Breathe easier...

Improving dyspnoea through GP and community care.

GP INFORMATION:

About the Dyspnoea Pathway Pilot

The Royal Melbourne Hospital, North Western Melbourne PHN, cohealth, and Merri Health are pleased to present The Collaborative Dyspnoea Pathway Pilot.

This pilot is for patients experiencing dyspnoea due to congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) who are at risk of multiple admissions to hospital.

This pilot will trial the new dyspnoea pathway which aims to:

1. **Improve the clinical management of patients** with COPD and/or CHF in the community by supporting GPs to manage these complex patients through enhanced discharge summaries, clear management and escalation pathways to acute care, access to telephone advice from general medicine doctors, and provision of support, education and training.
2. **Improve the psychosocial management of patients** with COPD and/or CHF in the community by providing access to a community navigator to undertake a psychosocial needs assessment and refer to a range of local community health and non-health services to help address social determinants impacting health and wellbeing.
3. **Improve patient experience** by linking existing pathways, improving information flows between professionals involved in a patient's care, and by providing high-quality care, closer to home.

Note: Patients who are Covid positive are managed via the North Western Melbourne Covid Positive Pathway.

The Collaborative
working together for better health

cohealth · The Royal Melbourne Hospital · Merri Health Healthcare that moves with you · phn North Western Melbourne An Australian Government Initiative

collaborative.org.au

1. The Collaborative dyspnoea pathway

There are three levels of patient management within the pilot pathway, see Figure 1. The intent of the pathway is to maximise management in the community with GPs. Figure 2 describes how patients move through the pathway.

