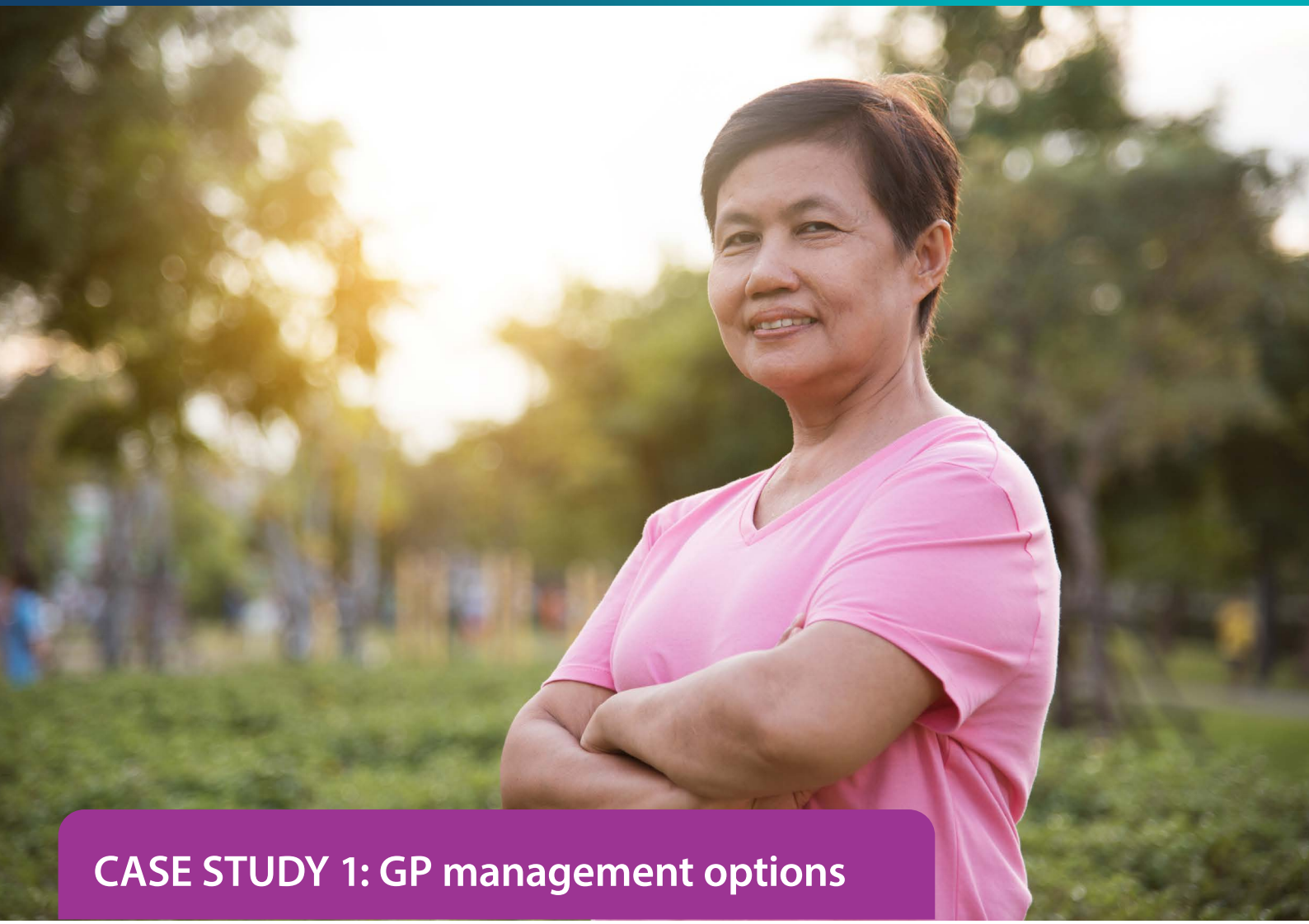
# Breathe easier...

*Improving dyspnoea through GP and community care.*



## CASE STUDY 1: GP management options

## About the Dyspnoea Pathway Pilot - for people with COPD or CHF

This pilot aims to help people who have dyspnoea (shortness of breath) and chronic obstructive pulmonary disease (COPD) or heart failure (CHF), to have an overall better quality of life by receiving quality care in their local community. The pilot also supports GP and community health providers to better manage these conditions and support patients to stay out of hospital as much as possible. See over the page for the case study.

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# CASE STUDY 1: Mrs M

Mrs M is an 84-year-old woman. She lives alone in an independent living village and is visited by her regular GP at the village once a month and can come to the clinic as needed. Mrs M has presented with increasing shortness of breath (SOB) and variable peripheral oedema over the last 3 months. She is breathless in her exercise class but can walk on flat ground without symptoms.

