# Health Pathways Program
# Brisbane North Primary Health Network

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RBWH

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Clinical Editor

# Background

- Joint project between Brisbane North PHN and Metro North Hospital and Health Service (HHS)
- Commenced in October 2016
- Aims to improve the continuity of patient care between primary care, community & hospital settings
- Development of clinical pathways for a range of conditions and services.

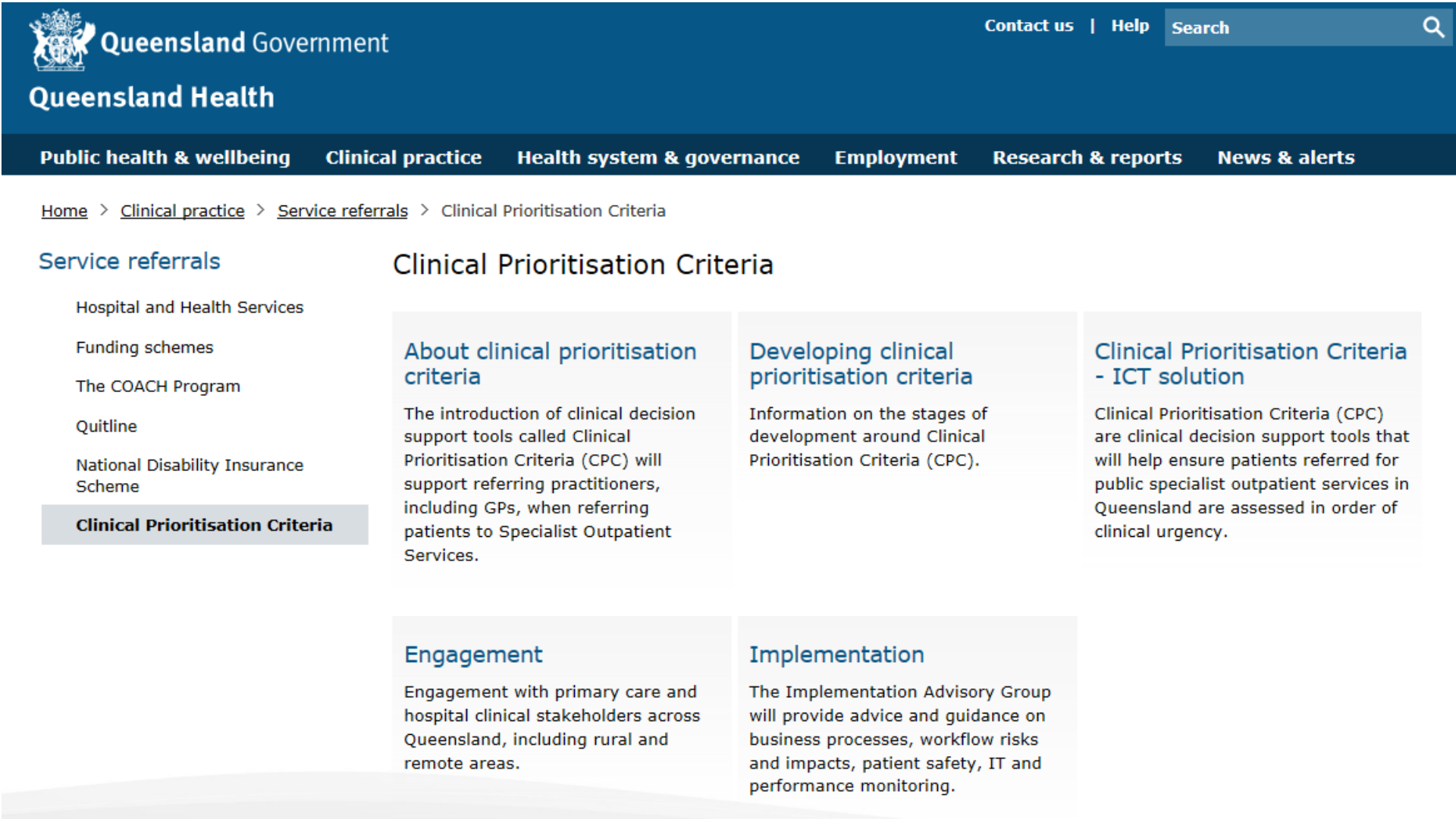
# History

- 98 pathways for 50 clinical conditions published and hosted via Map of Medicine
  - Map of Medicine  UK based
- evaluation completed 2016 – found that the tool was used as a reference but there were challenges in use at point of care

