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IS001

Pilot Project-Prolanis asthma on implementation of Prolanis as an excellent program in the management of asthma for participants of BPJS health in primary care

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Brief outline of context: The Prolanis is a health care system with the characteristics a self-management support, a proactive approach, structured-multilevel approach, and an integrated health care system is implemented in harmony involving each level in health care system in the context of health care for participants BPJS health to attain optimal quality of life by health care cost which effectively and efficiently.

Brief outline of what change you planned to make: Restructuring Prolanis and redesign program, with new concepts focus on primary care and self-care by working more productively with patients and their families. Furthermore, hopefully to be a formal structure in Indonesia.

Assessment of existing situation and analysis of its causes: Before implementing Prolanis, management of Asthma patients was inefficient and ineffective, low of patient's compliance, lack of socialization and dissemination, expensive treatment, out of pocket payment, socioeconomic problems, exposure to risk factors, comorbidities, and located far from of Hospital. It becomes burden for patients and their families, and the Healthcare because it spends a large funds, and also become burden for BPJS health because there are many referral cases.

Strategy for change: Prolanis implementation is the obligation of each level in the health service and primary care is a leading sector. Spirit, philosophy, and new concepts of Prolanis can be seen and described by "Vortex Of Prolanis", used "Strategy For Change" namely by engaging and empowering patient and their family, strong leadership and the establishment of a shared vision and mission furthermore, conducting "Steps Of Implementation" which comprehensively, consistently, and sustainable.

Measurement of improvement: Percentage of patients; who participated; who followed all the Prolanis activities regularly; who understand and avoid their risk factors; the development level of asthma symptom control; degree of obstruction (FEV₁); an exacerbation and was referred during joining Prolanis and the level of patient satisfaction.

Effects of change: The doctors-patients relationship be better, improved patient compliance, all expenses covered by BPJS health, an exacerbation greatly decreased, patients who referred to the hospital because exacerbation the last 3 month was nothing. The initial response to the project has indicated that Prolanis Asthma was significantly improve the quality of Asthma treatment.

Lessons learnt: Prolanis Asthma provide benefits and advantages in the management of Asthma, ensuring continuity of Asthma care, and a concrete manifestation from Function of Primary Care as a Gate Keeper.

Message for others: Let's continue to improve themselves and develop the new program to improve primary health care as a form of our devotion especially for management of asthma.

Declaration of interest: None

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IS002

Skilled manpower assistance for management of chronic respiratory diseases (CRD): Does India really need it?Komalkirti Apte¹, Madhuragauri Shevade¹, Sapna Madas¹,
Sundeep Salvi¹¹Chest Research Foundation, Pune, India

Brief outline of context: India has a high burden of chronic respiratory diseases (CRD). Physicians in practice see a large number of patients daily for whom they can give little time.

Brief outline of what change you planned to make: In this pilot study we aimed to identify the need and utility of additional skilled healthcare resource assistance for the proper management of CRD in India. Based on the results of this study, we aim to design and implement a specialized course to train a second tier of healthcare workers.

Assessment of existing situation and analysis of its causes: 1784 General Practitioners (GPs), Pulmonologists (Ps), Internists (Is) and Pediatricians (Peds) from our database were invited via email to participate in this observational study from across India. The study questionnaire consisted of doctor demographics, burden of CRD, time spent on each patient and questions assessing the need and utility of additional skilled assistance. 84 doctors consented and completed the study questionnaire. Simple descriptive analysis was performed. The results are displayed in Table 1.

Strategy for change: We have now designed a 2 month specialized course which will involve lecture sessions, extensive hands-on training, discussions, pre- and post- course assessments and an internship. We have attempted to involve the Indian government in this process and this is currently under discussion.

Measurement of improvement: Pre and post assessment tests will help evaluate the knowledge and skill sets acquired by the candidates of this course. The physician under whom they will do their internship will also help assess the change in their practice with acquisition of this new trained and skilled second tier of healthcare providers.

Effects of change: With appropriate implementation, the burden of primary care physicians may be reduced significantly and yet the quality of healthcare will not suffer. Patients of CRD will ultimately benefit as they will receive additional healthcare attention. This will enable a better health and socio-economic outcome for the patients as well as for the country.

Lessons learnt: A heavy workload of CRD patients and insufficient time and manpower necessitates a second tier of skilled healthcare providers to bridge this gap. There is a need to develop chronic respiratory disease managers in India who can contribute significantly to improving quality of patient care in India.

Message for others: Similar studies conducted in countries of the IPCRG network will help understand the healthcare outcomes and socio-economic implications of CRD across these countries. Countries not doing very well on this front will get ideas and suggestions for implementation from countries doing better with their CRD patients.

Declaration of interest: None

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[IS002]

Table 1. Overview of the burden of chronic respiratory diseases and the healthcare provision abilities in India

	GPs (n = 19)	Is (n = 35)	Ps (n = 23)	Peds (n = 7)
Number of CRD patients seen per doctor per month	972 ± 614	922 ± 594	541 ± 664	2273 ± 992
Average time spent on each patient (mins)	10 ± 4.1	9.5 ± 5.7	9.5 ± 7.4	5 ± 0
Number of patients seen/month				
Obstructive Airway Diseases	80 ± 104	53 ± 65	139 ± 230	15 ± 7
Allergic Rhinitis	68 ± 70	43 ± 46	121 ± 172	50 ± 52
Tuberculosis	51 ± 130	18 ± 32	167 ± 178	17 ± 26
Others	9 ± 14	10 ± 11	24 ± 75	3 ± 2
Assistance available for inhaler training (nurses, pharmacists, etc.)	31.6%	28.6%	43.5%	14.3%
Need to have assistance (% who said yes)	84.2%	88.6%	91.3%	85.7%

IS003

Introducing the "6 minute cycle: for emergency administration of oxygen to East of England Ambulance Trust

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Brief outline of context: There is recognition that inappropriate oxygen for patients with COPD may be responsible for 2-4000 deaths (National COPD Audit 2003). An audit of emergency oxygen administration by ambulance and emergency department staff identified low recognition of COPD diagnoses (58%) by ambulance personnel. Consequently 73% were treated with inappropriate high flow oxygen (>4L/min) (Hale KE et al Emerg Med J. 2008. National emergency oxygen guidelines recommend the use of controlled oxygen for certain populations (BTS 2008)). With limited guidance for emergency personnel an assessment tool was implemented by South East Coast Ambulance Trust demonstrating a 26% reduction in acute NIV rates. Our aim was to further develop and implement this model.

