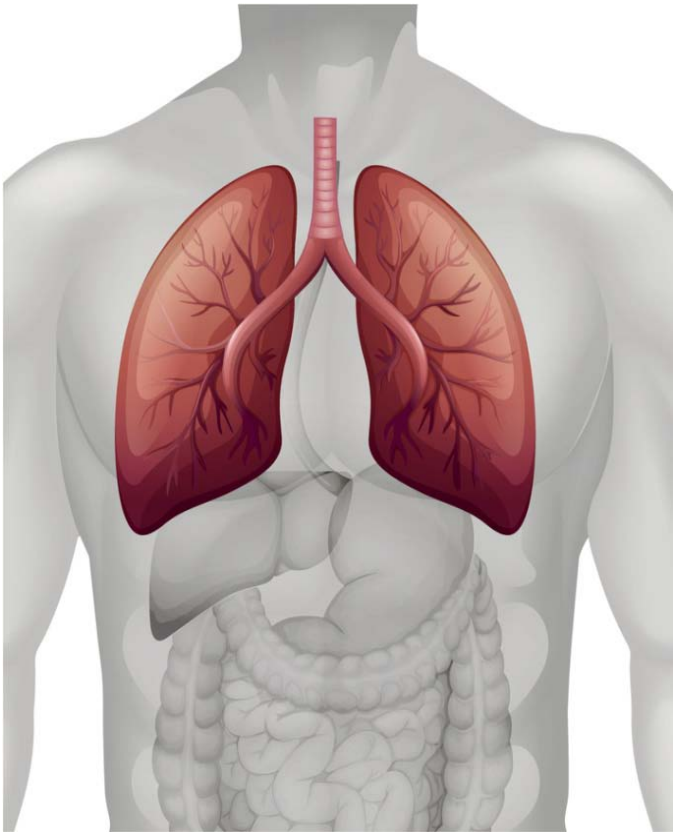
A HANDBOOK FOR CLINICIANS

PRIME HOME HEALTH SERVICES

QUALITY MANAGEMENT DEPARTMENT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)



A HANDBOOK FOR CLINICIANS

PRIME HOME HEALTH SERVICES

A SELF MANAGEMENT GUIDE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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Introduction

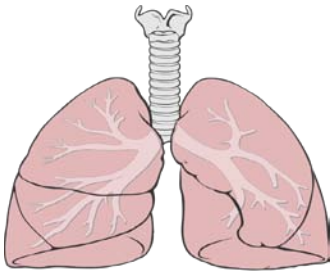
Disease Management consists of multiple components and is an effective approach for the management of chronic diseases. According to the World Health Organization (WHO), an effective COPD management plan includes four components:

1. Assess and monitor disease
2. Reduce risk factors
3. Manage stable COPD
4. Manage exacerbations

This manual was developed to be used by Prime Home Health Services clinicians as a resource guide for the management of patients with Chronic Obstructive Pulmonary Disease (COPD).

Prime Home Health Services is dedicated to the training and development of a multidisciplinary team of professionals and support staff who will work collaboratively during the provision of care, treatment and services to COPD patients.

Our multidisciplinary team of nurses, case coordinators, rehabilitation therapists, social workers and paraprofessional support staff is committed to addressing the challenges and the implementation of disease management components to meet the needs of our patients with COPD.



PRIME HOME HEALTH SERVICES

A SELF MANAGEMENT GUIDE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Mission

Prime Home Health Services will endeavor to provide care to COPD patients that meet the highest standards of care. We will strive to meet the needs of adult COPD patients in the comfort of their homes in a safe manner.

We will provide holistic, patient-centered quality care by a group of caring, compassionate and dedicated professionals.

Our professionalism, knowledge and skills, coupled with genuine warmth and concern for our patients' well-being and safety, is the foundation on which we have built the Prime Home Health Services disease management program.

Goals

1. To identify risk factors associated with COPD and high risk for hospitalization
2. Educate clinicians on best practices strategies that utilize evidence based practice guidelines
3. Encourage clinicians to utilize best practices that guide decision making with COPD patients
4. Promote and educate patients on self-management of COPD to empower patients living with the chronic illness
5. Develop processes which include communication and integration of care across all disciplines
6. Provide appropriate and safe care to patients with COPD

Overview of COPD

According to the Centers for Disease Control and Prevention (CDC), 16 million Americans have COPD. Millions more suffer from COPD but have not been diagnosed and are not being treated. COPD is the third leading cause of death in the United States. Although there is no cure for COPD, it can be treated effectively.