Figure 1: Management of patients in the dyspnoea pathway

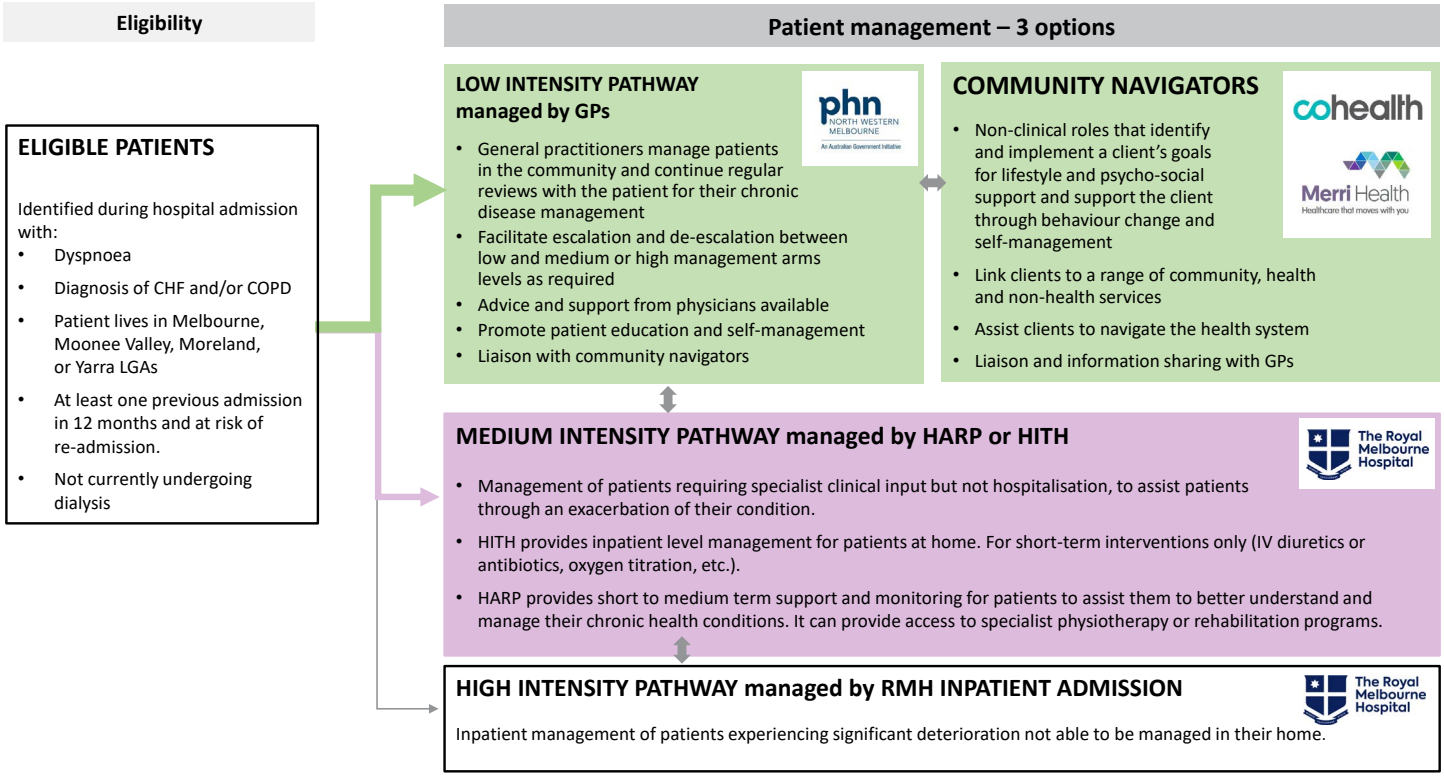
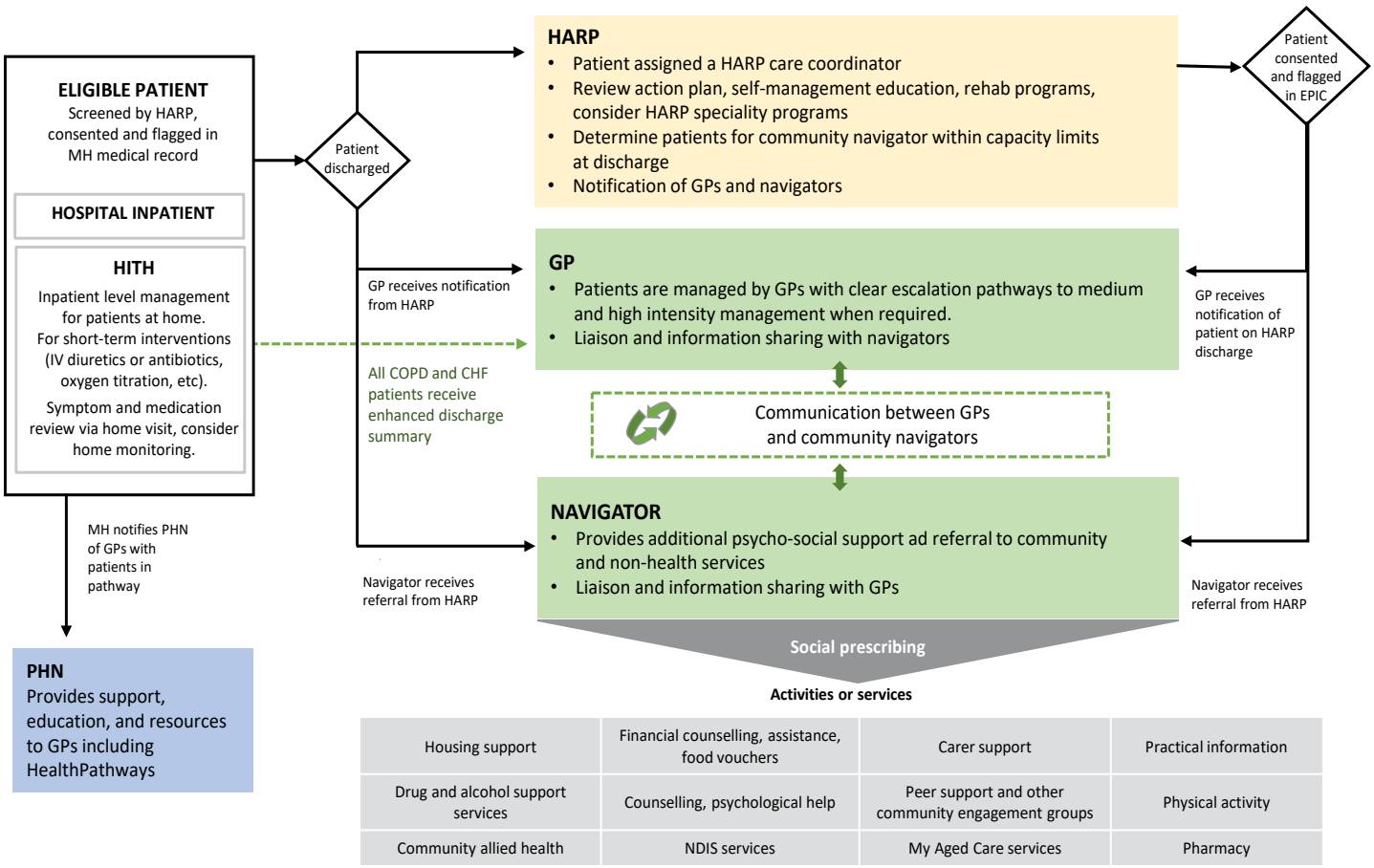