Brief outline of what change you planned to make: Based on previous work, the "6 minute cycle" (6MC), a continuous loop assessment tool using pulse oximetry and targeted oxygen administration, was further developed along with "top tips" guidance to improve pre-hospital management & outcomes across East of England.

Assessment of existing situation and analysis of its causes: EEAST recognised emergency oxygen administration required review and identified the 6MC as a means to enable emergency staff to safely administer oxygen, providing a simple aide memoire to identify patients at risk.

Strategy for change: The 6MC and top tips were positively received by senior EEAST clinicians and managers in conjunction with a need to review oxygen administration. A decision was made to implement the 6MC across EEAST starting with an educational project supported by EoERSCN. The outcomes audited to include: % of patients where 6MC used, conveyance rate, number of patients requiring acute NIV, paramedics' satisfaction with the guidance.

Measurement of improvement: Outcome measures assessed: conveyance rates, NIV rates, paramedic satisfaction with the process. A small pilot testing its feasibility demonstrated a small reduction in conveyance rates to hospital for patients with breathing problems. Additionally, positive feedback was received by EEAST staff.

Effects of change: The 6MC and top tips were positively received by senior EEAST clinicians and manager. The process to implement the 6MC began with an educational project supported by EoERSCN and written clinical educational support tools. The supporting documentation is to be distributed to Primary Care, ED's and secondary care oxygen champions.

Lessons learnt: Sharing good practice across Trust staff and geographical boundaries is key to effective change. Clinical leadership, enthusiasm and good team work to support change within a large organisation are essential. **Message for others:** This project was possible owing to role of the EoERSCN with the ability and flexibility to work on the project with clinical authority and administrative resources.

Declaration of interest: None

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IS004

Improving the management of patients' assigned COPD treatment (IMPACT): A pilot study to evaluate the REG COPD exacerbation risk algorithm

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Brief outline of context: North Norfolk Clinical Commissioning Group (NNCCG) comprises of 19 GP surgeries and has seen an increase in COPD admissions of 30% 2012-13 and 2013-14 (figures Dr Foster database). The change in the way Healthcare is delivered in England as a result of the 2012 Health & Social Care Act means that CCG's are under increasing financial pressure. In addition to reducing emergency hospital admissions, reducing prescribing costs is a priority. The CCG has a large proportion of COPD admissions of less than 48 hours and many practices have ICS/LABA combinations as the highest single drug cost. The area is rural elderly and covers approximately 168,000 patients.

Brief outline of what change you planned to make: A 7 point risk tool (designed by Respiratory Effectiveness Group) using data extracted by Optimum Patient Care (OPC) from GP clinical systems was used to identify patients at risk from two or more COPD exacerbations and those on high dose ICS who may be suitable for stepping down or stopping ICS therapy. Practices were taught how to use the spreadsheets provided by OPC to maximise the benefits and produce a list of patients at risk of 2 or more exacerbations and additionally those who are at low risk.

Strategy for change: 15/19 practices took part and mentored clinics were held with either DF, VG, or another nurse specialist to show practices how to manage high risk patients and how to approach an ICS step down for low risk patients. A unified approach across the CCG was encouraged with standardised documents namely self-management plans, step down guidance & high risk patient management.

Measurement of improvement: Q2-3 2016 further data extraction will take place to evaluate impact on exacerbations and prescribing. Patient feedback was used to influence future services.

Effects of change: 1.12.2015 an additional educational meeting was held to continue the project to which GPs, Nurses (Primary & Community Care) and dispensary staff were invited. Feedback from the process was positive, practices have agreed to co-operate: and we have agreed to develop a CCG wide respiratory template for GP computer systems to standardise care.

Lessons learnt: Considerable variation in nurse standards was seen across the CCG during delivery of the mentored clinics with some excellent care & somewhere training needs were identified, a process has been set in place to help.

Message for others: The IMPACT work has produced benefits for the CCG, for patients and for practices and has galvanised interest in respiratory care.

Declaration of interest: AZ, GSK, NAPP, Novartis, have been involved in supporting the project.

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[IS004]

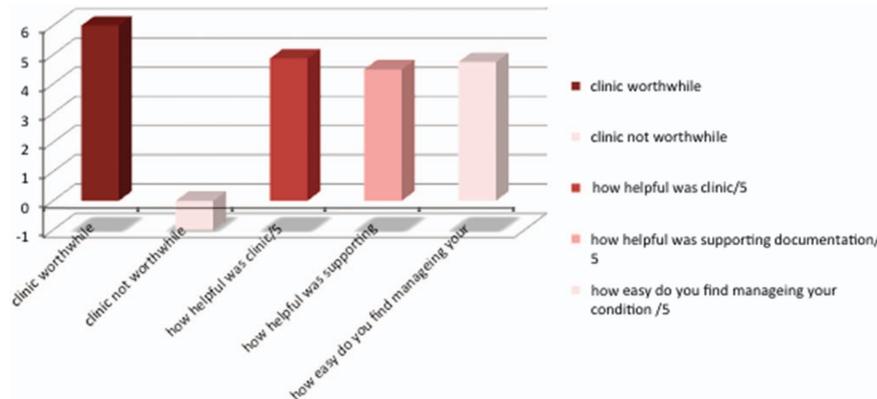


Figure 1. Patients views of their mentored clinics (max score=5).

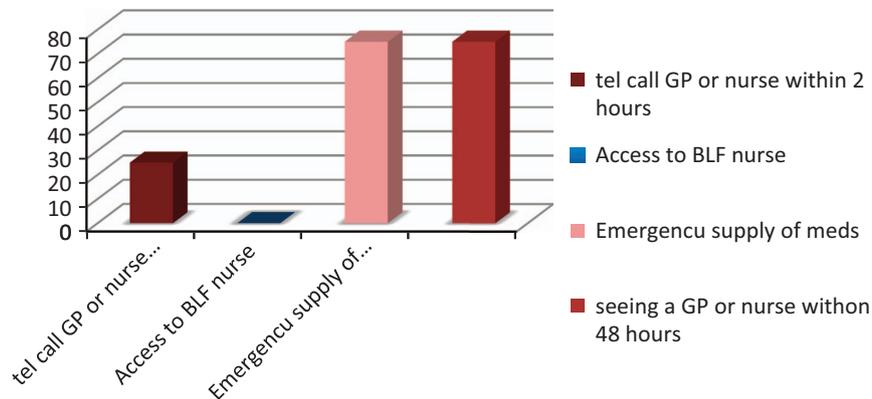


Figure 2. Patients preferences for HCP access when unwell %.