According to statistics compiled by the CDC and National Institutes of Health (NIH), close to 410,000 people were hospitalized due to COPD and more than 155,000 died as a result of the effects of COPD during 2017.

Data from the National Heart, Lung, and Blood Institute reveals that COPD is more common than people realize and it disproportionally affects the following: American Indian/Alaska Native, women, older adults, and those living in the southern states along the Mississippi-Ohio River Valley.

- One in five adults in the United States over the age of 45 has COPD
- Women are more likely to have COPD than men (6.7 percent vs. 5.2 percent, respectively)
- Of those diagnosed, 56 percent are women and 44 percent are men
- More women die from COPD than men (approximately 70,000 vs. 64,000)
- Of those diagnosed, 39 percent are current smokers, 36 percent are former smokers and 25 percent have never smoked

Genetics may also play a role in the development of COPD. People with a rare condition called alpha-1 antitrypsin (AAT) deficiency are at an increased risk for COPD.

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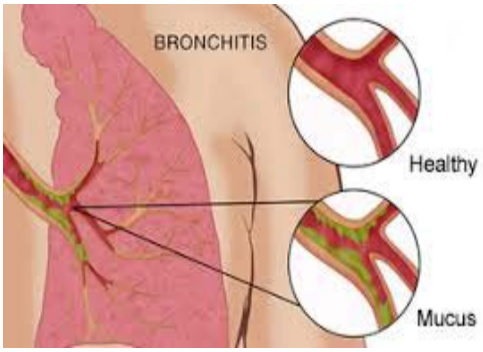
Definition

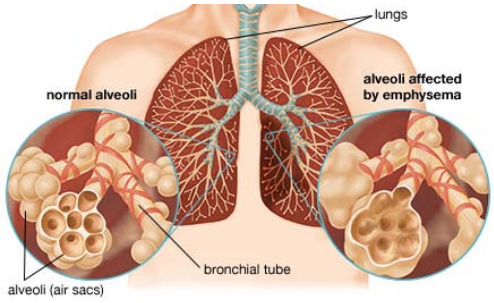
WHO defines COPD as a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. COPD is a term that is used to include chronic bronchitis, emphysema or a combination of both conditions. There is no known cure for COPD presently but with appropriate treatment individuals with COPD can live full, productive lives.

Pathophysiology of COPD



Chronic Bronchitis – is one type of COPD diagnosed with a long-term cough with excessive mucus production. It is an inflammation of the bronchial tubes (airways) causing them to become irritated and produce large amounts of mucus/sputum. With the increased production of mucus, a persistent cough usually develops. This cough can be worse in the morning. The airways can be easily infected, because it is difficult to cough out the excess mucus. When there is an infection, sputum production can increase even more and turn yellow-green in color. Chronic bronchitis can coexist with emphysema. The diagnosis of chronic bronchitis is made based on symptoms of a cough that produces mucus or phlegm on most days, for three months for two or more years (after other causes for the cough have been excluded).

Emphysema - in emphysema, the other type of COPD, the air sacs (alveoli) and small airways (bronchioles) are damaged, resulting in permanent enlarged airspaces, or holes, within the lung. Once the air sacs and small airways are damaged, it makes it difficult to inhale and exhale. When the person breathes out, the air becomes trapped inside the air sacs which in turn makes it more difficult for fresh air carrying oxygen to enter. This makes the lung act like a balloon that has been stretched out and is unable to return to its original shape. Damage to the air sacs happens over time and is not reversible.



COPD vs Asthma

COPD is often confused with asthma as they are both chronic respiratory diseases and have similar symptoms. Asthma is distinctly different from COPD as it is characterized by a reversible bronchospasm brought about by an exaggerated response to various stimuli or allergens. Asthma is most commonly diagnosed during childhood as opposed to COPD which is common among middle aged adults who have a history of chronic smoking and symptoms are consistently present day by day. Asthma symptoms are only manifested during attacks or exacerbations.