# Transition to Health Pathways

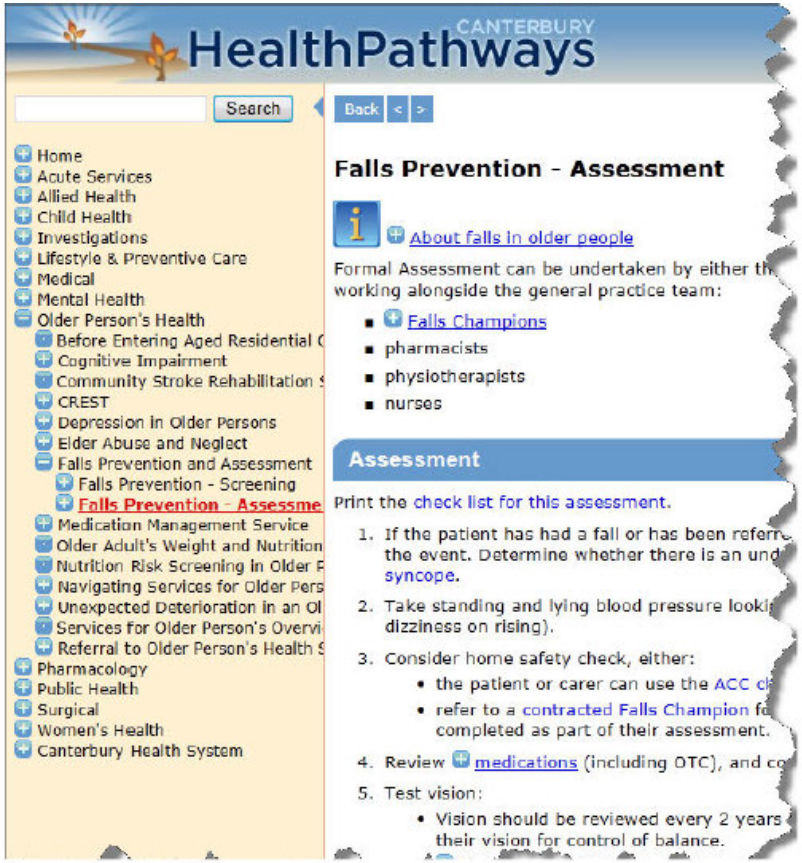
- Improve referral quality through Clinical Prioritisation Criteria (CPC) Queensland Health has purchased the licence
- Provides a consistent tool across the state
- www.health.qld.gov.au/clinical-practice/referrals/clinical-prioritisation/about

# Clinical Prioritisation Criteria



# Six years in Canterbury

- 500+ locally developed pathways
- agreements between primary care and specialists on management of conditions
- hundreds of clinicians involved in their creation
- used daily

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# Benefits of Health Pathways

- Web-based tool
- Relevant local clinical information
- Easy to use at point of care
- Over 100 clinical pathways complete
- Responsive to GP feedback

Search

- Differentiating Asthma from COPD
- Stable COPD Management and Review
- Medications in COPD
- Home Oxygen
- **Acute Exacerbation of COPD**
- Advanced or End-stage COPD
- COPD Referral
- Community Acquired Pneumonia (CAP) in
- Dyspnoea
- Haemoptysis
- Legionnaires' Disease
- Pulmonary Embolism (PE)
- Spirometry Testing and Interpretation
- Tuberculosis
- Respiratory Requests
- Rheumatology
- Sexual Health
- Sleep
- Spinal Cord Impairment (SCI)
- Mental Health
- Older Adults' Health
  - Before Entering Aged Residential Care
  - Behavioural and Psychological Symptoms (B
  - Carer Stress
  - Cognitive Impairment
  - Depression in Older Persons
  - Elder Abuse and Neglect
  - Falls Prevention
  - Health and Frailty Assessment for Older Adu
  - Medication Management Review
  - Older Adults' Health Assessment
  - Weight and Nutrition in Older Adults
  - Unexpected Deterioration in an Older Adult
  - Navigating Services for Older Persons
  - Older Adults' Health Requests
- Pharmacology
- Public Health
- Surgical
- Women's Health
- Our Health System

# Acute Exacerbation of COPD

About acute exacerbations of COPD

## Red Flags

- Respiratory failure e.g., cyanosis, oxygen saturation < 88%, confusion
- Drowsiness
- Sepsis
- Rapid decline
- Peripheral oedema

## Assessment

1. Assess for features of exacerbation.
2. Perform pulse oximetry.
3. Consider arranging investigations:
   - Spirometry.
   - If peripheral O2 saturation on pulse oximetry is < 92%, assess arterial blood gases.
   - Chest X-ray and ECG.
4. If purulent sputum, or patient is not responding to therapy:
   - consider sputum testing.
   - proceed with empirical antibiotic treatment while waiting for results.
   - avoid routine sputum testing in clinically stable patients with COPD.

## Management

More than 80% of exacerbations can be safely managed in general practice.

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- Short-acting bronchodilators
- Prednisone in moderate to severe exacerbations to reduce the severity and shorten recovery.
- Antibiotics only if clinical signs of infection i.e., increased volume and change in colour of sputum, fever, or leukocytosis. If no response to antibiotics, consider sputum testing.