IS005

The potential impact of a financial incentive on GP prescribing and patient use of inhaled corticosteroids for asthma

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Brief outline of context: Clinical practice guidelines recommend use of low-dose inhaled corticosteroids (ICS) preventers for most patients with asthma, with ICS/long-acting β 2-agonist (LABA) only recommended if good asthma control is not achieved. However, most preventer prescribing in Australia is for ICS/LABA. In Australia, the cost of ICS/LABA is higher than low-dose ICS for both government and patients.

Brief outline of what change you planned to make: This qualitative study examined: factors that influenced patients' purchase and use of preventers; and the feasibility and acceptability to patients and GPs of financial incentives to encourage the prescribing and use of low-dose ICS.

Assessment of existing situation and analysis of its causes: ICS are intended for regular use but currently only 18% of Australians who are dispensed ICS have a dispensing rate consistent with daily use. Overall, 81% of ICS-containing medications are dispensed as ICS/LABA. The causes are likely to be multifactorial but include prescriber perceptions of superiority of ICS/LABA.

Strategy for change: This study constitutes one component of a multi-method investigation that includes a discrete choice experiment, economic modelling and stakeholder consultation. In this first phase, semi-structured telephone and face-to-face interviews were conducted with a purposive sample of patients with asthma/carers ($n=45$) and GPs ($n=15$). Data were analysed to identify themes and intersections between themes.

Measurement of improvement: The project will identify the key influences on asthma preventer prescribing and use, and investigate financial incentives for prescribing and use of lower cost medicines that are acceptable to patients and stakeholders.

Effects of change: The intended effect of the financial incentive would be to encourage more appropriate prescribing and regular use of ICS.

Lessons learnt: Patients did not regard themselves as primary decision-makers about preventer choice, as GPs played a crucial 'gatekeeper' role for prescriptions. GPs reported poor access to information about medication costs and seldom initiated discussions of costs with patients. Effectiveness of preventer medicines was the stated priority for patients and GPs. Cost was important to users of multiple medicines and low income-earners.

Message for others: The impact of existing cost incentives on prescribing could be enhanced by improving GP awareness of patient co-payments. This could improve the quality of exchanges between patients and GPs and may encourage patients to accept ICS-only inhalers. Patients and GPs require evidence and reassurance from reliable sources about the effectiveness of lower cost preventer medicines.

Declaration of interest: None

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IS006

Activating primary care COPD patients with multi-morbidity (APCOM) pilot project

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Brief outline of context: Understanding of COPD and uptake of evidence-based healthcare by patients is suboptimal in primary care, particularly in the context of multi-morbidity.

Brief outline of what change you planned to make: This innovative study aims to empower primary care COPD patients with co-morbidities by improving their disease knowledge and self-efficacy by piloting a practice nurse-delivered, tailored self-management programme in Sydney, Australia.

Assessment of existing situation and analysis of its causes: Our recent qualitative study¹, which explored the impact of COPD diagnosis in primary care patients with co-morbidities, found suboptimal understanding of the disease and underutilisation of appropriate healthcare. These findings indicate that interventional studies improving COPD patients' self-efficacy in the context of multi-morbidity are needed.

Strategy for change: Potential COPD patients with co-morbidities were recruited from participating general practices. Following an initial needs assessment, the self-management programme is being tailored by trained practice nurses and delivered to patients in subsequent one-to-one sessions. The programme, based on constructs from the Health Belief Model, involves active engagement of patients with strategies aimed at enhancing their COPD knowledge, self-management capacity and skills in prioritising multiple chronic conditions.

Measurement of improvement: Primary outcome of the study is assessment of patient knowledge, skills and self-management capacity of multiple chronic conditions using the Patient Activation Measure (PAM). Secondary outcome measures include COPD Knowledge Questionnaire, COPD Assessment Test, Multi-morbidity Illness Perceptions Scale, Morisky Medication Adherence Scale and accuracy of inhaler technique.

Effects of change: The study is currently in the phase of intervention delivery and follow-up. The average PAM score from baseline data of 49 participants (24 male and 25 female, mean age: 69.2) was 57.67, indicating lack of confidence and skill to modify health behaviour. Impact of the programme will be tested by comparing pre and post-test outcome measures after six months' follow-up. Feasibility and sustainability will be evaluated by qualitative feedback from participating clinicians.

Lessons learnt: There has been good uptake of the programme by participating nurses following training workshops conducted by the researchers. We have faced challenges in practice recruitment and patient retention, mainly due to their co-morbidities.

Message for others: A first of its kind, our study could lead to improved long-term health outcomes, healthcare utilisation and patient-provider relationships. The study also broadens the practice nurse's role in patient empowerment, which is vital given the surge in multi-morbidity worldwide. Declaration of interest: The study is funded by GlaxoSmithKline Australia.

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Reference:

1. Ansari, S., Hosseinzadeh, H., Dennis, S. & Zwar, N. Patients' perspectives on impact of COPD diagnosis in the face of multi-morbidity – a qualitative study. *Primary Care Respiratory Medicine* 2014; 24; 14036 doi:10.1038/npjpcrm.2014.36.

IS007

Lessons from designing and implementing pulmonary rehabilitation in Kampala

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Brief outline of context: In developing a pulmonary rehabilitation (PR) programme in Kampala, Uganda, we adapted traditional UK model of PR for use in Kampala for patients with post-TB lung disease. Post-TB lung damage is irreversible and varies from mild to devastating in Uganda; it represents 20% of adult respiratory outpatient attenders. There is no useful treatment, but sufferers have poor health status and often are stigmatised.

Brief outline of what change you planned to make: Working with Ugandan respiratory specialists, community health workers, nurses and physiotherapists we developed a PR team. We devised an exercise regime based on conventional PR; the education programme covered normal lungs, tuberculosis and post TB damage as well as conventional messages about breathlessness exercise, nutrition, and smoking and drug treatments.

Assessment of existing situation and analysis of its causes: We spoke in detail to patients, doctors, nurses and physiotherapists, and attended outpatients and ward rounds. We performed a notes review of consecutive outpatients. After a pre-pilot feasibility study of 2 groups of patients, we performed a development study with qualitative and quantitative assessment of the programme including recruitment, assessment, PR programme and outcome measures including exercise capacity and health status questionnaires.

Strategy for change: The 2 pre-pilot groups were conducted in 2013, and with a grant from MRC / Wellcome Foundation the development study was conducted from March 2015- February 2016, 4 groups were conducted and completed 6 week follow up on schedule.

