Modern Innovative SolutionS Improving Outcomes iN COPD

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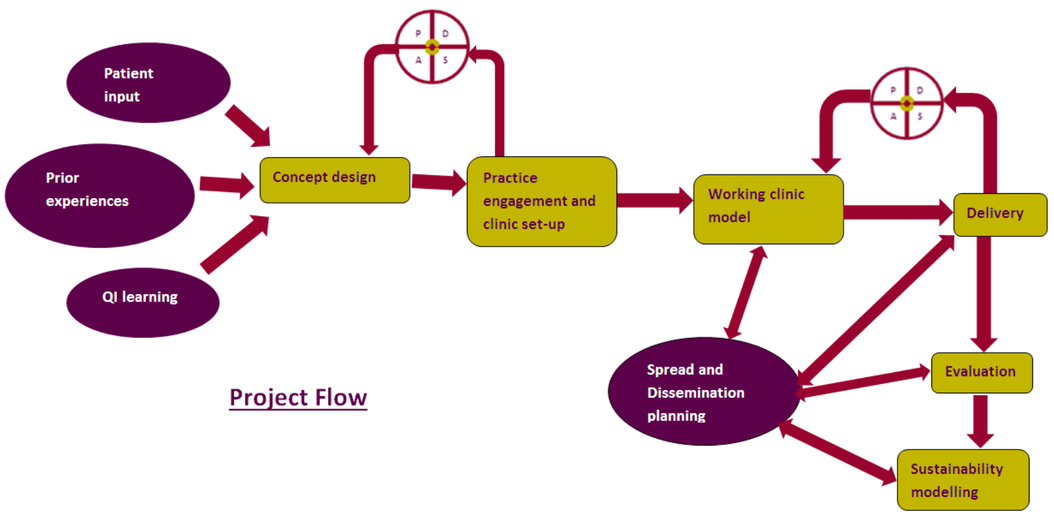
1. Aim: MISSION COPD is a Quality Improvement project that aimed to deliver patient-centred, timely care that promoted integration of Primary, and Secondary care. We strived to provide rapid and holistic assessments of patients with moderate to severe COPD and those at greatest risk of having the disease, improving time to accurate diagnosis and improving the patient experience. The MISSION clinic comprised of a Multi-Disciplinary Team (MDT) assessment with hospital-based specialists working alongside the primary care team within the patient's usual primary care practice. It delivered a thorough disease assessment, targeted education and tools to equip patients and their carers with confidence to manage their own health.

2. Project Drivers

Aim	Primary Drivers	Interventions
➢ To provide timely patient-centered care to people with COPD or those with symptoms suggestive of the diagnosis. ➢ To integrated primary and secondary care of these patients delivering assessment to NICE quality standards. ➢ Through integration of care, to share learning between primary and secondary care providers.	Identify patients with a high symptom burden or who are frequent exacerbators	✓ Search of GP records ✓ Timely medical review
	Look for the "missing millions"	✓ Search of GP records ✓ Timely medical review ✓ Use of high quality diagnostics
	Medicines Optimisation	✓ Accurate diagnosis ✓ Inhaler technique check ✓ Face to face and written education
	Screen for comorbidity	✓ Screening questionnaires ✓ Medical and psychological review
	Individualized smoking cessation advice	✓ Community stop smoking services
	Tools for self management	✓ Education sessions at clinic and later in their journey ✓ Written self management plans ✓ Signposting to community support
	Deliver care where it is needed	✓ Rapid clinics held at local GP surgery. ✓ Mobile diagnostic tools taken to primary care
	Share learning	✓ Clinics run by primary and secondary care ✓ MDT discussions at each clinic ✓ Ongoing education after clinic