Identification of Risk Factors

The most common cause of COPD is cigarette smoking.
Other causes may include:

- Second-hand smoke
- Work-related dusts and chemicals (fumes, irritants, vapors) and outdoor pollution
- Indoor air pollution from fuels used for cooking and heating in homes that are poorly ventilated
- Childhood respiratory infections and diseases such as asthma may be linked with decreased lung function and increased likelihood of breathing problems in adulthood
- Alpha-1 antitrypsin deficiency (a genetic disorder)

The reason why some smokers never develop COPD and why non-smokers develop COPD is not fully understood. Most likely, hereditary factors play a role in the development of COPD.

Co-morbidities associated with COPD

Patients with COPD may have one or more of the following diseases which contributes significantly to the chronic nature of the illness. Treatment of the condition will improve the quality of life for the COPD patient.

- Hypertension
- Diabetes
- Lung Cancer
- Coronary Artery Disease
- Congestive Heart Failure
- Pulmonary Hypertension
- GERD
- Obesity

Signs and symptoms of COPD

It is imperative to understand and recognize the signs and symptoms of COPD. Patients with COPD may experience symptoms suddenly, or they may occur gradually over a period of time. The most common symptoms of progressive COPD are:

- Feeling tired and lack of energy
- Inability to perform normal activities
- Shortness of breath during activities such as climbing stairs and walking uphill
- Chronic cough and sputum production. Producing more sputum, a change in the color of the sputum, or seeing blood
- Wheezing

COPD Stages

A COPD diagnosis is categorized by stages based on the patient's symptoms and test results.

Stage 1

- There may be shortness of breath when moving quickly or walking up slight inclines
- Generally there is no cough or mucus at this stage
- Most people do not realize they have a lung problem at this stage
- There is about 80 percent or more of normal lung function.

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Stage 2

- The patient may walk slower than other people their age on a flat surface
- The patient may become short of breath walking on flat surface
- The patient may need to stop and catch his/her breath when using energy
- The patient may or may not have a cough or sputum at this stage
- Many people first seek medical attention at this stage because of breathing symptoms
- • At this stage, the patient has about 50 to 80 percent of normal lung function

Stage 3

- The patient will have to stop to catch his/her breath after only a few minutes of walking on a level surface
- Exercise or exertion is very difficult at this point
- The patient will become tired easily and his/her quality of life starts to decrease
- The patient has about 30 to 50 percent of normal lung function

Stage 4

- This is the most severe stage of COPD. Shortness of breath and fatigue results in significant loss of quality of life
- The patient is too breathless to leave the house
- The patient may become breathless doing everyday activities
- Trouble breathing may become life threatening during flare-ups. The patient may have as many as 2 to 3 hospitalizations in a one-year period
- The patient has less than 30 percent of normal lung function

Medical Management/Treatment of COPD

The medical management of COPD must occur timely to ensure better outcomes and enhance the quality of life for patients. The goal of the medical treatment of COPD is to improve symptoms and exercise tolerance, decrease risk of exacerbations/flare-ups and decrease risk of disease progression.

- Medical evaluation
- Smoking cessation
- Medications including oxygen treatment
- Lifestyle changes (stop smoking and limit alcohol consumption)
- Diagnostic tests
- Diet: healthy foods, staying hydrated and maintaining fluid restrictions if ordered by MD
- Surgical procedures which may include: bullectomy, lung volume reduction surgery, lung transplantation
- Vaccinations

Medications

- Bronchodilators
  - Short acting (Albuterol, Ipratropium, Levalbuterol, Ipratropium Bromide and Albuterol)
  - Long acting (Aclidinium, Arformoterol, Formoterol, Indacaterol, Salmeterol, Tiotropium)
- Steroids
  - Budesonide, Fluticasone

- Combination bronchodilator and inhaled steroid
  - Budesonide and formoterol (Symbicort)
  - Fluticasone and salmeterol (Advair)
- Phosphodiesterase-4 (PDE-4) Inhibitors
  - Roflumilast (Daliresp)
- Nebulizers
- Oxygen Therapy
- Antibiotics
- Other: mucolytic medications, antitussive medications

Diagnostic Tests

The physician may prescribe one or more of the following tests to confirm the diagnosis of COPD. These tests will assist the physician in determining the best treatment.