Measurement of improvement: The recruitment of patients was recorded using a screening log and only 10% dropped out. Major improvements were seen in exercise capacity and health status. Unexpected improvements in chest pains and haemoptysis were observed.

Effects of change: Qualitative interviews and focus groups with patients were conducted to examine the feasibility and acceptability of PR; the impact of respiratory disease and PR; whether PR could be improved. Patients were disabled by their condition before PR with fear of exercise. Patients reported the exercises were initially hard but soon brought improvement in their well-being, increased walking distance and ability to work; as their self-confidence improved they were less stigmatised. They reported improved social and intimate relationships.

Lessons learnt: PR is feasible and appears effective in post TB patients in Uganda, but the programme must be culturally appropriate and education tailored to the patients' conditions. International collaboration worked very well, and as internet and skype was unreliable face-to-face meetings are essential. This study informs calculation of sample size of a full trial planned for Zambia, Kenya and Tanzania.

Declaration of interest: None

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IS008

To address unmet NCD (respiratory) needs by using a model for diagnosis and follow-up applicable in developing countries

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Brief outline of context: Non Communicable Diseases (NCDs) kill more than 36 million people each year. Nearly 80% of NCD deaths occur in low and middle countries. More than nine million of all deaths attributed to NCDs occur before the age of 60 years. The prevalence of chronic respiratory diseases increase day by day. COPD was the sixth leading cause of death worldwide in 1990; it is predicted to become the third by 2020. The majority of asthma and COPD patients are treated by general practitioners; their conditions are often uncontrolled despite prescribing of multiple therapies because there is a lack

of continuity of care or appropriate service model to support patient adherence.

Brief outline of what change you planned to make: To change the practice behaviour of general practitioners by testing a single model of service delivery aimed at better patient compliance with care plans.

Assessment of existing situation and analysis of its causes: Using a retrospective observational study conducted at primary care respiratory centre at Rangpur, Bangladesh from January 2015 to December 2015. Ages 18 to 60 years. Data collected by face to face interview. Patients used inhalers and others oral medication but they were not controlled due to poor inhalation technique, inappropriate severity assessment and step care management, when taking the history of the patients.

Strategy for change: Implementing a service pathway: Mandatory registration, asthma & COPD education, investigation, diagnosis using spirometry, treatment & counselling, inhalation technique were mandatory.

Measurement of improvement: Measurement by using a questionnaire of their satisfaction, increase patient compliance rate, to check inhalation technique etc.

Effects of change: Well controlled asthma, decrease incidence of COPD, increase patient compliance. We analyzed 3478 patients (asthma 2800, COPD 678), male 2170; female 1308. Highly satisfied 88% and 12% complained about longer waiting time. Patient compliance was excellent.

Lessons learnt: To practise a unique and effective primary care respiratory service delivery system is effective but time-demanding.

Message for others: Any general practitioner of developing countries can utilize this model for better service delivery and increase patient compliance.

Declaration of interest: None

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IS009

Pulmonary rehabilitation- initial experiences in Bangladesh

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Brief outline of context: Pulmonary rehabilitation is an effective intervention of COPD management, however, there is insufficient PR capacity to serve all COPD patients, thus necessitating creative solutions to increase the availability of PR.

Brief outline of what change you planned to make: Introduction of PR to reduce the impact of COPD on patients in Rangpur, Bangladesh.

Assessment of existing situation and analysis of its causes: Patients experience symptoms and poor quality of life that is not resolved with existing pharmacological management.

Strategy for change: One hundred sixteen spirometrically diagnosed COPD, GOLD-3 patients participated in a twelve week PR program delivered by pulmonary rehab center Rangpur, Bangladesh from 1st January 2015 to 30 September 2015. Pre-intervention symptom score, activity score and impact score measured by St. George Respiratory Questionnaire. Rehabilitation sessions were administered two days per week and patients exercised under direct supervision of doctor and paramedic. Primary outcome measure was change in quality of life as evaluated by the St George's Respiratory Questionnaire (SGRQ).

Measurement of improvement: Before PR mean symptom score was 74%, activity score 66%, impact score 63% and after PR mean symptom score was 67%; activity score 55%, impact score 54%. Clinically and statistically significant ($P < 0.05$) improvements in SGRQ scores.

Effects of change: Patient can do their daily household activities and free from anxiety and depression. They are also able to get sound sleep and have a good appetite.

Lessons learnt: In COPD pharmacological and rehabilitative intervention is necessary for effective management.

Message for others: Advocate to patients to participate in pulmonary rehabilitation programmes.

Declaration of interest: None

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IS010

Role of E mentoring in improving performance of primary care doctor on asthma- chronic obstructive pulmonary disease in rural province, Vietnam

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Brief outline of context: Find the appropriated solution for improving performance of Primary care Doctor on asthma-chronic obstructive pulmonary disease in rural province, Vietnam

Brief outline of what change you planned to make: E mentoring will be the promising solution for this problem in our Department.

Assessment of existing situation and analysis of its causes: After graduated Vietnamese Medical school, the question still raise about follow up of FP's performance due to the lack of CME activities. Even though they attended CME, we observe that they do not have the practical learning atmosphere as they was in medical school so they cannot be confident in practice of 3 first cases about the learning issue. Besides this, the self-learning activities is not enough for FP in Vietnam through CME activities. The survey showed a large discrepancy between practice and GOLD COPD guidelines in rural area. COPD diagnosed by spirometry was still low in PCPs' practical sites. Guideline compliant COPD among PCPs in our sample was still low than our expectation also the same picture with given structure program of cessation smoking and the consultation for COPD.

Strategy for change: E mentoring will be the promising solution for this problem in our Department which build up in 3 components such as the expert panel that include of lung diseases expert, Family physician, Clinical Pharmacists was established for patients safety issue and adjusted the mal practice; Telemedicine based in I Cloud software that can work at ADSL speed in rural area; EHR of Family medicine integrated the format of Asthma and COPD that can help mentors team to improve mentees group performance through case presentation. That Specific E mentoring have a schedule one per week for our FM residents.

Measurement of improvement: These specific E mentoring promising to solve the problem of low performance after training in our residents in rural area, we have to evaluate this impact and cost in the next phase.

Effects of change: This solution match to situation of limited time, resources, low compliance to guideline.

Lessons learnt: Good team work among primary care and specialists integrate in Telemedicine and Electronic health record of Family Medicine that makes group mentors for group mentees in Vietnam rural areas to improve their performance in Asthma -COPD care.

Message for others: Information Technology is not a luxury instrument for developing countries but become appropriate technology when they be included in E mentoring process. These specific E mentoring promising to solve the problem of low performance after training in our residents in rural area.

