It is important to note that these guidelines are meant to be of assistance to assessors in making observations. They do not represent complete standards of care as approved by the various fields of medicine.

MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine/Internal Medicine
 # 1 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Preventive Measures:

- ✓ discussion of smoking cessation; annual influenza vaccination; pneumococcal vaccine; exercise program

Screening and Diagnosis:

- ✓ screen those at risk for COPD (smoking history, second-hand smoke or occupational exposures)
- ✓ spirometry is screening test of choice
- ✓ post-bronchodilator ratio of the FEV1/FVC of <0.70 on spirometry is diagnostic

All Patients with COPD:

- ✓ documented history of exacerbations with increased sputum production and purulence, increased dyspnea
- ✓ documented physical findings of increased respiratory rate and wheezing; diffuse crackles without localization
- ✓ repeat spirometry prn, measurement of oxygen saturation (+/- blood gases) in moderate - severe cases

Therapies:

- ✓ Bronchodilator Therapy: use of short-acting muscarinic and short-acting beta agonists for mild cases; long acting bronchodilators alone or in combination for moderate to severe COPD
- ✓ Corticosteroid Therapy: appropriate use of systemic or inhaled steroids
- ✓ Oxygen Therapy: optimum oxygenation; use of respiratory specialist referral
- ✓ Antibiotics: antibiotic use appropriate for exacerbations and level of severity
- ✓ Pulmonary rehab as appropriate

	N/A	E	S	D
There is evidence that the appropriate preventive measures have been discussed and/or implemented.				
One or more of the appropriate therapies has been undertaken.				
Regular monitoring and documentation of treatment is evident in the event of exacerbation of COPD.				

COMMENTS:

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Family Medicine
- # 2 - DYSLIPIDEMIA

Routine screening of:

- ✓ Men over 40 and women over 50 (or postmenopausal)
- ✓ Patients with other risk factors (smoking, diabetes, hypertension, obesity, COPD, HIV, renal disease, erectile dysfunction, family history of dyslipidemia, inflammatory disease)
- ✓ Use of a cardiovascular risk score (e.g. Framingham). If < 5 %, screen every 3-5 years, if > 5 % screen every year.

Health Behaviour Modification

- ✓ Healthy eating habits
- ✓ Smoking cessation
- ✓ Physical exercise (aim for 150 minutes per week)

Awareness of lipid target levels

- ✓ High Risk (Framingham > 20%), consider statins for all patients, target LDL < 2 mmol/L
- ✓ Intermediate risk (Framingham 10 – 19 %), statins if LDL > 3.5, target LDL < 2
- ✓ Low risk (Framingham < 10%), statins if LDL > 5, target is 50 % reduction in LDL

Evidence of continued cardiovascular disease risk monitoring

	N/A	E	S	D
Appropriate screening has been done; baseline lipid profile has been determined.				
Appropriate medication, diet and lifestyle changes have been prescribed.				
Regular monitoring and long-term follow-up is being done.				

COMMENTS

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Cardiology/Family Medicine/Internal Medicine/Nephrology
#3 HYPERTENSION

Screening and Diagnosis

✓ Measure BP in all adults at appropriate visits

✓ Use proper technique and standardized equipment when taking blood pressure

All patients with hypertension

✓ Blood pressure measured and recorded in all office visits and/or home 24 hr BP monitor

✓ Manage global cardiovascular risk

✓ Monitor for target organ damage

✓ Health Behaviour Management
- Physical exercise 30-60 minutes 4-7 days per week
- Smoking cessation
- Weight reduction, waist circumference monitoring
- Alcohol ≤ 2, Men <14/week, Women <9/week
- DASH diet
- Stress management

Medical Therapies

✓ Antihypertensives should be strongly considered if office measurements
- SBP > 160 mmHg or DBP > 100 mmHg and no other cardiovascular risk factors
- SBP > 140 mmHg or DBP > 90 mmHg and target organ damage or other CV risk factors

✓ Goals of treatment
- Moderate risk patients: SBP < 140 mmHg, DBP < 90 mmHg
- Diabetic patients: SBP < 130 mmHg, DBP < 80 mmHG

✓ Choice of therapies
- Initial therapy should be one, or a combination, of
  Thiazide / thiazide-like diuretic
  B-blocker (in patients younger than 60, non-diabetic, non-asthmatic)
  ACE inhibitor (in non-black patients, preferred in diabetic patients)
  Long-acting calcium channel blocker
  ARB
- If failure of initial therapy, add-on drugs should be chosen from first line choices

Monitoring

✓ Side effects of medications, i.e. B-Blockers (bradycardia), ACE I and ARBs (creatinine and potassium checked 1-2 weeks after drug initiation); diuretics (electrolyte abnormalities)

	N/A	E	S	D
There is evidence of treatment to targets and consistent long-term follow-up (BP monitoring; lifestyle issues)				
The appropriate therapies are being used.				
Regular monitoring and review of therapy and medications is evident.				