Figure 2: Patient identification, enrolment and movement through the dyspnoea pathway



2. The GP role in the pathway

On discharge from hospital, GPs will receive additional information in the discharge summary that will include:

- more detailed information on medications – what has changed, what is for short term, what the goals are;
- baseline statistics such as oxygen saturation, weight, kidney function; and
- guidance on managing further exacerbations.

GPs retain the ongoing management of patients in the community and continue regular reviews with the patient for their chronic disease management.

GPs will be notified when one of their patients is enrolled in the pilot and provided with details of the community navigator and a contact at the PHN.

HealthPathways Melbourne

HealthPathways Melbourne is the best place to find up-to-date clinical advice and guidelines plus local referral information. HealthPathways has suites of pathways to support the assessment and management of Dyspnoea, COPD and CHF:

- Acute exacerbation of COPD
- Non-acute COPD
- Advanced or end-stage COPD
- Dyspnoea
- Heart failure and acute exacerbations

To access HealthPathways Melbourne visit melbourne.healthpathways.org.au
Username: connected Password: healthcare

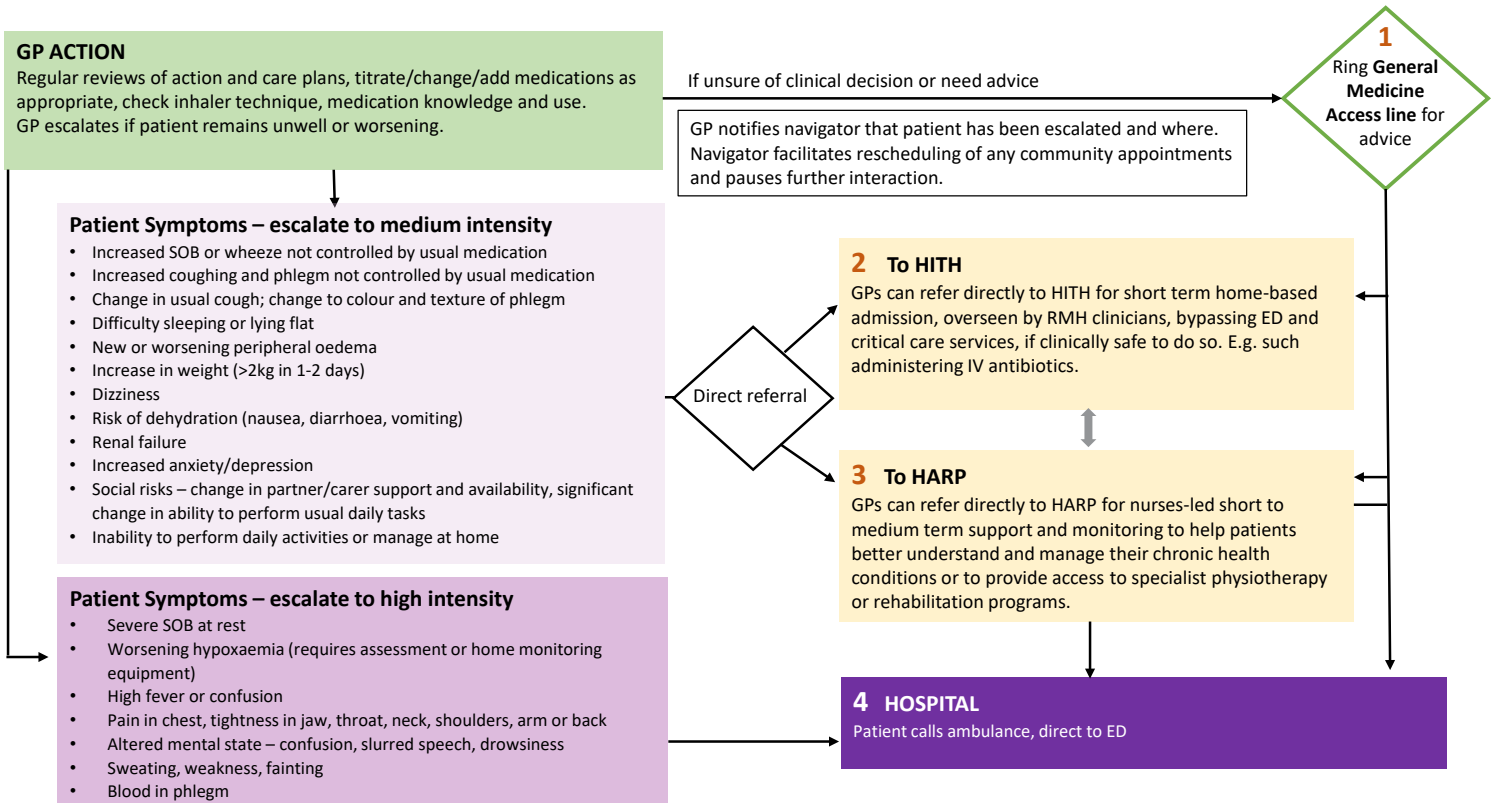
3. Escalation process

There are 4 escalation pathways for patients in the pathway dependent on symptoms and severity. The diagram below shows symptoms to consider and the appropriate escalation pathway.

1. GPs 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 a GP can action allowing a patient 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. Organise an ambulance transfer (000) for patients who need to be escalated directly to hospital.
4. **Organise an ambulance transfer (000)** for patients who need to be escalated directly to hospital.

If a patient requires escalation or if the GP becomes aware of events that may impact the patient's ability to cope at home, GPs are asked to notify the community navigator so that they can help cancel other scheduled community services if needed and re-assess their own work with these clients. Likewise, community navigators will contact GPs if they become aware of concerns that may impact the client's health.

Figure 3: How and when to escalate a patient



4. Community navigators

Community navigators, based at either cohealth or Merri Health, are non-clinical roles that focus on identifying and implementing a patient's goals for lifestyle and psychosocial support.

Patients will be assigned a community navigator based on where they live and access other services.

Community navigators will undertake a psychosocial needs assessment and work with each client to identify barriers to achieving good self-care and assist them to develop a care plan to meet their identified goals.

Social prescribing will be used as a mechanism of linking people with non-medical sources of support within their local communities to improve their physical, emotional and mental wellbeing, which in turn impacts their clinical outcomes. The navigators work in parallel with GPs, but do not have any clinical responsibility.