Declaration of interest: None

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IS011

General practitioners' perceptions of COPD treatment: thematic analysis of qualitative interviews

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Brief outline of context: In Denmark the treatment of chronic obstructive pulmonary disease (COPD) is mainly managed by general practitioners.

Pulmonary rehabilitation is available to patients with COPD in the local community by general practitioner referral, but studies show that many patients fail to participate in rehabilitation. The aim of our study was to explore (i) General practitioners' perceptions of how they manage patients with COPD, and (ii) General practitioners' perceptions of how patients manage COPD.

Brief outline of what change you planned to make: It is of interest to explore whether the identified challenges are present in Denmark. COPD has been a target area for the Danish Government, just as health care services are financed through income tax, and it might be assumed that this could result in better management of COPD treatment by general practitioners, e.g. high referral to pulmonary rehabilitation or follow up on patient motivation.

Strategy for change: The study had a qualitative design using semi-structured key-informant interviews with general practitioners. Investigator triangulation was applied during data generation and data analysis using thematic analysis methodology.

Lessons learnt: Our main findings were that general practitioners relied on patients to take the initiative to make clinic appointments and on professionals at health centres to provide pulmonary rehabilitation including a discussion of life-style changes. The general practitioners experienced that patients chose to come to the clinic when they were in distress and that patients failed to comply with rehabilitation when offered. The general practitioners were relieved that the health centres had taken over the responsibility for rehabilitation because general practitioner clinic time was limited.

Message for others: Our study suggested a vicious cycle in COPD treatment due to a reactive approach in general practitioners and patients. We recommend that general practitioners take the lead in providing referral to pulmonary rehabilitation and assume a proactive approach as suggested in international guidelines.

Declaration of interest: None

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IS012

Evaluating a pilot educational initiative across a European network of primary care organisations: the IPCRG's Teach the Teacher Programme

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Brief outline of context: IPCRG is a global network of organisations with an interest in assessing and treating chronic respiratory disease (CRD) in primary care. IPCRG has a key role in supporting improvement using evidence-based resources such as its SIMPLES structured asthma review and desktop helper on difficult to manage asthma. Evidence from the recent U-BIOPRED project, on severe asthma needs to be disseminated. IPCRG has developed an education strategy that proposes various approaches/programmes to build capacity for primary care development.

Brief outline of what change you planned to make: In January 2015, we launched a pilot 'Teach the Teacher: Difficult to Manage Asthma' programme. We brought together 14 clinical colleagues from seven European countries, to take part in a workshop in Rome. Our aim was to build their ability to teach other clinical colleagues the key messages concerning difficult to manage asthma; including how to use and adapt existing IPCRG resources for local use. We convened an Expert Faculty, including patient representation (EFA) and supported attendees to design and plan educational programmes to take place in their own country.

Measurement of improvement: An evaluation immediately following the workshop in Rome, was rated highly by all participants, with overall scores of 4 or 5 (where 5 was 'excellent'). Subsequently, all the participants developed proposals for programmes in their own countries – these seven events took place in autumn 2015 and involved over 230 health professionals - including specialist nurses, physiotherapists, General Practitioners (GP); early career GPs; and GPs with a special interest in Asthma/COPD.

Effects of change: We proposed an evaluation framework.¹ This includes - i) participant reactions, ii) learning, iii) organisational changes, iv) use of new knowledge and v) impact on practice and service users.

Early indicators suggest that programmes were well received by participants ('positive participant reaction') – other dimensions of evaluation require more time to report and the impact on participants clinical practice and services users may prove more challenging to demonstrate.

Lessons learnt: Findings will be presented that describe the challenges that teams encountered in assessing learning needs, setting up education programmes and in supporting clinical practice change. We reflect on the challenge of meaningful evaluation of practice change or impact. These insights are important in thinking about the design, implementation and evaluation of clinical educational programmes globally.

Message for others: We would like to acknowledge our collaborators, the Teach the Teacher Faculty and the first cohort of Teachers.

Declaration of interest: The European programme U-BIOPRED funded the programme and included an update on the findings of U-BIOPRED on severe asthma.

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Reference:

1. Guskey, T.R., 2000. Evaluating Professional Development. Corwin Press.

IS013

Interim findings: fostering the exchange of real life data across different countries to answer primary care research questions: an UNLOCK study from the IPCRG

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Brief outline of context: UNLOCK is an international collaboration between primary care researchers to analyse multiple datasets for COPD and asthma management in different primary care settings. It has been five years since the UNLOCK collaboration began. In that time its membership has expanded to include 15 countries: Sweden, Spain, Ukraine, Canada, Greece, UK, Netherlands, Norway, Australia, Portugal, Belgium, India, Germany, Uganda and Chile.

Brief outline of what change you planned to make: The primary purpose of UNLOCK is to validate policy and treatment guideline decisions by using data from unselected primary care populations.

Assessment of existing situation and analysis of its causes: Individual members of the UNLOCK Group value the collaboration. However, the Group has identified a range of structural challenges in working on a single study with several researchers from different countries such as constraints in working with datasets collected for different purposes using different methodologies/coding systems.

Strategy for change: The study will be carried out between December 2015 and April 2016 and will use the following methodology: A review of studies produced by and documents related to the UNLOCK Group; A structured on-line questionnaire for members to explore their perceptions of the strengths of the UNLOCK Group, the barriers to participating and the learning to date. Structured interviews with UNLOCK Group members who have acted as lead authors for UNLOCK studies to explore barriers to undertaking and completing UNLOCK studies, how these can be overcome and learning to date. A review of the datasets held by current UNLOCK members.

Measurement of improvement: Perceptions of successes of members of the UNLOCK Group. Analysis of UNLOCK published studies and their impact. Analysis of other impacts of UNLOCK, including the development of coding and information systems.

Effects of change: Additional evidence is needed about the process of translating basic scientific discoveries into clinical practice, known as the "bench to bedside continuum". The study contributes to this.

Lessons learnt: Interim findings will be presented for the following research questions: What are the incentives, motivations and enablers for sharing real life data across borders? What are the challenges and constraints, what strategies have been developed to overcome these and how effective have they been? Are there specific challenges to fostering the exchange of primary

care data in comparison to other datasets? What are the core respiratory data variables that should be collected to enable chronic respiratory disease research to better answer primary care research questions?

Message for others: The experience the UNLOCK Group has developed offers learning for other researchers seeking to share datasets from different countries to answer questions about the needs of primary care populations.