She has a past history of hypertension, IBS, reflux oesophagitis, recurrent UTI, CHF, mild COPD and anxiety. Her medications include Asmol, Frusemide, Panadol osteo prn, Perhexiline and Mirtazapine. Her GP reviews her regularly.

Mrs M is admitted to hospital with a high fever and sudden onset shortness of breath with a productive cough and is diagnosed with pneumonia.

**In hospital management included:**

- A Covid test (negative), d-dimer and cardiac investigations (no change)
- Treatment with antibiotics and diuretics up titrated
- Enrolment in the new dyspnoea pathway pilot. Mrs M is discharged home to the low intensity pathway under the care of her GP.

Mrs M wakes at night with sudden increase in shortness of breath several times over the next 6 weeks. She finds the increasing shortness of breath worrying, especially as it occurs at night when she feels she has less support. She has started to withdraw from social activities as she feels too fatigued to attend.

**GP review**

- Her GP uses the nonacute COPD HealthPathway for assessment and advice.
- A Tiotropium inhaler is added
- Mrs M has gained weight and is more breathless than documented on the hospital discharge summary.

**With the new Dyspnoea pathway, there are now more options:**

1. Her GP can call the **General Medicine Access line on 0427 566 159** and speak to a hospital clinician (between 8am-8pm) to ask advice about assessment and further management. This might include further medication changes that her GP can action allowing Mrs M to stay out of hospital.
2. The GP can refer directly to Hospital in the home (HITH) for a home-based admission, such as IV antibiotics, bypassing ED and critical care services if clinically safe to do. Access is by contacting HITH **RMH@Home Acute Coordinator on 0466 868 986, available 24 hours a day.**
3. The GP could refer back to HARP for further patient education and respiratory rehabilitation, if appropriate, by telephoning the **Direct Access Unit on (03) 8387 2333, Monday to Friday 7.30am-4pm.**

Meanwhile, the GP also speaks to the community navigator who recently undertook a psychosocial needs assessment after Mrs M was discharged from hospital. The GP and navigator discuss appropriate peer and mental health support programs that might benefit Mrs M and help with her anxiety and growing isolation.

The discharge information from the hospital will include the name and contact details for the Community Navigator assigned to your patient. Community navigators can be contacted by calling :

- **cohealth: (03) 9448 5844**
- **Merri Health: (03) 8319 7420**

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## CASE STUDY 2: HARP and Navigator Support

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# CASE STUDY 2: GARY

Gary is a 75-year-old man with heart failure (CHF), osteoarthritis and hypertension who was admitted to hospital with exacerbation of his CHF. It was his second admission in the past 12 months. Gary lives alone and has a supportive daughter who visits often. After this recent hospitalisation, Gary was discharged to HARP.

As part of his HARP episode of care, Gary received

- patient education and self-management support to understand his condition, his action plan and know when to escalate to a GP,
- titration of his medications, as per discharge instructions,
- exercise review, and
- a cardiologist review.

In addition, Gary was seen by a HARP care co-ordinator who facilitated a My Aged Care Home Support Assessment with the Regional Assessment Service to work out their aged care service needs. This resulted in several referrals codes for services, which Gary's daughter indicated she would follow up.

The HARP care co-ordinator also discussed:

- different types of carer supports and contact details for the Carer's Gateway.
- some strategies to help his daughter manage her anxiety, including the possibility of a GP Mental Health Care Plan.

Gary is clinically ready to be de-escalated back to usual GP care, however, the daughter's high level of anxiety would usually make it difficult for him to be discharged from HARP.

With a new avenue available through the dyspnoea pathway, Gary can be discharged to GP care with community navigator support.

The community navigator undertook a psychosocial assessment and developed a co-designed Goal Directed Care Plan that included both Gary and his daughter. The plan identified Gary's high priority care needs and provides a plan for managing any barriers to achieving these goals.

From this assessment and discussion with Gary and his daughter, the navigator:

- supported Gary to join a structured strength training group program, facilitated by a physiotherapist, with the purpose of helping him maintain his 'activities of daily living' and manage his chronic health conditions.
- linked Gary and his daughter in with the local Heartbeat Victoria peer support group program, which connected them to like-minded people going through similar experiences.
- identified that Gary was interested in improving his technological skills to better connect with family and friends. The navigator assisted Gary to register for a basic computer skills program at the local neighbourhood house.

The navigator followed up on the referral codes the client received through the My Aged Care Assessment and was able to access Gary's My Aged Care Client Record, which helped to determine what actions had been taken and the details of the My Aged Care Home Support Assessment.

The navigator followed up on the supports that were suggested by the HARP care coordinator and regularly reviewed the carer's wellbeing.

The navigator provided regular updates by letter to the client's GP.