Examples of common tests include:

- Pulmonary Function Test
- Chest X-Ray
- Computerized Tomography (CT) Scan
- Arterial Blood Gas (ABG) Test
- Oximetry
- Electrocardiogram (ECG,EKG)
- Sputum examination

Lifestyle changes and risk reduction strategies

Smoking

The American Lung Association and the Centers for Disease Control and Prevention (CDC) report that 85 to 90 percent of all COPD cases are caused by smoking and also account for up to 8 out of 10 COPD-related deaths. Smoking cessation is the only reliable treatment to slow the progression of COPD and help maintain current lung function. Smoking cessation also helps to avoid serious flare-ups of COPD. The clinician can recommend using Helpline, Quit.com, contacting the American Lung Association or asking their MD for smoking cessation treatments.

Diet

Eating well and maintaining a healthy weight gives more energy. The clinician should explore the patient's and family's usual dietary habits and counsel the patient to select foods that provide a high-protein, high-calorie diet. If a patient is short of breath while eating, instruct them to eat smaller meals more often throughout the day and to chew slowly with their mouth closed to avoid swallowing air. They should also avoid gas producing foods and carbonated drinks. Patients should buy and make foods when they have more energy. They should also cook foods in large amounts and store in the freezer. This will allow for faster meal preparation on days that they may be tired.

Stay Active

Most patients will have a rehabilitation therapist ordered by their doctor that will instruct them in strengthening exercises for their lungs and their body. It is important to encourage patients to continue with the exercises given to them by the therapist as well as additional exercises approved by their doctor.

Stress

Stress leads to anxiety which can cause shortness of breath. Stress and anxiety are some of the triggers that can cause a flare-up of COPD. The clinician encourages the patient to talk about his/her anxiety and fears with family members and the clinician. The clinician explores relaxation techniques such as meditation, prayer, pursed lip breathing, diaphragmatic (belly) breathing, listening to music and other types of stress relief.

Depression

Having a diagnosis of COPD can lead to feelings of depression. The patient may express feelings of sadness or depression. Once the nurse identifies the patient as being at risk for depression through the depression screening, a referral to a social worker may be needed for counseling and strategies to increase coping with the COPD diagnosis, as well as the MD notification for further depression evaluation and treatment.

Clinician Assessment Strategies

The clinician should assess the patient and obtain and document baseline information for the following parameters: weight, blood pressure, pulse, respirations, and lower extremities circumference measurements and identify changes from the baseline data. Early identification and reporting of changes in symptoms by the clinician will result in early medical intervention and a decrease in the acute care hospital rate.

On the initial visit to the patient, the clinician will conduct a comprehensive assessment and at each revisit will:

1. Assess for general appearance (appearance and hygiene may be indicators of symptom interference with ADLs). Patient may appear underweight, overweight, or bloated and skin color may be dusky or pale
2. Assess heart sounds, lung sounds and for increase in shortness of breath
3. Assess for use of accessory muscles of breathing, forward-leaning (tripod) posture or pursed-lip breathing
4. Assess for sputum production: amount, color, consistency, time of day or any change from baseline

5. Assess for elevated temperature, tachycardia or tachypnea
6. Assess current dietary knowledge, cultural preferences, patterns and compliance
7. Assess mental status
8. Assess psychosocial coping skills and for the presence of depression

Clinician Intervention Strategies

Patients with Chronic Obstructive Pulmonary Disease (COPD) need assistance in changing their lifestyle. Our job is to motivate the patient into taking an active role in reducing the risk posed to them from COPD and other illnesses.

The most common co-morbidities are hypertension, diabetes, heart failure, lung cancer and coronary artery disease. It is important for the patient and doctor to develop a COPD flare-up plan and COPD treatment plan. The clinician should confirm that one has been created. If there is no plan in place, the clinician should contact the doctor to assist the patient in obtaining one. If a flare-up is identified and treated early, there is a decreased risk of the patient being hospitalized.

It is important for the clinician to assess the patient and understand the specific signs and symptoms the patient is exhibiting. They can then plan the interventions that will help the patient optimize their wellness.

After the assessment of the patient, the clinician will discuss the treatment plan with the MD, patient/caregiver and the case coordinator. Together they will develop a patient specific plan of care to address the patient's needs.

The assigned disciplines will develop individualized care plans with the patient and family/caregivers. Clinicians should encourage the patient's family/caregivers to participate and cooperate with the treatment plan.

The clinician will instruct the patient on when to contact the doctor and when to call 911 for specific signs and symptoms.

