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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
  - _ Gluccocorticosteroids
  - _ 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

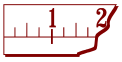
❑ Seek emergency care when:

- _ 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