Declaration of interest: None

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IS014

Team work in respiratory care in a family practice

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Brief outline of context: The Family Medicine Clinic at the Kaye Edmonton Clinic is a teaching clinic affiliated with the University of Alberta. There are ten physicians and the population includes many elderly patients with complex disease and also families with children. We wished to develop the services available for patients in line with Alberta Health Services Policy.

Brief outline of what change you planned to make: To access spirometric testing and respiratory education as well as smoking cessation advice, we wished to include a qualified respiratory therapist in the team.

Assessment of existing situation and analysis of its causes: Education for patients with asthma or COPD was not easily available and is time consuming so often neglected by the physicians. A previous audit had identified that less than 50% of COPD patients had ever had spirometry. Physicians did not feel confident in giving education in depth or in performing and interpreting spirometry themselves. We have shown the benefit of educators attached to physicians' offices.

Strategy for change: We planned to enlist a new team member with the appropriate skills. Physicians would refer eligible patients to a 30 minute or 60 minute consultation with the Respiratory Therapist. Arrangement would be made with the administration in the same clinic for the RT to attend in the Family Medicine clinic each Thursday afternoon for three hours along with the lead physician.

Measurement of improvement: Administrative agreement and support was obtained and clinic time organised. After six months, the sessions were opened up to physicians from neighbouring practices. Evaluation is ongoing by survey of participating patients and referring physicians.

Effects of change: Satisfaction results and feedback are pending. Referred patients are seen within a week of referral. Spirometry when indicated is performed and interpreted the same day. Diagnosis has been established in several cases of doubt and asthma excluded in a case of Vocal Cord Dysfunction. Trials of therapy with follow-up have been undertaken. Since the respiratory sessions are conducted in the clinic, the record of the consultation is immediately available to the referring physician without the delay intrinsic to external referral.

Lessons learnt: Several patients have failed to attend. It may be necessary to call patients to confirm their attendance. Once a week clinic does not provide Point of Care testing and this may have been a contributor. We are negotiating with the Clinic administration to hold the clinic twice a week or more as demand increases which may also alleviate this problem somewhat.

Message for others: Adding a respiratory therapist to the clinic team is feasible and effective in family practice.

Declaration of interest: None

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IS015

Telematrix support to asthma, COPD and smoking cessation: improving integrated care between primary and secondary health system

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Brief outline of context: Asthma and COPD are the major causes of hospitalizations and death in Sao Bernardo do Campo (SBC) city. We implemented matrix support, an educational intervention to promote the collaborative care in 3 health territories with the highest number of referrals. Telematrix (TMX) support could allow problem solutions in the primary healthcare (PHC), enabling the interaction with experts.

Brief outline of what change you planned to make: To enhance the *in loco* PHC matrix support through a virtual environment network (TMX) aiming to maintain and go forward in the educational process, reducing even more the referrals of chronic respiratory diseases (CRD).

Assessment of existing situation and analysis of its causes: Referrals to secondary pulmonology care dropped significantly for all CRD ($p < 0.05$) with matrix support *in loco*. Joint consultations and case discussions must be performed frequently, to reinforce education and promote the training of new professionals. Considering the few available specialists and the distance access to the 3 health pilot territories, a new strategy of e-learning was design.

Strategy for change: A pivotal real life study targeting to reach health professionals of the E-QUALITY I project. Specialists of the core of TMX provided teleconsultations and second opinions (8 hours) from questions submitted by BHU. Synchronous real time chat, web, video conferencing or telephone meetings with or without the presence of patients. Asynchronous contacts were held by e-mail. The teleconsultant/regulator evaluated the referrals allowing or rejecting the appointment to the expert, identifying demands, doing educational interventions. The evaluations were made based on regulation protocol access, scientifically evidences and clinical experience.

Measurement of improvement: We observed gradual better qualifications of referrals. During the year, from 104 referrals the pulmonologist acting as the teleconsultor/regulator accepted that 58 (55%) were in accordance with the protocol access. Figure show the percentage of referrals for quarters accepted/denied (avoided) according to this criteria, which we believe is related to increased skills.

Effects of change: Information technology was essential to deployment process, enabling access to 12 BHU. During 2015, there were 34 synchronous video teleconsultings, 8 by email and 7 by telephone, enrolling 55 BHU professionals. Case discussion reached 150 patients (10 of them alive) and 144 doubts were solved (avoiding referrals). Additionally, 38 professionals participated in web conferences.

Lessons learnt: TMX consolidated the matrix support through educational reinforcement, and could reduce the waiting time for patients with complex diseases. In addition, it allows a new working process to the specialist.

Message for others: Comprehensive matrix support seems to be a powerful device for continuous health education and assistance practices, indicating better quality of patient care.

Declaration of interest: None

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IS016

Trends in integrated care of COPD through care groups in the Netherlands on prevalence and process indicators

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Background: Increasingly integrated care through care groups is implemented in COPD care in the Netherlands. Quality indicators are used to make provided

[IS016]

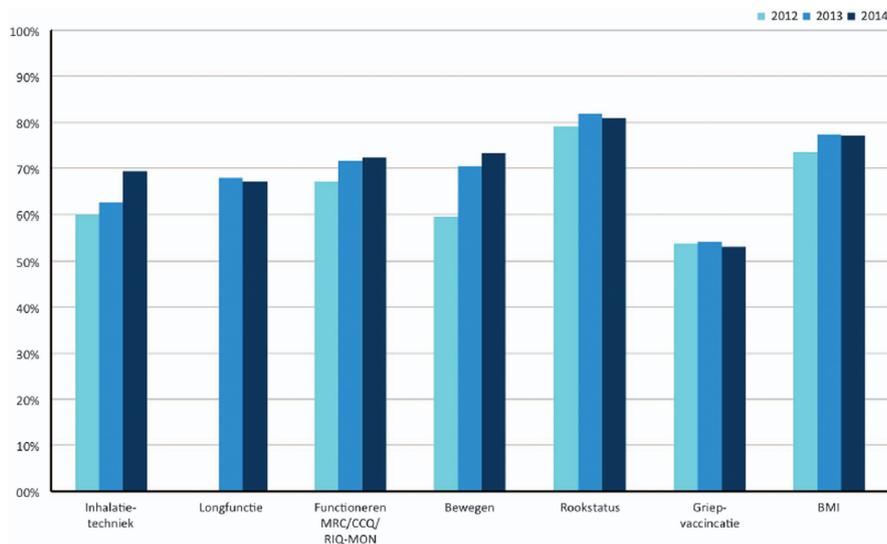


Figure 1. Registration of process-indicators COPD 2012-2014

care transparent and make further improvements in the COPD care. The purpose of this study was to provide insight into the prevalence of COPD patients receiving this integrated care and into the quality of care provided by primary care groups in the Netherlands from 2012 to 2014.