Call the doctor when:

- Experiencing shortness of breath that has become worse or occurs more often. Examples:
  - Unable to walk as far as usual
  - Need more pillows or have to sit up to sleep because of breathing difficulty
  - Feeling more tired because it takes more effort to breathe
  - Need breathing treatments or inhalers more often than usual
  - Wake up short of breath more than once a night
- Sputum changes including:
  - Changes in color
  - Presence of blood
  - Changes in thickness or amount (more than usual or more than can be coughed out)
  - Odor
- More coughing or wheezing
- Swelling in the ankles, feet or legs that is new or has become worse and doesn't go away after a night's sleep with the feet elevated
- Unexplained weight loss or gain of 2 pounds in a day or 5 pounds in a week
- Frequent morning headaches or dizziness
- Fever, especially with cold or flu symptoms
- Restlessness, confusion, forgetfulness, slurring of speech or irritability
- Unexplained, extreme fatigue or weakness that lasts for more than a day

Call 911 when:

- New or worsened shortness of breath that is not relieved by medicines or prescribed treatments
- Confusion
- Severe headache
- Difficulty walking even short distances
- A difficult time catching a breath

Important: Always keep the following close to the phone for easy access:

- A list of doctors' phone numbers
- A current list of medications and dosages
- A list of any allergies

Patient Education: Self Management Strategies

Patient/family/caregiver education by the clinician will require the use of more visual aids since some elderly patients may have difficulty with communication.

The clinician will promote self management of Chronic Obstructive Pulmonary Disease and work with the patient to develop daily goals.

The clinician will teach the patient on:

- Weighing self daily and keeping a log
- Action and side effects of medications
- How to use inhalers/nebulizers
- Read labels carefully for the correct dosage and to take medications as prescribed by the MD
- Smoking Cessation; limit alcohol intake
- Oxygen use and precautions
- Pursed-lip breathing and diaphragmatic breathing (belly breathing)
- Pacing activities

- Following prescribed exercises from Prime's rehabilitation therapists
- Eating healthy meals and adhering to fluid requirements
- Eating smaller meals more often throughout the day
- Relaxation techniques to relieve stress and anxiety
- How to recognize and report signs and symptoms of COPD flare-ups (experiencing more coughing, wheezing, and mucus than usual, elevated temperature)
- Getting immunized for Flu and Pneumonia

The clinician will also utilize other appropriate teaching tools such as: COPD Patient Education booklet; COPD Care Pathway; My COPD Action Plan; My COPD Management Plan to educate the patients on self-management of COPD.

- Obtain doctor's orders for PRN medications for COPD flare-ups based on symptoms of exacerbation and teach patient when to take the ordered medications.

Emergency Management

Patients with Chronic Obstructive Pulmonary Disease will require extra support and assistance during an emergency situation, if there is a need to evacuate the building. The clinician should encourage the patient living alone to plan for an emergency and encourage them to have a prepared "Go Bag" that should include copies of all important documents in a waterproof bag, extra set of house keys, bottled water and energy snacks, flashlight, extra batteries, as well as a list of any or all medications patient is taking and name of physician, portable radio, toiletries and phone numbers of friends and family.

Case Coordination

The Case Coordinator's role is very important in the management of patients with COPD. The Case Coordinator is responsible for ensuring that the information from the multidisciplinary team of nurses, therapists, social workers and paraprofessional worker (if applicable) is integrated and addresses the needs of the patients.

The Coordinator will need to follow up with the MD/family/caregiver to ensure that the patient is obtaining the appropriate medical services and additional follow up when appropriate to ensure that terminal patients receive information on palliative care and end of life counseling.

Education Tools

- COPD Patient/Caregiver Education Booklet
- COPD Care Pathway
- My COPD Action Plan
- My COPD Management Plan

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Education Tools

Appendix A

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CARE PATHWAY
VISIT BY VISIT PLAN OF CARE

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A SELF MANAGEMENT GUIDE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Visit 1

Assessment – OASIS

- Comprehensive physical assessment
- Vital signs
- Psychosocial assessment
- Environmental and safety assessment
- Pain assessment
- Nutritional assessment – both diet and hydration
- Fall risk and activity level assessment
- Assess for signs of depression
- Assess immunizations
- Use of medications (oral, inhalers and O2) as well as care of equipment, medication changes, Comprehensive drug regimen review
- Evaluate patient's response to therapeutic medical regimen
- Available caregivers/support system

