**
- systematic review of sympto control, peak-flow/spirometry, trigger factor avoidanc
- adjustment of inhaled/oral therapie
- the setting of a further date for further reassessmen

5) **Step 5 - Referra**
- Patients may require referral to other agencies at any stage of the process e.g. GP, Hospital OPD, Rapid Response Respiratory team (RRRT), Hospital (as an emergency), Rescue unit or Pulmonary rehabilitation

Criteria for referral are those proposed by the BTS

6) **Rescue Uni**
This is the 'blue light' which is designe Do standardise emergency asthma/COP management. It comprises:
- A fully operational nebuliser on stand-by accompanied by laminated action cards on emergency asthma/COPD management
- Dedicated referral letters and stationery
- Appointment cards for subsequent revie

Reference Unit
This is a database of information held in ring binder file for all practice staff to refe to when required. It includes copies of
-)Current BTS guidelines (Asthma/COPD
- Local respiratory guideline
- The practice formular

8) **Recall Unit**
This is a system to 'chase' patient defaulting their initial, or follow-u appointments
Their progress is tracked through curren READ code

The above system is designed to be easil implemented in most modern practices an can be adapted to run with practices based o computer only' record systems or 'combine computer/ paper' record systems

By the use of established READ codes practices can implement effective respirator data registers with the aid of establishe medical computer software. Respirator patients can be easily identified and targete so that clinical care and standards bot improve in practice

Over the two years that we have been usin the system, we have noticed a dramatic fall i the number of acute exacerbations. We hav established an effective and dynami respiratory register, reduced the ove prescribing of β-2-agonists and have bee dble to target the more challenging an elusive of our respiratory patients. It has bee adopted as the system of choice in th AIM2000 initiative

The above system may be of benefit to man practices managing respiratory care. With th advent of clinical governance the abov system allows the audit of performanc related data with regard to respirator practice. Local interventions can be easil defined, implemented, evaluated an improved as necessary

The above system offers a relatively easy an cheap way of practises modernising thei approach to respiratory care in a cash strapped and time-limited modern Nationa Health Service

READ Codes Use
90J4 asthma monitor 1st letter, 68c3 asthma screening, 90J7 asthma monitor verbal invite 68M spirometric screening, - emergency admission- asthma, 6631- initial respirator Assessment, 90J3 asthma monitor offer default, 6632 follow-up respiratory assessment, 90J Asthma monitoring check done, H33z1 Asthma NOS, H33z1 asthma attack, 90JS asthm monitor 2nd letter, 90J6 asthma monitor 3rd letter, 90J7 asthma monitor verbal invite, 90J8 asthma monitor phone invite, 90J2 refuses asthma monitoring.