Breathe easier...

Improving dyspnoea through GP and community care.

The Collaborative Dyspnoea Pathway at a glance

The Collaborative is piloting a new pathway 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.

There are three levels of patient management within the pilot pathway – low intensity (GP led care), medium intensity (HARP/HITH management of short-term interventions) and high intensity (hospital admission).

The aim of the pilot is to keep the majority of patients within the low intensity management arm where possible, which is managed by GPs and community navigators, with rapid escalation pathways back to acute care if needed.

The purpose of Dyspnoea pilot pathway is to:

1. **Improve the clinical management of patients**
2. **Improve the psychosocial management of patients**
3. **Improve patient experience**

Royal Melbourne Hospital (RMH) will provide GPs with enhanced discharge summaries for all patients with COPD or CHF. The discharge letter will also tell you the name and contact details for the Community Navigator that your patient has been put in contact with for additional psychosocial support.

GP role in pathway

GPs are responsible for the ongoing management of patients and continue regular reviews for chronic disease management.

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

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

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 for support and information.

Getting help or escalating your patient

There are 4 options for GPs who are concerned about a patient enrolled in this pathway or want advice to help manage an exacerbation.

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.**
4. Organise an ambulance transfer (000) for patients who need to be escalated directly to hospital.

The Collaborative
working together for better health

cohealth