COMMENTS: _____

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Cardiology/Family Medicine/Internal Medicine
 # 4 - CONGESTIVE HEART FAILURE

All patients with heart failure:

- ✓ documentation of clinical history and physical exam: symptoms, functional limitations, risk factors, prior cardiac illness, co-morbidities, drugs, alcohol use
- ✓ routine tests including CBC, ECG, chest X-ray, renal function, urinalysis, glucose, lipids, liver enzymes and thyroid function; consider use of natriuretic peptide
- ✓ echocardiography recommended to assess ventricular and valvular function
- ✓ manage contributing and associated conditions such as hypertension, myocardial ischemia, diabetes, thyroid dysfunction, and Reno vascular disease.

Therapies:

- ✓ lifestyle modification: smoking cessation, restriction of alcohol consumption, regular physical activity; no added salt diet; encourage daily morning weights
- ✓ referral to a heart function program
- ✓ flu shot and pneumococcal vaccine

Drug Therapies:

- ✓ cardiovascular risk factors should be aggressively managed with appropriate drugs
- ✓ all patients with heart failure and ejection fractions less than 40% should be on an ACE inhibitor with a beta blocker or carvedilol unless contraindications exist
- ✓ ARB's should be used if ACE I is not tolerated. Combining ACE inhibitors and ARBs should only be done with caution
- ✓ long-term monitoring of renal function and electrolytes needed with ACE I and ARB's
- ✓ loop diuretics recommended in patients with congestive symptoms
- ✓ electrolytes should be carefully monitored in patients on diuretics
- ✓ use of mineralocorticoid receptor antagonists in patients with EF < 30% if >55 years old or diabetic
- ✓ avoid use of NSAIDS, COX inhibitors, glitazones, non-dihydropridine CCB's
- ✓ Omega 3 fatty acids 1g daily in patients with severe HF and reduced EF
- ✓ Patients with chronic atrial fibrillation should be anitcoagulated

	N/A	E	S	D
Clinical history and physical exam are documented.				
It is evident that routine tests have been ordered and completed.				
Appropriate therapies are used and regularly reviewed.				

COMMENTS: _____

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Endocrinology/Family Medicine/Internal Medicine
 # 5 - TYPE II DIABETES MELLITUS

Screening:

- ✓ Screen all patients > 40 yrs every three years with fasting plasma glucose or A1C
- ✓ More frequent screening for patients with risk factors: 1st degree relatives with DM; member of high-risk population (Aboriginal); history of impaired glucose tolerance; vascular disease; history of gestational DM; hypertension; dyslipidemia; obesity

Diagnosis:

- ✓ Test results x 2 in diabetes range (e.g. A1C ≥ 6.5% x 2, FPG ≥ 7.0 mmol/L x 2, or A1C ≥ 6.5% AND FPG ≥ 7.0 mmol/L)

Therapies:

- ✓ referral to dietician or diabetic education centre
- ✓ healthy lifestyle education (exercise, weight management, smoking cessation)
- ✓ treat to targeted glycemic control: A1C monitoring every three months
- ✓ appropriate use of medications given patient comorbidities
- ✓ education re medications and their use
  - ✔ hypoglycemia
  - ✔ "sick day" medication management
- ✓ patient self-monitoring of blood glucose as appropriate
- ✓ manage other cardiovascular risk factors

Complications monitoring:

- ✓ retinopathy: loss of vision (yearly ophthalmology referral)
- ✓ nephropathy: renal failure (yearly urine for microalbuminuria)
- ✓ neuropathy: any neurologic symptoms or signs (monofilament testing)
- ✓ lower limb complications: foot sores or amputations (foot inspection)

	N/A	E	S	D
Documentation of appropriate screening is evident.				
Appropriate therapies and referrals are being used.				
Patients are actively involved in their own care.				

COMMENTS:

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine
 # 6 - Opioid Prescribing in Non-Cancer Chronic Pain

Documentation for all patients to include

✓ Proper investigation of disease (history, physical findings, imaging and appropriate consultations)

✓ Personal history of drug or alcohol addiction or psychiatric illness, family history of alcohol or drug addiction

✓ Documentation of lifestyle/non-pharmacologic approach to pain management

✓ A stepwise approach for the administration of pain medication suggesting a sequence of medications
- Non-pharmacologic therapy +/- non-opioid medications
- Opioids (e.g. Codeine) for mild to moderate pain, +/- non-pharmacologic therapy, +/- non-opioids
- Stronger opioids (e.g. Morphine) for severe pain, +/- non-pharmacologic therapy, +/- non-opioids

✓ Non-opioid meds include: anticonvulsants (gabapentin and pregabalin), antidepressants (Tricyclic antidepressants, SSRIs, SNRIs), topical agents (lidocaine, topical NSAIDS), antispasmodics, botulinum toxin

✓ Prescribing information:
- Use of patient narcotic information sheet and patient contract
- Use of narcotic flow sheet
- Details of prescription which include name of drug, dosage and amount of drug prescribed.
- Restrict dosing to less than 90mg morphine equivalent units

✓ Follow-up visits:
- Documentation on response to treatment, progress toward therapy goals, functional status
- Rationale for any increase in dosage
- Monitoring of adverse effects
- Drug screening for patients who are at higher risk for aberrant drug related behaviors
- Taper doses greater than 90mg morphine equivalent; may require multidisciplinary team

	N/A	E	S	D
The documented investigations and diagnoses are appropriate to the complaint/condition.				
A patient contract, narcotic flow sheets and/or other evidence of narcotic control is present.				
Response to treatment is appropriately recorded and regularly reviewed.				

COMMENTS:

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