Peer Assessment Committee
College of Physicians and Surgeons of New Brunswick

MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine/Internal Medicine

 # 1 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Preventive Measures:

- ✓ discussion of smoking cessation; exercise program
- ✓ annual influenza vaccination, updated Covid, pneumococcal, +- RSV and zoster vaccines

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:

- ✓ treatments according to COPD severity as per current guidelines
- ✓ appropriate treatment of AECOPD / proper action plan
- ✓ referral to COPD Clinic +- Referral to Respirologist as appropriate
- ✓ referral to 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.				

MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Family Medicine

 # 2 - DYSLIPIDEMIA

Routine screening of:

- ✓ men and women over 40
- ✓ all patients with other risk factors (smoking, diabetes, hypertension, obesity, COPD, HIV, renal disease, clinical or subclinical CVD, erectile dysfunction, family history of dyslipidemia, inflammatory disease)
- ✓ history of gestational HTN
- ✓ 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 / referral to smoking cessation clinic / appropriate prescriptions to help in cessation

- ✓ physical exercise (aim for 150 minutes per week)
- ✓ manage global CV risk / patient education of risk factors and prevention

Awareness of lipid target levels

- ✓ treatment initiation according to current dyslipidemia guidelines
- ✓ treats to attain target according to current dyslipidemia guidelines (avoids therapeutic inertia).
- ✓ proactively assures regular follow-ups

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 are being done.				

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

#3 HYPERTENSION

Screening and Diagnosis

✓ measure BP in all adults at appropriate frequency
✓ use proper technique and standardized equipment when taking blood pressure

All patients with hypertension

✓ blood pressure measured and recorded periodically at office visits and/or home, or 24 hr ambulatory BP monitor
✓ manage global CV risk / patient education of risk factors and prevention
✓ monitor for target organ damage
✓ health Behaviour Management
  - physical exercise
  - smoking cessation
  - weight reduction, waist circumference monitoring
  - alcohol consumption
  - DASH diet
  - stress management

Medical Therapies

✓ treatment initiation according to current Hypertension guidelines
✓ treats to attain target according to current Hypertension guidelines (avoids therapeutic inertia)
✓ consideration of single pill combination if possible
✓ investigation of resistant hypertension (consideration of secondary causes e.g. OSA, medication, etc.)

Monitoring

✓ proactively assures regular follow-up of BP measurements and pertinent blood labs.
✓ 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.				

MANAGEMENT OF SPECIFIC DISEASE ENTITIES – Family Medicine

 # 4 – DEPRESSION / ANXIETY / ADJUSTMENT DISORDERS

Screening:

- ✓ there is documentation of past personal and family psychiatric history
- ✓ there is documentation of exploration of situational stressors (financial, personal, family, workplace)

Assessment:

- ✓ there is adequate symptom description, including chronology/timeframe of complaints
- ✓ there is use of clinical assessment tools (for example PHQ-9 for depression, GAD-7 for anxiety)
- ✓ there is documentation of assessment for risk of self-harm (auto mutilation, suicidal ideation, passive death ideation)
- ✓ there is documentation inquiring about lifestyle issues that may be contributing (diet, exercise, sleep, substance use)
- ✓ consideration is made for organic causes to symptoms (medication side effects, other medical investigations depending on presenting symptoms)
- ✓ there is documentation of brief mental exam
- ✓ a provisional differential diagnosis is documented
- ✓ inquiry about lifestyle habits are documented

Treatment:

- ✓ referrals for psychotherapy/counselling are considered
- ✓ when treating with medication there is documentation about discussion of side effects
- ✓ more serious presentations are promptly referred to ER / psychiatry in a safe manner
- ✓ a follow-up plan is documented
- ✓ suggestions for lifestyle improvements are documented when appropriate

	N/A	E	S	D
Documentation of appropriate screening is evident.				
Documentation of assessments is appropriate.				
Follow up of mental illness is:				

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

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 of CV risk factors / prevention
✓ 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)
✓ angina / stroke

	N/A	E	S	D
Documentation of appropriate screening is evident.				
Appropriate therapies and referrals are being used.				
Regular monitoring and review of therapy and medications is evident.				

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

✓ avoids concomitant use of benzodiazepine.

✓ 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.				