

LETTER TO THE EDITOR

COPD phone helplines: too soon to call?

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Dear Sir,

We read with interest the report by Hurst *et al.* on their 24-hour Telephone Support Service for 'high risk' COPD patients in the most recent issue of the *PCRJ*.¹ As the authors note, there is very little data currently available to inform decisions by policymakers and clinicians considering introduction of an acute telephone helpline for COPD patients.

Hurst *et al.* attempted to demonstrate a reduction in hospital admissions in users of their phone service.¹ They compared the admission rates of these callers during the study period with the admission rate for the same patients in the year before enrolment. While the authors stressed that the audit was not designed to assess a change in admissions, it remains difficult to assess the validity of the reduction that was reported. Admissions of callers to the helpline were reported to have fallen by 37% from the previous year, but comparable data was not given for the group of patients who did not call the helpline. We think that this information would significantly aid interpretation of the results.

We know from our own experience that COPD patients can be admitted very frequently, sometimes up to 30 times in one year. The number of admissions per patient was not reported in this study. Data on the distribution of the reduction in admissions would help the reader to understand whether the helpline was successful in reducing admissions across the board, or was successful in reducing admissions in one or two very frequently admitted patients.

Finally, we question the suggestion by the authors that services such as theirs may not be cost-effective. It seems to us to be too early a stage at which to draw this conclusion. If the reported reduction in admissions was indeed valid, a reduction of 25 admissions would translate to a saving of £43,300 for the 74 people in the study over the 18-month study period (assuming a mean cost per uncomplicated COPD admission of £1,752²). An indication of savings of this size would surely benefit from further investigation.

The telephone helpline was only one part of a complex intervention that included optimisation of treatment and patient education. It may well be that the other elements of the intervention accounted for the reported reduction in admissions. This might be illustrated by a commensurate reduction in admissions in patients who did not contact the helpline.

This study has provided valuable insight into an area which is at present under-reported. The chronic nature of COPD, combined with high hospital readmission rates, make the disease a prime target for home intervention. More data is required to demonstrate whether Telephone Support Services do indeed reduce the frequency of hospitalisations.

Conflict of interest declaration

None to declare.

References

1. Hurst JR, Fitzgerald-Khan F, Quint JK *et al.* Use and utility of a 24-hour Telephone Support Service for 'high risk' patients with COPD. *Prim Care Resp J* 2010; **19**(3):260-5. <http://dx.doi.org/10.4104/pcrj.2010.00035>
2. Dr Foster Intelligence. COPD. 2010. <http://www.doctorfoster.co.uk/services/copd.asp>

Authors' reply

We thank Thornton and White for their interest¹ in our study² and are delighted to provide some clarification.

First, we must re-emphasise that our study was not designed to show a reduction in hospitalisation in association with a complex intervention based around 24-hour telephone support. The report was designed to highlight the use of such a service, and definitive information on the ability of such programmes to result in reduced hospital admission would require a randomised trial.

Second, as described, the analysis relating to a reduction in hospital bed days was not restricted solely to those patients who used the service, but included data on all patients who completed one year of data collection on the service.

Finally, our comments on cost-effectiveness were made in reference to 24-hour support services. Very few calls were made overnight, and even in those that were it was only possible to divert one in three from further emergency assessment. We maintain that a local service is unlikely to be cost-effective when 24-hour cover is included.

References

1. Thornton H, White P. COPD phone helplines: too soon to call? *Prim Care Resp J* 2010;**19**:406-07. <http://dx.doi.org/10.4104/pcrj.2010.00072>
2. Hurst JR, Fitzgerald-Khan F, Quint JK *et al.* Use and utility of a 24-hour Telephone Support Service for 'high risk' patients with COPD. *Prim Care Resp J* 2010;**19**(3):260-265. <http://dx.doi.org/10.4104/pcrj.2010.00035>

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