Interventions

- Develop an emergency plan
- Initiate referrals as needed
- Develop plan of care with the patient and family or caregiver
- Provide the patient with a copy of the COPD patient education booklet
- Telephone call to MD to verify initial POC and report abnormal findings if needed
- Obtain a standing order for PRN medication/dosage changes and parameters to manage flare-ups

Teaching

- Teaching of fall prevention measures
- Skin care/pressure ulcer prevention
- Instructions of all medications dosage, purpose, schedule (comprehensive drug review)

- Detailed teaching including side effects of 1-3 high risk medications
- Emergency measures/signs and symptoms when to call MD/911
- Signs and symptoms of infection/infection control measures
- Oxygen use and safety
- Teach and obtain return demo of using nebulizer and/or inhaler

VISITS 2 AND 3

Assessment

- Vital signs
- Head to toe physical and psychosocial assessment
- Environmental and safety assessment

Interventions

- Contact MD for any abnormal findings
- Discharge planning with patient and family
- Review safety checklist
- Discuss Medicare Notice of Non-Coverage if applicable and obtain patient's signature

Teaching

- Evaluate patient's knowledge of teaching from previous visit and instruct as needed
- Teaching of COPD disease process
- Teaching of other relevant comorbidities
- Continue teaching of all medications
- Instruct on nutrition, hydration and fluid restrictions if ordered by MD
- Instruct on energy conservation, pacing of activities, purse-lipped and belly breathing
- Review COPD booklet with patient and family/CG

- Continue to provide teaching on oxygen safety and proper use of equipment

VISITS 4

Assessment

- Same as visits 2 and 3, and
- Re-assessment of medication/inhaler use and care of equipment
- Patient self-management/readiness for discharge

Interventons

- Contact MD for any abnormal findings/ obtain orders for any POC changes
- Discharge planning with patient and family
- Discuss Medicare Notice of Non-Coverage if applicable and obtain patient's signature if not done on the previous visits

Teaching

- Evaluate patient's knowledge of teaching from previous visits and instruct as needed
- Continue medication teaching
- Instruct on lifestyle changes
- Instruct on stress, anxiety and relaxation
- Instruct on importance of MD follow-up
- Instruct on obtaining supplies as needed
- Instruct on community resources
- Review appropriate information from COPD booklet

VISIT 5 – FINAL VISIT

Assessment

- Complete physical evaluation
- Complete environmental and safety evaluation
- Patient self-management and readiness for discharge

Intervention

- Evaluate patient's knowledge of teaching from previous visit and instruct as needed
- Elaborate on discharge planning
- Monitor patient's self-management activities and re-instruct as needed
- Evaluate patient's knowledge of fall reduction strategies and educate as needed
- Review and evaluate patient's knowledge of emergency measures and medication management
- Evaluate patient's knowledge of oxygen use and safety

Teaching

- Review appropriate information from COPD booklet
- Continue medication teaching
- Instruct in medical follow-up after discharge

Nursing Considerations prior to discharge of patient

- Ensure Notice of Provider Non-Coverage was issued and signed by patient at least 2 days prior to discharge (if applicable).
- Patient is competent with self management activities and/or caregiver is knowledgeable, available, willing and able to assist patient.
- Patient/Caregiver understands the emergency protocol.

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MY COPD **ACTION PLAN**

It is recommended that patients and physicians/healthcare providers complete this action plan together. This plan should be discussed at each physician visit and updated as needed.

The green, yellow and red zones show symptoms of COPD. The list of symptoms is not comprehensive, and you may experience other symptoms. In the "Actions" column, your healthcare provider will recommend actions for you to take based on your symptoms by checking the appropriate boxes. Your healthcare provider may write down other actions in addition to those listed here.