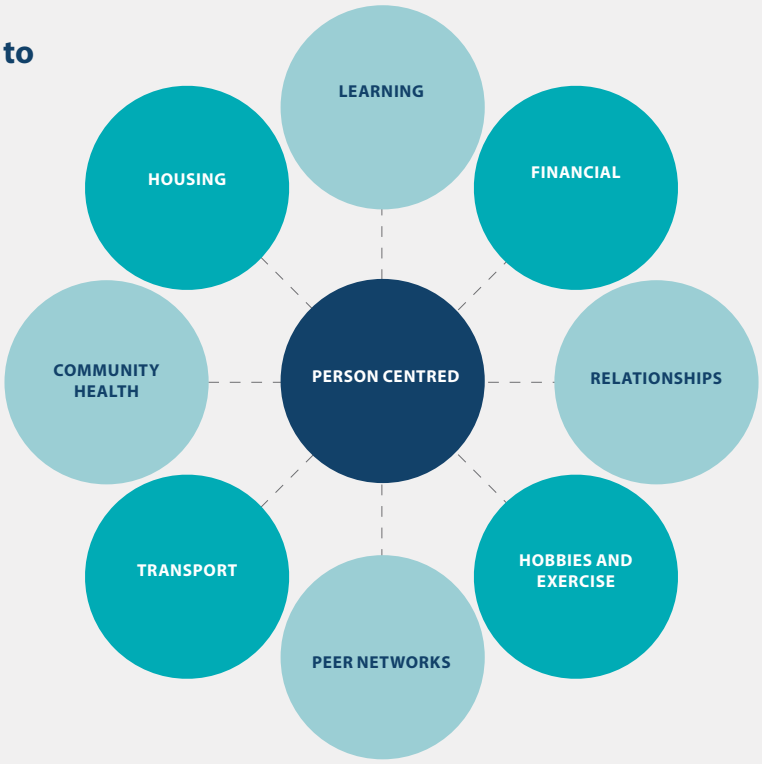
Navigators can assist clients with:

- a goal directed care plan
- access to community allied health
- links to community and peer networks
- access to housing support
- access to financial support
- practical information and much more.

Navigators will notify GPs by letter, secure email or phone call at the start and end of their care plan with each client, and if they become aware of concerns that may impact the client's health.

If a patient requires escalation or if the GP becomes aware of events that may impact the patient's ability to cope at home, GPs are asked to notify the community navigator to re-assess the patient needs.

Community navigation - linking people to care in the community



Monitoring and Evaluation

Evaluation and monitoring of this pilot program will take place through a variety of methods. There will be regular hospital data collections and audits of discharges summaries. At 12 months there will be surveys of patients, GPs, community navigators and hospital clinicians to provide feedback.

Feedback

We are keen to hear from practices who have feedback, concern or queries on how the model is working for you and your patients.

Please email us: primarycare@nwmphn.org.au using the following subject line: Dyspneoa Pilot

Contacts and resources

Contact NWMPHN's Primary Health Care Improvement team on (03) 9347 1188 9am-5pm, Monday - Friday or email primarycare@nwmphn.org.au

The PHN GP educational webinars can be viewed on our YouTube Channel: youtube.com/c/NorthWesternMelbournePrimaryHealthNetwork

Visit The Collaborative Dyspnoea website page for all related Dyspnoea resources for patients and GPs.

Other pilot related contacts include:

- **General Medicine Access Line**:
  Call 0427 566 159 to speak with a general medicine doctor between 8am and 8pm.
- **HITH:** Call the RMH@Home Acute Coordinator on 0466 868 986, 24 hours a day.
- **HARP:** Call HARP Liaisons on (03) 9342 4530 Monday to Friday 7.30am to 4pm.
- **Community navigators**:
  cohealth: (03) 9448 5844
  Merri Health: (03) 8319 7420