Disease Management Guidelines
A working tool intended to assist with the development of an individualized comprehensive plan of care

COPD

Please note: This tool is intended to assist with the development of an individualized comprehensive plan of care. Not all outcomes and action steps will apply to all Members.

Goal: Optimize Management of COPD and Minimize Risk of Debilitating Complications

Action Steps:

✔️ As Directed by the Member, CM will:
  - Explore and provide MEMBER/caregivers with information on COPD resources such as the American Lung Association, local support groups, and area pulmonary rehab programs.
  - Facilitate an IDT with RN, PT, OT, Member, PCA, Informal Caregivers and/or other providers as deemed appropriate by the Member and the team, to assess disease status, safety/supervision needs, program and community appropriateness, and to develop an individualized program of COPD management
  - Provide ____ home visits (frequency to be determined by MEMBER need) to:
    - Assess medical, psycho/social and economic needs and explore needed resources
    - Assess cultural beliefs, values and practices
    - Monitor and evaluate MEMBER health and welfare that may include but is not limited to review of:
      - Medications
      - COPD symptoms
      - Functional abilities
      - Exercise plan
      - Smoking cessation
      - Exposure to risk factors
      - Nutritional status
      - Mental health
      - Caregiver stability
      - Life Transition planning
      - Immunizations
      - Regular medical visits
    - Evaluate effectiveness of plan and as requested by the Member, assist with barriers and challenges
Observe and verify MEMBER and caregiver skills and knowledge level

- Provide information on obtaining Medic Alert identifier
- Provide referrals as agreed to by the Member, which may include but are not limited to:
  - Physical Therapist:
    - Assess MEMBER ability for physical activity
    - Contact Member’s physician to obtain exercise recommendations
    - Assess MEMBER need for mobility and safety assistive devices
    - Develop an exercise plan adapted to the specific needs and abilities of the MEMBER
    - Provide CM with written report documenting assessments, interventions, activity plan, outcomes, and recommendations
  - Occupational Therapist:
    - Assist MEMBER to simplify daily routines/tasks
    - Recommend assistive devices
    - Provide CM with written report documenting assessment, interventions, outcomes, and recommendations.
- Obtain needed equipment and supplies as recommended by the IDT and approved by MEMBER’s physician
- Obtain and review reports of each visit by all providers, including RN, PT, and OT
- Collaborate with MEMBER, caregivers and all providers and amend the plan as needed to meet changing MEMBER needs, including referrals for specialty care

As Directed by the Member, the Skilled Nurse will provide _____ home visits (frequency to be determined by MEMBER need) for assessment, disease management planning and monitoring to include:

- Thorough history, including exposure to risk factors, family history, pattern of symptom development, exacerbations, hospitalizations, and presence and impact of other diseases.
- Physical examination including: blood pressure, heart rate and regularity, respirations, abnormal lung sounds, signs and symptoms of infection, weight and height, and calculation of body mass index.
- Assess COPD symptoms: cough quality and frequency, presence and quality of sputum, and shortness of breath.
- Review of medical records.
- Assure medical regimen is consistent with practice guidelines.
Medication review and evaluation, including use that is consistent with practice guidelines, side-effects and adverse effects of:
  - Quick-acting bronchodilators
  - Long-acting bronchodilators
  - Glucocorticosteroids
  - Combination drugs
  - All other OTC and prescription medications

Monitor and evaluate physician ordered laboratory tests including
  - Spirometry
  - Chest x-ray
  - Blood gases
  - Pulse oximetry

Exercise capacity
Impact on daily activities
Risk for falls
Equipment/assistive devices needs
Signs and symptoms of depression and/or anxiety
Pain assessment
Comprehension and ability of Member to adhere to medical regimen
Comprehension and ability of Member to perform self-care activities
Assess caregiver and PCA knowledge and skills
Contact Member’s physician office to discuss COPD clinical management strategies and obtain physician recommendations for plan of care
Assess readiness to learn and offer COPD information as allowed by Member that could include but is not limited to:
  - Disease process
  - Impact of co-morbidities
  - Medication purpose, administration, side effects and adverse reactions
  - Correct inhaler technique
  - Safe use of oxygen
  - Access to in-patient, out-patient or in-home pulmonary rehab services such as PT, OT, RT.
  - Signs, symptoms and management of disease progression and exacerbations
  - Strategies for reducing risks associated with:
    - Smoking
- Occupational exposure
- Indoor pollution
- Outdoor pollution

☐ Assess Member’s cultural beliefs, values and practices and assist the Member to create individualized COPD self-care strategies that may include but are not limited to:
  _ Medical care
  _ Medication management
  _ Smoking cessation
  _ Preventing exacerbations
  _ Diet
  _ Exercise
  _ Breathing techniques
  _ Economy of effort
  _ Mental health

☐ Monitor and evaluate COPD disease management outcomes, MEMBER adherence to disease management plan and explore and assist MEMBER with barriers and challenges.

☐ Monitor and evaluate MEMBER, caregivers, and PCA for safe use of equipment and supplies

☐ Provide CM with written reports of all visits, documenting assessments, education and clinical interventions, outcomes and recommendations

✓ MEMBER, informal caregivers and/or providers will:
  ☐ Take medications as prescribed by the physician
  ☐ Participate in an activity program as prescribed by the physical therapist and/or physician
  ☐ Make and keep all medical appointments including but not limited to:
    _ Routine check-ups to monitor health status
    _ Annual flu vaccination
    _ One-time pneumococcal vaccination with revaccination as recommended by physician

☐ Call the doctor if you experience:
  _ Increased coughing
  _ Increased sputum
  _ Increased thickness and/or change in color of sputum
  _
  _ Increased shortness of breath
Using their rescue meds more often than usual
Have a fever
Experience adverse effects from medications

Seek emergency care when:

- It becomes hard to talk
- It becomes hard to walk
- Lips or fingernails turn blue
- Your heartbeat is very fast and irregular
- Medicine does not help for very long or not at all and breathing is fast and hard.
- You become mentally confused

Verbalize understanding of when and how to seek emergency care
Verbalize understanding of risks and benefits of adherence/non-adherence to plan
Report difficulties with plan adherence, changes in health status, or service plan needs to CM

Expected Outcomes:

- MEMBER manages his/her health conditions and directs all assistance and care
- PCA, caregivers and/or MEMBER can verbalize COPD disease process management plan
- PCA, caregivers and/or MEMBER recognize symptoms of disease progression or complications and can verbalize when to call the physician or seek emergency care
- PCA, caregivers and/or MEMBER can demonstrate safe use of equipment and supplies
- MEMBER and caregivers have adequate information to make informed decisions, including the risks and benefits of adherence/non-adherence to plan