Green Zone: I am doing well today

- Usual activity and exercise level
- Usual amounts of cough and phlegm/mucus
- Sleep well at night
- Appetite is good

Actions

- ☐ Take daily medicines
- ☐ Use oxygen as prescribed
- ☐ Continue regular exercise/diet plan
- ☐ At all times avoid cigarette smoke, inhaled irritants*
- ☐ _____

Yellow Zone: I am having a bad day or a COPD flare

- More breathless than usual
- I have less energy for my daily activities
- Increased or thicker phlegm/mucus
- Using quick relief inhaler/nebulizer more often
- Swelling of ankles more than usual
- More coughing than usual
- I feel like I have a "chest cold"
- Poor sleep and my symptoms woke me up
- My appetite is not good
- My medicine is not helping

Actions

- ☐ Continue daily medication
- ☐ Use quick relief inhaler every ____ hours
- ☐ Start an oral corticosteroid (specify name, dose, and duration)

  _____
- ☐ Start an antibiotic (specify name, dose, and duration)

  _____
- ☐ Use oxygen as prescribed
- ☐ Get plenty of rest
- ☐ Use pursed lip breathing
- ☐ At all times avoid cigarette smoke, inhaled irritants*
- ☐ Call provider immediately if symptoms don't improve*
- ☐ _____

Red Zone: I need urgent medical care

- Severe shortness of breath even at rest
- Not able to do any activity because of breathing
- Not able to sleep because of breathing
- Fever or shaking chills
- Feeling confused or very drowsy
- Chest pains
- Coughing up blood

Actions

- ☐ Call 911 or seek medical care immediately*
- ☐ While getting help, immediately do the following:
- ☐ _____

*The American Lung Association recommends that the providers select this action for all patients.

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MY COPD **MANAGEMENT PLAN**

It is recommended that patients and physicians/healthcare providers complete this management plan together. This plan should be discussed at each physician visit and updated as needed.

General Information

Name: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Physician/Health Care Provider Name: _____ Phone Number: _____

Lung Function Measurements

Weight: _____ lbs	FEV1: _____ L _____ % predicted	Oxygen Saturation: _____ %
Date: _____	Date: _____	Date: _____

General Lung Care

Flu vaccine _____	Date received: _____	Next Flu vaccine due: _____
Pneumococcal conjugate vaccine (PCV13) ☐ Yes ☐ No	Date received: _____	Next PCV13 vaccine due: _____
Pneumococcal polysaccharide vaccine (PPSV23) ☐ Yes ☐ No	Date received: _____	Next PPSV23 vaccine due: _____
Smoking status	☐ Never ☐ Past ☐ Current	Quit Smoking Plan ☐ Yes ☐ No
Exercise plan ☐ Yes ☐ No	☐ Walking ☐ Other _____ min/day _____ days/week	Pulmonary Rehabilitation ☐ Yes ☐ No
Diet plan ☐ Yes ☐ No	Goal Weight: _____	

Medications for COPD

Type or Descriptions of Medicines	Name of Medicine	How Much to Take	When to Take

My Quit Smoking Plan

☐ **Advise:** Firmly recommend quitting smoking

☐ **Assess:** Readiness to quit

☐ **Encourage:** To pick a quit date

☐ Discuss use of medications, if appropriate: _____

☐ Freedom From Smoking® Lung.org/ffs

☐ Lung HelpLine 1-800-LUNG USA

☐ **Assist:** With a specific cessation plan that can include materials, resources, referrals and aids

Oxygen

Resting: _____ Increased Activity: _____ Sleeping: _____

Advanced Care and Planning Options

Advance Directives (incl. Healthcare Power of Attorney): _____

Other Health Conditions

☐ Anemia ☐ Anxiety/Panic ☐ Arthritis ☐ Blood Clots ☐ Cancer ☐ Depression

☐ Diabetes ☐ GERD/Acid Reflux ☐ Heart Disease ☐ High Blood Pressure ☐ Insomnia ☐ Kidney/Prostate

☐ Osteoporosis ☐ Other: _____

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RESOURCES

My COPD Action Plan; My COPD Management Plan
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Global Initiative for Chronic Obstructive Lung Disease
www.goldcopd.org

American Association for Respiratory Care
www.aarc.org

U.S. COPD Coalition
www.uscopd.com

National Heart, Lung and Blood Institute
www.nhlbi.nih.gov

American Thoracic Society
25 Broadway
New York, NY 10004
(212)315-8600
www.thoracic.org

Centers for Disease Control and Prevention
www.cdc.gov/copd

World Health Organization (WHO)
www.who.int

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QUALITY MANAGEMENT DEPARTMENT

PRIME HOME HEALTH SERVICES LLC

3125 Emmons Avenue
Brooklyn, NY 11235

Tel. :(718) 646-1900
Fax: (718) 646-4900

www.primehomehealth.com