3. Delivery Overview

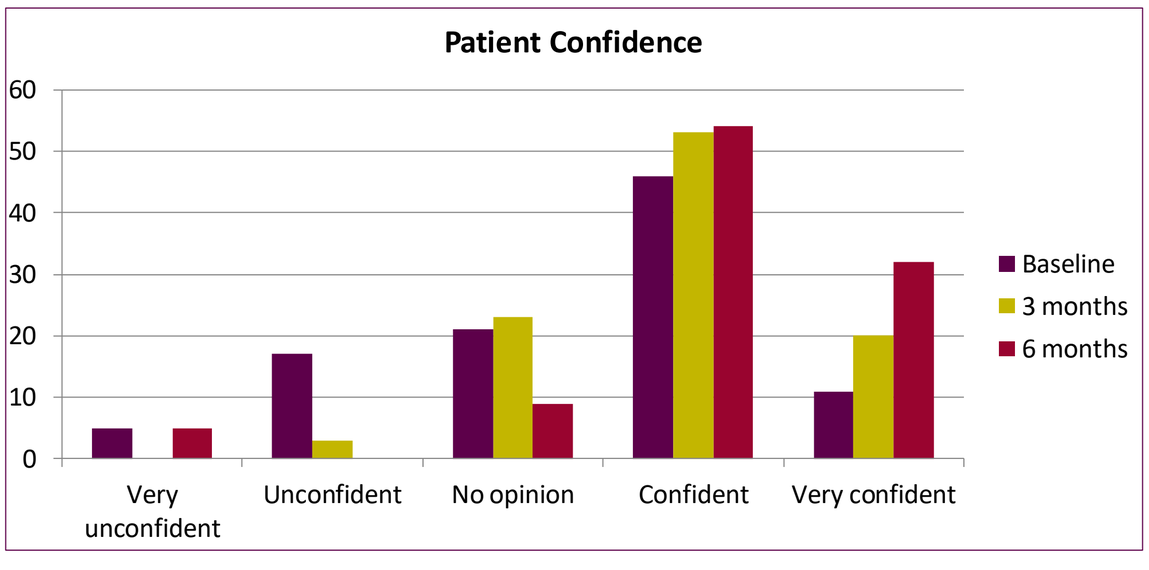


Project Flow

Delivery Summary

- 108 patients seen at 5 rapid clinics in September to November 2015
- 29 patients required further review at the severe clinic
- 100% reviewed to NICE quality standards
- 100% delivered bespoke inhaler technique training
- 100% offered small group teaching and personalised self-management tools
- 100% screened for comorbidity

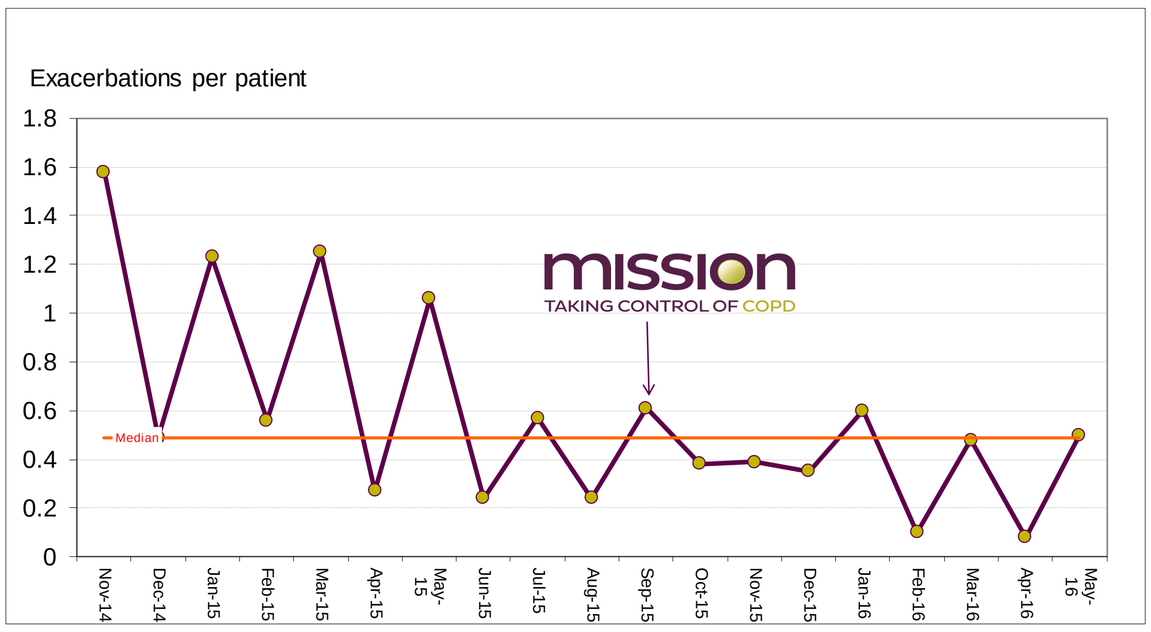
4. Outcomes



Using a Likert Scale, patients were asked to rate their confidence in self-management at baseline, 3 and 6 months. The results are shown in the bar chart above.

	12 months prior				6 months post				Annualised figures	
	Total number	Mean	Mode	Range	Total number	Mean	Mode	Range	Total number	% change
Exacerbations	259	2.56	2	0-9	62	0.61	0	0-7	124	-52%
Unscheduled GP visits	212	3.66	2	0-9	107	1.05	0	0-14	214	+0.01%
OOH calls	15	0.16	0	0-4	4	0.04	0	0-1	8	-46%
ED visits	13	0.15	0	0-4	3	0.03	0	0-1	6	-60%
Admissions	7	0.07	0	0-3	1	0.01	0	0-1	2	-71%

The table above demonstrates health care usage before and after the MISSION clinic. 7 patients were excluded where they had moved practice, and so were lost to follow-up.



Run chart demonstrating number of exacerbations per patient per month over the period November 2014 to May 2016. Clinics ran from September to November 2015 – the start date is indicated.

"I was totally oblivious to what was going on. If I had not come to MISSION, we would not have had a future. To me this has been a God Send!" - Patient

"The clinic has been very helpful. I have found problems I did not know I had. The staff have been excellent. I could not praise them more." - Patient

"A very helpful and useful clinic which taught me things about my self I didn't know; I would definitely recommend it to other people. MISSION is BRILLIANT!" – Patient

"I've seen it can have a bigger impact by coming out and seeing and realising that you can actually change a lot" – HCP

5. Feedback

6. Conclusions:

- The MISSION COPD pilot demonstrated that this novel care model is feasible to implement and is welcomed by patients, family and Health Care Professionals (HCPs).
- The MISSION model can be adapted and co-designed to address the needs of the population it serves, in fact to promote integration of usually distant teams a project must be able to adapt.
- Patients gained confidence in self-management.
- Identifying and addressing cultural barriers is necessary for effective buy-in – a key lesson from this project that we have carried forward.
- Further testing to scale is planned, followed by adapting the model to other long-term conditions or multimorbidity.