Methods: We analysed the results of integrated COPD care by care groups in the Netherlands, recorded in annual reports of 2012, 2013 and 2014. Registration of process-indicators was analysed. Data were provided by primary care groups, in one third of cases through regional data centres.

Results: Over the years more care groups provided data on integrated COPD care (41 in 2012, 102 in 2014). The prevalence of 57% of its COPD patients receiving primary integrated care seems to stabilize although the registration of patients restraining from integrated care increases (9.5% in 2014). All process-indicators have clearly improved in score except from 'influenza vaccination' (Figure 1). The indicator 'smoking status' scores best while 'checking inhalation technique' and 'monitoring physical exercise' have risen substantially. Since outcome indicators have only been registered from 2013 it is too early to signalize trends in outcome.

Conclusion: Prevalence of COPD patients in care groups receiving integrated care in the Netherlands seem to stabilize. However, registration of the number of patients restraining from this care is increasing. Analysis of quality indicators recorded in three annual reports shows that registration is improved, which might implicate that primary care groups have mastered the processes.

Declaration of interest: None

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IS017

Care of asthma and COPD overlapping syndrome (ACOS) through new window

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Brief outline of context: Asthma and COPD are well known disease entity, but adult patients over age 40 may present with symptoms of a chronic airways disease have features of both asthma and COPD, labelled as ACOS. These patients are relatively difficult to manage than asthma or COPD alone. They

should be identified with their phenotype and manage accordingly for the better outcome.

Brief outline of what change you planned to make: We planned to diagnose ACOS with its phenotype early as per GINA/GOLD experts and formulate the protocol of care. We used diagnostic GINA/GOLL tool (Figure 1) and divided patients in 4 phenotypes.

Assessment of existing situation and analysis of its causes: We have analysed 540 patients of our Community-Respiratory-Clinic and found 67 patients with ACOS, 101 Asthma, 237 AR+Asthma, 53 COPD etc. (Table 1). They were managed conventionally as either asthma or COPD.

Strategy for change: As ACOS needs more intensive care, we separated them and planned to empower for self-care with education, written self-management plan and other available options in our practice e.g. case manager.

Measurement of improvement: We planned to measure the effect by exacerbation, QoL by SGRQ, patient satisfaction, decline of lung function, and utilization of health care and morbidity level.

Effects of change: As we are at the initial stage of implementation, there is not yet measurable effect of change, but obviously, patient's satisfaction and our confidence improved.

Lessons learnt: ACOS may not be a mere mixture of asthma and COPD. It may be completely different entity of disease with its specific pathophysiology, which will be explored by more investigation by the experts. Early identification of ACOS with its phenotypes gives better outcome in primary care respiratory service.

Message for others: Asthma, COPD and ACOS are not the same and need their specific approach for the better care. Early identification of ACOS with its

Table 1. Total patients: 540 (in Community Respiratory Clinic Khulna – Bangladesh)

Disease	Number	%
Br Asthma	101	18.7
Allergic Rhinitis with Asthma	237	43.9
ACOS	67	12.4
COPD	54	10
High probability of Asthma	28	5.2
Other respiratory diseases	53	9.8

[IS017]

STEP 2 SYNDROMIC DIAGNOSIS IN ADULTS					
(i) Assemble the features for asthma and for COPD that best describe the patient.					
(ii) Compare number of features in favour of each diagnosis and select a diagnosis					
Feature: if present suggests -	ASTHMA			COPD	
Age of onset	<input type="checkbox"/> Before age 20 years			<input type="checkbox"/> After age 40 years	
Pattern of symptoms	<input type="checkbox"/> Variation over minutes, hours or days			<input type="checkbox"/> Persistent despite treatment	
	<input type="checkbox"/> Worse during the night or early morning			<input type="checkbox"/> Good and bad days but always daily symptoms and exertional dyspnea	
Lung function	<input type="checkbox"/> Triggered by exercise, emotions including laughter, dust or exposure to allergens			<input type="checkbox"/> Chronic cough & sputum preceded on-set of dyspnea, unrelated to triggers	
	<input type="checkbox"/> Record of variable airflow limitation (spirometry or peak flow)			<input type="checkbox"/> Record of persistent airflow limitation (FEV ₁ /FVC < 0.7 post-BD)	
Lung function between symptoms	<input type="checkbox"/> Normal			<input type="checkbox"/> Abnormal	
Past history or family history	<input type="checkbox"/> Previous doctor diagnosis of asthma			<input type="checkbox"/> Previous doctor diagnosis of COPD, chronic bronchitis or emphysema	
	<input type="checkbox"/> Family history of asthma, and other allergic conditions (allergic rhinitis or eczema)			<input type="checkbox"/> Heavy exposure to risk factor: tobacco smoke, biomass fuels	
Time course	<input type="checkbox"/> No worsening of symptoms over time. Variation in symptoms either seasonally, or from year to year			<input type="checkbox"/> Symptoms slowly worsening over time (progressive course over years)	
	<input type="checkbox"/> May improve spontaneously or have an immediate response to bronchodilators or to ICS over weeks			<input type="checkbox"/> Rapid-acting bronchodilator treatment provides only limited relief	
Chest X-ray	<input type="checkbox"/> Normal			<input type="checkbox"/> Severe hyperinflation	
NOTE: • These features best distinguish between asthma and COPD. • Several positive features (3 or more) for either asthma or COPD suggest that diagnosis. • If there are a similar number for both asthma and COPD, consider diagnosis of ACOS					
DIAGNOSIS	Asthma	Some features of asthma	Features of both	Some features of COPD	COPD
CONFIDENCE IN DIAGNOSIS	Asthma	Possible asthma	Could be ACOS	Possibly COPD	COPD

Figure 1. Diagnostic GINA/GOLLD Tool.

phenotype and appropriate approach may result an immense success in patient care.

Declaration of interest: None

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IS018

Developing integrated primary respiratory care: outcomes of the E Quality project, Sri Lanka

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Brief outline of context: Respiratory disease is the commonest disorder encountered in clinical practice.

Brief outline of what change you planned to make: Lack of training for primary care physicians on early optimal diagnosis and lack of common guidelines on appropriate management prompted the training under the E Quality grant.

Assessment of existing situation and analysis of its causes: Most physicians treat obstructive and restrictive airway disease without spirometry testing.

