INTEGRATED CARE FOR THOSE WITH LUNG DISEASE

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Integrated care may be defined as "the best possible care for the patient, delivered by the most suitable health professional, at the optimal time, in the most suitable setting". The current interest in the subject of integrated care has come about largely because of the unplanned fragmentation of care which has occurred in many health care systems over the last two decades; and secondly because it represents the most effective patient centred manner in which to provide healthcare.

In many countries healthcare has been traditionally provided on a primary care, secondary care and tertiary care model. Depending upon the funding model in use within a country the primary care physician may also be the gatekeeper controlling access by the patient to the specialist, whereas in other countries patients may directly access either a general practitioner or the specialist they perceive as being most appropriate for their condition or symptoms. In most countries general practitioners or family doctors have been community based and specialists have been hospital based. In years gone by the hospital based specialists were often quite broad in their interests and expertise but over the last 10-15 years there has been increasing sub-specialisation. Whilst this may appear advantageous and be justified for complex problems or where advanced competency or practical skills are needed, it has also meant that more patients with polymorbid conditions, for example diabetes and heart disease have to be under the care of several practitioners rather than one general physician providing all their care. In addition the sharing of care with other healthcare practitioners such as specialist nurses or physician associates and the dual care of most patients by a general practitioner and a hospital based specialist has meant that the possibility of confusion, misunderstanding, duplication of effort and waste of resources has increased and patients complain of not knowing who is responsible for them and complain about having to repeat their stories and of receiving conflicting advice.

As a result of this unplanned fragmentation and because of increased pressure upon the healthcare system physicians undertook trials to see if better care could be achieved by integrating care, with such integration involving both processes of care and new ways of health professionals working. In respiratory medicine the increasing burden of those with chronic obstructive pulmonary disease requiring often repetitive hospital admissions because of exacerbations of their condition lead to trials of admission avoidance or assisted discharge schemes such that carefully selected patients received medical assessment followed by treatment at home by nurses and physiotherapists according to local and national guidelines[1]. Evaluation of some 26 trials involving nearly three thousand patients demonstrated that this form of working was associated with better quality of life for patients, better exercise tolerance, reduced rate of hospital admissions and shorter hospital stays[2]. Further work has therefore been undertaken to implement guidelines by the use of "bundles of care" where different members of the team provide different parts of the care but according to an agreed protocol which interdigitates each portion in a planned way.

To extend integration further, in countries such as the United Kingdom respiratory physicians have also started to work in a less hospital centric way and take specialist care nearer to the patient. Such physicians, who are all fully accredited chest physicians, may thus spend 10-70% of their working time not undertaking

hospital based outpatient clinics or doing ward rounds seeing in-patients but instead working in community health centers. Examples of the innovative and diverse forms of care given can be seen in the stories on the British Thoracic Society website[3] but colleagues are undertaking virtual clinics where with a GP and pharmacist the specialist might review a portion of all the last months respiratory prescriptions or the notes of those referred to hospital. Others are supervising respiratory diagnostics nearer to the patients' home with open access spirometry services, whilst all are providing specialist support to nursing teams and physiotherapists who are themselves working in the community. Some usually overlooked patients such as those in mental health institutions or prisons are also for the first time receiving specialist respiratory review. Early evaluation of such community activities suggests significant savings by stopping inappropriate prescriptions and more accurate diagnosis and assessment of severity.

These examples of integration of care are examples of vertical integration, the breaking down of barriers or divisions between primary and secondary care, between hospitals and the community. However horizontal integration is also necessary whereby we provide more total care for patients across the common comorbidities to avoid the necessity for muti-consulting. Respiratory physicians caring for those with COPD thus need to be expert in detecting and treating the increased incidence of depression in these patients, and need to be able to accurately investigate and grade how much of a patients shortness of breath is due to heart failure, atrial fibrillation or due to the COPD as well as being fully competent in treating the problems of muscle deconditioning, bone weakening and tobacco addiction. A creeping trend towards super-specialisation needs to be guarded against and perhaps each speciality should determine exactly what needs a super specialist (eg lung transplantation, MDR TB, cystic fibrosis and bronchial thermoplasty) and what should be looked after competently by all chest physicians (e.g. TB, Asthma, COPD, lung cancer).

Integrating respiratory care is a responsibility we all have to ensure that those with lung disease receive the most appropriate care from the most appropriate person in the most convenient place at the correct time.

PREFRENCES

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