3. If the patient regularly brings up copious or tenacious sputum, consider requesting physiotherapy for treatment and education in airway-clearance techniques e.g., mechanical vibration and positive expiratory therapy (PEP).
4. Monitor for and manage other conditions, e.g., heart failure, asthma.
5. Follow up after one week:
   - Review medications and inhaler technique.
   - Ensure that the patient has a COPD action plan for managing future exacerbations.
   - If the patient's condition has stabilised, manage according to the Stable COPD Management and Review pathway.

## Request

- Request emergency assessment if:
  - red flags.
  - failure of an exacerbation to respond to initial medical management.
  - presence of serious co-morbidities e.g., heart failure or newly occurring arrhythmias.
  - frequent exacerbations.
  - insufficient home support.
- If the patient regularly brings up copious or tenacious sputum, consider requesting physiotherapy.

## Information

Clinical Resources

Patient Information

References

Search

- Assault or Abuse
- Cardiology
- Dermatology
- Diabetes
- Endocrinology
- Gastroenterology
  - B12 Deficiency
  - Bowel Cancer
    - **Bowel Cancer Screening**
    - Bowel Cancer Follow Up - Post Treatm
  - Colorectal Polyps and Surveillance
  - Coeliac Disease in Adults
  - Colorectal Symptoms
  - Constipation in Adults
  - Dysphagia
  - Dyspepsia and Heartburn / GORD
  - Enteral Feeding Tubes
  - Inflammatory Bowel Disease (IBD)
  - Iron Deficiency Anaemia
  - Irritable Bowel Syndrome (IBS)
  - Liver Conditions
  - Gastroenterology Requests
- General Medicine
- Genetics
- Haematology
- Hyperbaric Medicine
- Immunology
- Infectious Diseases
- Intellectual Disability
- Neurology
- Oncology
- Pain Management
- Palliative Care
- Renal Medicine
- Respiratory
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# Bowel Cancer Screening

About bowel cancer screening

## Assessment

**Practice Point!**

- Use faecal occult blood test (FOBT) screening only for asymptomatic patients at average risk of colorectal cancer (CRC).
- Do not request:
  - colonoscopy if patient asymptomatic or at average risk of CRC.
  - FOBT for patients with colorectal symptoms, or at medium or high risk of CRC, or with related conditions.

1. Take a history, assessing for:
   - any symptoms of colorectal disease.
   - personal history of CRC or related conditions (colonic polyps or adenomas, inflammatory bowel disease).
   - family history of CRC.
2. Determine the patient's risk category.
3. Investigations for screening:
   - Not indicated for patients with symptoms of colorectal disease or personal history of CRC or related conditions. These patients require colonoscopy either for diagnosis or surveillance.
   - For other patients, base investigations on risk category:
     - Category 1 – offer FOBT every 2 years, from age 50 years until age 74 years.
     - Category 2 – arrange colonoscopy every 5 years, either from age 50 years or from 10 years earlier than the youngest diagnosis of CRC in a relative.
     - Category 3 – arrange colonoscopy surveillance, with or without genetic screening or counselling.

## Management

1. If positive FOBT result:
   - discuss the importance of further testing with the patient. Offer patient information about colonoscopy.
   - request non-acute gastroenterology assessment for colonoscopy.
   - if positive result under the NBCSP, complete the NBCSP GP Assessment Report either online or manually.

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   - request non-acute gastroenterology assessment for colonoscopy.
   - if positive result under the NBCSP, complete the NBCSP GP Assessment Report either online or manually.
     - The general practitioner will be remunerated for notifying the register.
     - This payment will be removed with the establishment of the National Cancer Screening Register.
2. Request non-acute gastroenterology assessment for patients with:
   - colorectal symptoms – see the relevant pathway.
   - related conditions unless already under specialist surveillance.
   - medium or high risk of CRC (categories 2 and 3) unless already under specialist surveillance.
3. If negative FOBT result, recommend and continue FOBT screening:
   - every 1 to 2 years in patients aged ≥ 50 years, and
   - until the age of 74 years, provided they remain asymptomatic.
4. Advise the patient to seek advice from their general practitioner if they develop any colorectal symptoms, even if they have had a negative FOBT recently.
5. If a patient at high risk of CRC (category 3) with known or suspected familial syndrome, consider referral for non-acute genetic health assessment.

## Request

- Request non-acute gastroenterology assessment if:
  - colorectal symptoms.
  - patient (unless already under specialist surveillance) with:
    - related conditions.
    - medium or high risk of CRC (category 2 or 3).
  - patient with low risk of CRC and a positive FOBT – indicate on the referral whether the patient is an NBCSP participant.

  Your patient may also want to consider a private non-acute gastroenterology assessment.
- If high risk (category 3) patient with known or suspected familial syndrome, consider requesting non-acute genetic health assessment.

## Information

Clinical Resources

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# Access

for access contact the Pathways Program team healthpathways@brisbanenorthphn.org.au, phone 07 3630 7300, or speak to your Primary Care Liaison Officer

Login: **Brisbane**

Password: **North**

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