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New models of care for respiratory disease: A thematic edition

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Several years ago, and almost by chance, I attended an early meeting of what would later become the Cambridge-based Breathlessness Research Interest Group. I found myself in the company of such luminaries as Dr Sara Booth and Professor Irene Higginson and colleagues in an atmosphere of exemplary intellectual and clinical enquiry that I knew that I had, in some ways, "come home." Halifax, Nova Scotia, is 4600 km from Cambridge, England, and yet we subsequently managed to forge a collaboration that allowed for productive exchange visits. One such trip led to my coauthor, Morag Farquhar, and her physiotherapist colleague, Petrea Fagan (early key players in Sara Booth's Breathlessness Intervention Service (BIS)), presenting at Medical Grand Rounds where the audience in Halifax heard for the first time how a focused, patient-centered, home-based, and multidisciplinary approach to the disabling symptom of dyspnea could prove beneficial to patients, caregivers, and the health system alike.

More than a decade on and I am delighted to be able to introduce, with Morag, a series of manuscripts for *Chronic Respiratory Disease* that will highlight various initiatives under an umbrella of "new models of care." Two models (BIS, from Cambridge, and INSPIRED, from Halifax) featured in a recent review in the *Canadian Medical Association Journal* entitled "Palliative care for chronic illness: driving change."[1] While our respective approaches and reach are different, both programs are based on the fundamental premise that an understanding of patient and caregiver need, and a multidisciplinary intervention that meets that need, can have profoundly beneficial effects. Evaluation has been key to the success of both models. We differ in that Cambridge (not unexpectedly) took a more rigorous academic approach, developing BIS through the Medical Research Council (MRC) framework for complex interventions with early pilot work, a pilot RCT, and subsequent more definitive mixed-method RCT work.[2–4] I was content to ride on their coattails and take a more pragmatic quality improvement approach with a heavy emphasis on addressing existential distress. It was this approach in Halifax that came to the attention of my other coauthor, Jennifer Verma, at the Canadian Foundation for Healthcare Improvement (CFHI), who was leading a chronic disease collaborative in Atlantic Canada. INSPIRED's mix of positive patient feedback and substantial and sustained reductions approximately 60% in emergency visits and bed occupancy for patients with advanced disease and previous heavy facility reliance[5] appealed to CFHI. Not only did INSPIRED show the potential to contain costs for health system administrators and policy makers, it did it in a way that prioritized dignity of the patient and their family and offered a coordinated approach to care, provided in the comfort of home, inclusive of dying at home if requested.[6] Crisis aversion showed

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patients and families a ''new possible.'' A pan-Canadian spread collaborative was born.[5]

There are always barriers to implementing a new clinical service and those constructed by colleagues shouldn't be underestimated. After presenting the INSPIRED model (in essence four educational/supportive home visits shortly after a hospital admission for an exacerbation of COPD), a senior UK physician responded: ''this couldn't work here.'' That kind of ''perpetual uniqueness syndrome'' in healthcare often proves false, but, as a 2015 Canadian healthcare innovation panel found, remains a predominant barrier to spreading best practices:[7]

> . . . even practical and definitive findings do not spark widespread innovation in the absence of winning conditions in the healthcare system. The frustrating reality is that many excellent ideas or inventions are never translated in saleable or scalable innovations.

In contrast, a ''coalition of the willing'' can overcome barriers to successful spread and scale-up of an effective initiative. The pan-Canadian INSPIRED COPD collaborative supported 19 teams across Canada, successfully adapting INSPIRED. The experience makes the point that champions, enthusiasm, patient, and caregiver participation in design and delivery of evidence-based practices in a feasible approach within the community, coupled with insightful investment in change,[8] can triumph over forces of negativity that pervade our traditional healthcare systems. With more than 1000 patients enrolled across Canada (as of September 2016 and in addition to the $\sim$500 enrolled in Halifax), several teams have already demonstrated similar outcomes to the Halifax initiative, and over the next few months, we will gather outcomes that matter both to patients and to those with funding responsibilities.

The review series on ''models of care'' will provide illustrative examples of successful initiatives playing out on two continents with contributions from Canada, the United Kingdom, and Europe. We thank the editors at *Chronic Respiratory Disease* for the opportunity to proceed with this thematic edition and hope the readership will find the series of interest.

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