Strategy for change: The objectives of the program were to train primary care physicians on the importance of screening patients with respiratory disease by spirometry, to create awareness of the availability of spirometry close to their setting and to train them on the use of Practical Approach to Lung health (PAL) Guidelines in optimal diagnosis and management of respiratory disease.

Measurement of improvement: Primary care Physicians ($n = 118$) working in 6 areas in Sri Lanka were invited to participate in the free training program. A pre-test was administered to identify their base line knowledge. The special training programme included sessions on the importance of screening of patients with respiratory disease by spirometry, and the adoption of PAL guidelines in diagnosis & management of respiratory disease. At the end of the one day training session the post test was administered. Base line data of participants were obtained by a questionnaire followed by a feedback form to assess the quality of the training sessions.

Effects of change: The male female ratio of the participants were 5:3. Amongst the participants 37 (32%) were engaged in full time primary care, and 81 (68 %) were engaged in part time primary care. The mean pre-test score was 55.68 ± 6.8 SD and the mean post test score was 68.47 ± 5.6 SD ($p < 0.05$). Participants appreciated the training as the PAL guidelines are implementable in their own practice setting. Most were motivated to refer patients for spirometry. Awareness was created on the availability of spirometry close to each ones practice area and contact information of the clinical physiologists were provided for each area.

Lessons learnt: Physicians were made aware of the availability of spirometry close to their own practice. The E Quality programme provided a much needed update on the importance of testing for respiratory function amongst primary care physicians. It introduced the participants to the PAL guidelines, provided a free copy of the guidelines to each participant and trained on the usefulness of PAL guidelines to better diagnose and treat respiratory disease patients in a primary care setting.

Message for others: Implementable guidelines to early diagnose and treat respiratory disease are essential.

Declaration of interest: None

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IS019

Patient and Healthcare Professional's Experience of MISSION COPD - A Novel One-Stop Model for Delivering Integrated COPD Management in a Primary Care Setting

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Brief outline of context: MISSION (Modern Innovative SolutionS Improving Outcomes iN) COPD is a quality improvement project, delivering a holistic assessment of patients with COPD. The clinic comprises a Multi-Disciplinary Team (MDT) assessment with hospital-based specialists working alongside the primary care team within the patient's usual practice.

Brief outline of what change you planned to make: This approach reduces the length of the assessment pathway, brings care closer to home, and standardises the quality of assessment and management for patients. The transfer of knowledge and skills between primary and secondary care professionals is also enhanced. We aimed to assess the impact on patient's, carer's and Health Care Professional's (HCP's) experience of MISSION COPD.

Assessment of existing situation and analysis of its causes: Discussions with Health Care Providers identified the following: Poorly controlled patients are on the journey to severe COPD, Co-morbidities commonly remain unrecognised, The time taken to specialist referral is too long, The majority of opportunities to intervene are in primary care, Patients with undiagnosed COPD frequently present with exacerbations, Knowledge among HCPs is variable, Patient adherence to medication is variable, COPD patients value written information, Systems between primary and secondary care are poorly integrated.

Strategy for change: 108 patients across 5 primary care practices were reviewed in their usual surgery in a carousel style clinic. Primary and secondary care professionals worked together to enhance knowledge and skills transfer. Assessment included spirometry, FeNO testing, medical and inhaler technique review, smoking cessation and input from the British Lung Foundation. All patients attended an education session and received a personalised self-management plan. 30 of the 108 patients were invited to a secondary care clinic. Those invited required further investigation or more intensive support. This carousel included HRCT, echocardiography, full lung function testing, breathing control, blood tests, dietician, social worker and psychologist assessment as well as access to smoking cessation, palliative care, inhaler review and medical assessment.

Measurement of improvement: Feedback was obtained from HCP's, patients and carers through satisfaction questionnaires and video logs. HCPs underwent qualitative interviews regarding their experiences.

Effects of changes: 100% of patients would recommend the clinic to family and friends. They specifically highlighted their appreciation of inhaler technique education. The 'one-stop shop' nature of the clinic and being close to home were two important aspects for patients. The feedback on the second carousel clinic revealed that a single visit encompassing all was highly valued by patients. Feedback from HCPs was that they valued the shared learning that bridged the traditional divide between primary and secondary care.

Lessons learnt: MISSION COPD is a feasible and effective way of providing high quality care for patients with COPD. The rapid, local MDT approach was highly valued by patients, carers and HCPs.

Message for others: Integrated respiratory care is a valued and feasible model to improve outcomes in patients with COPD and is of benefit to the HCPs delivering the model.

Declaration of Interest: None

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IS020

Designing, implementing and evaluating a compassionate care course for healthcare professionalsGeorge Samoutis¹, Sue Shea²¹University of Nicosia Medical School, Cyprus, ²International Institute for Compassionate Care, UK

Brief Outline of Context: Evidence suggests that a compassionate approach can help to prompt a faster recovery from acute illness, improve the management of chronic illness, and help to relieve anxiety, whilst benefits have also been reported in studies which show that kindness and touch alter the heart rhythm and brain function in both the person providing compassion and the person receiving it (Fogarty et al 1999; Shaltout et al 2012; Science Daily 2012). A compassionate approach is also believed to alter the brain's response to stress and assist in increasing pain tolerance (Youngson, 2012). A key question that has been posed, is can compassion be taught?

Brief outline of what change you planned to make: We designed and implemented a 6 module course on compassionate aiming to deepening the qualities of compassion, empathy, kindness, self-awareness, self-reflection, conflict resolution, communication, therapeutic relationship and compassionate care skills. Furthermore, the course intended to provide a vehicle for bringing both practicing healthcare professionals (physicians, nurses) and managerial/administrative staff together in unison to reflect on and discuss the importance of a compassionate approach across the healthcare setting.

Measurement of improvement: The course was rated highly by all participants. Feedback from the participating healthcare professionals demonstrated high levels of satisfaction with reports that the course was considered 'excellent' and 'inspiring'. Quality of care is measured in the organization through different processes (clinical audit etc) and the management team considered the course an important quality improvement tool.

Effect of change: An improvement in quality of care is expected. We are planning a follow up course in 2016 to support continuous quality improvement.

Lessons Learnt: In conclusion, based on the feedback that was received from the participants compassion can be taught or assisted in its sustainability through short courses. Cultivating a compassionate care organizational culture is pivotal in quality improvement. Finally, training should include all the members of the healthcare team, including the administrative and management staff. Based on the course experience and outcome we have established an International Institute for Compassionate Care in order to foster network, research and education in this field.

Message for other: Acknowledge the contribution from all the tutors of the Compassionate Care Course.

Declaration of interest: None

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