THE ACT BREATHLESSNESS INTERVENTION SERVICE (ABIS): A NEW PARTNERSHIP MODEL OF COMMUNITY CARE (15 WORDS MAX)

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KEYWORDS

Breathlessness, allied health, community, primary health network

EXECUTIVE SUMMARY (100 words maximum)

The ACT Breathlessness Intervention Service ABIS is the first BIS model worldwide to be co-designed with consumers and clinicians and delivered to patients free of charge by a private allied health provider with funding and support from a primary health network. ABIS is being implemented and evaluated as a quality improvement project from March 2023 to December 2024. As of April 2024, 91 patients have been referred. All completed patients have reported improvements on at least one outcome measure. Challenges with eliciting referrals from general practice have prompted diversification to include specialties through Canberra Health Services.

INTRODUCTION

Persistent breathlessness is a distressing symptom commonly associated with various life-limiting illnesses, including lung, heart and renal failure and cancer. We co-designed a community breathlessness intervention service for the ACT (ABIS) with consumers and clinicians. ABIS is the first BIS model worldwide to be delivered free of charge to patients by a private allied health provider with funding and support from a primary health network. Implementation of ABIS as a quality improvement project commenced in March 2023, and will end in December 2024. Patients are eligible if they have breathlessness from chronic disease rated as ≥2 on the modified Medical Research Council (mMRC) scale ("*I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level*"). Referrals are invited from general practice and, more recently, specialist services through Canberra Health Services. Patients and carers receive initial assessment from a physiotherapist at home, with up to 6 follow-ups at home and/or by phone according to need. Physiotherapists take a person-centred, coaching approach that helps patients set goals for activities of daily living and provides them with education on non-pharmacological strategies for breathlessness, exercise and other lifestyle factors. Patients who need tailored dietary advice are referred to a dietician from the same allied health provider. This presentation will report up-to-date findings on ABIS's feasibility and impact on patient and carer outcomes.

HIGHLIGHTS

- ABIS is the first BIS to be delivered using a public-private partnership
- To date, all ABIS patients have improved on at least one outcome measure
- ABIS's greatest challenge has been eliciting referrals from general practice

METHODOLOGY/ PROCESS

Evaluation is using plan-do-study-act (PDSA) cycles. The project's SMART goal is 100 patients completing ABIS within 12-months, with at least 75% reporting clinically important benefits on ≥1 outcome as follows: activities of daily living (ADL) selected by each patient, breathlessness mastery, and severity of worst breathlessness. Self-reported ambulance avoidance and carer confidence are also being measured. Patients, carers and referring clinicians are invited to participate in semi-structured interviews to provide feedback.

RESULTS/ OUTCOMES

By the end of April 2024, 91 patients had been referred to ABIS and 59 have completed, falling short of the goal of 100 within 1 year. All completing patients have achieved improvements on at least one outcome. Fourteen (24%) of completing patients reported avoiding calling an ambulance through using the strategies they learned from ABIS. 33/44 (75%) carers of completing patients reported improvements in confidence.

Interviews have so far been conducted with 12 patients, 2 carers, and clinicians from two general practices and the respiratory service at Canberra Health Services. Patients and carers have reported benefits to mental as well as physical health, especially praising its person-centred, coaching approach and accessibility in the community. Very few patients had received previous support for management of breathlessness, despite specialist involvement. General practices have struggled to refer consistently, despite support with processes and incentivisation (e.g. Continuing Professional Development (CPD) credits). Recent diversification of referrals to specialist services through Canberra Health Services has led to increasing numbers of patients accessing the service.

CONCLUSION

Public-private partnerships can enable community-based access to support for people with chronic illness whose lives are impacted by persistent breathlessness. Rather than rely on referrals from general practice, a mixed model that includes specialist services may be necessary to sustain feasibility.