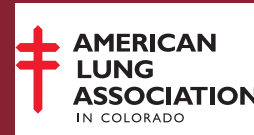


# Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



The following questions can be utilized by healthcare practitioners (specifically case/care managers) to develop an assessment for individuals with a known diagnosis of COPD. The 2006 Global Initiative for Chronic Obstructive Lung Disease (GOLD) served as a basis for the content of the assessment questions. All or select questions may be utilized by the healthcare practitioner during a telephonic or face-to-face assessment. The sequencing of the questions can be organized to meet the needs of the person conducting the assessment. Responses to the questions may be utilized by the healthcare practitioner to determine the patient's educational needs and to develop the

nursing plan of care. Healthcare practitioners should also consider supplementing this assessment by adding questions that cover the following topics:

- Dyspnea scale
- Readiness to change
- Barriers to learning
- Depression screening
- Medication adherence and compliance
- Substance abuse screening
- Quality of life



## COPD ASSESSMENT

Has a healthcare practitioner ever told you that you have COPD, chronic bronchitis, or emphysema?

- Yes (check all that apply)
- COPD
  - Chronic bronchitis
  - Emphysema
- No
- Uncertain

At what age were you first told you had COPD?

\_\_\_\_\_ (enter age)

Did your doctor tell you what caused your COPD?

- No       Yes
- Tobacco smoke
    - Personal use
    - Environmental tobacco smoke
  - Hereditary (alpha-1 antitrypsin)
  - Occupational dusts and chemicals
  - Indoor pollutants
  - Low birth weight
  - Frequent respiratory infections

Have you ever had a breathing test called a spirometry test?

- No
- Yes (if yes, complete a, b, c, and d)

a. Do you remember when you had the test?

- No
- Yes \_\_\_\_\_ (enter date)

b. Who ordered the test?

- Primary care physician
- Pulmonologist
- Had the test while hospitalized

c. Did your doctor review the results of the test with you?

- Yes
- No

d. How often did your doctor recommend that you have a spirometry test?

- Did not mention
- Only once
- Every year
- When there is a change in my COPD
- Other: \_\_\_\_\_

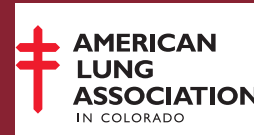
Have you seen a pulmonologist (lung doctor) for your COPD in the past 12 months?

- No, I didn't need to
- No, I would have liked to
- No, my primary care physician did not suggest it
- Yes (if yes, complete a, b, and c)

a. Do you remember the date of your last visit?

- Yes \_\_\_\_\_ (enter date)
- No

# Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



**b. How often do you usually see the pulmonologist?**

- Only one time  
 Every year  
 Several times a year

**c. Who usually takes care of your COPD?**

- Pulmonologist  
 Primary Care Physician (PCP)

**How often do you usually see the PCP for your COPD?**

- Every year  
 Twice a year  
 Several times a year  
 More than several times a year

**Over the past 12 months, have you gone to a hospital emergency room for care related to your COPD?**

- Yes  No

**Over the past 12 months, have you been admitted to a hospital for care related to your COPD?**

- Yes  No

**Have you ever participated in a pulmonology rehabilitation program?**

- Yes  
 Inpatient  
 Outpatient  
 No

**Is your physical activity limited by any condition?**

- Yes  
 No

**Do you have any type of exercise routine?**

- Yes  
 Please describe:  
 Walking  
 Low-impact exercise  
 Upper body weight training  
 Structured activity at a gym/fitness club  
 Other: \_\_\_\_\_  
 No

**Do you have a written COPD action plan or treatment plan that was developed by your doctor?**

- Yes  
 If yes, when was it last updated? \_\_\_\_\_ (enter date)  
 No

**In addition to COPD, do you have any of the following health conditions?**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Sleep apnea |

**Which of the following COPD symptoms would you say you experience on most days?**

- Shortness of breath  
 If yes,  
 With strenuous exercise  
 When hurrying on the level or walking up a slight hill  
 After walking a few minutes on the level  
 When dressing or undressing  
 Too breathless to leave the house  
 Cough  
 Cough with mucus?  
 No  
 Yes (if yes, complete a, b, and c)

**a. How frequently do you cough up mucus?**

- Only with colds  
 Less than once a day  
 About once or twice a day  
 Many times per day

**b. What is the usual color of your mucus?**

- |                                    |                                |
|------------------------------------|--------------------------------|
| <input type="checkbox"/> Colorless | <input type="checkbox"/> White |
| <input type="checkbox"/> Yellow    | <input type="checkbox"/> Green |
| <input type="checkbox"/> Brown     |                                |

**c. Are you aware of the "forceful coughing technique" that can help you keep your lungs clear?**

- Yes  
 No

# Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



**What makes your COPD worse (triggers, irritants)?**  
(check all that apply)

- Smoke                       Very cold air  
 Strong odors               Lung infection  
 Traffic fumes and environmental pollutants  
 Other: \_\_\_\_\_

**Do you generally experience a "good night's sleep"**

- Yes  
 No

**Where do you usually sleep?**

- Standard bed  
 Electric bed  
 Chair/Recliner  
 Sofa

**How many pillows do you use when you sleep?**

- 1  
 2  
 3  
 >3 or wedge pillow

**Have you ever had a lung infection?**

- Yes  
 No

**Are you able to tell the signs and symptoms of a lung infection?**

- Yes  
 If yes, please list the signs and symptoms.
  - Fever
  - Change in color of mucus
  - Change in amount or thickness of mucus
  - Increased shortness of breath

**How many eight (8) oz. glasses of fluids do you drink in one day?**

- 8 or more  
 Less than 8  
 Did your doctor tell you to limit your fluids?  
 Yes  
 No

**If you have felt panic or stress due to shortness of breath, what did you do?**

- Use relaxation techniques       Practice breathing exercises  
 Take medications                   Use oxygen  
 Call the doctor                       Call EMS

**Has a healthcare practitioner talked to you about ways to cope with panic or stress, which may happen when you become short of breath?**

- Yes  
 No

**Has a healthcare practitioner taught you any of the following breathing exercises?**

- Pursed-lip breathing  
 Diaphragmatic or abdominal breathing

**Do you plan your activities for the day (energy conservation techniques)?**

- Yes  
 No

**Have you ever smoked the following on a regular basis?**

- Cigarettes  
 No  
 Yes  
 Number of packs per day: \_\_\_\_\_  
 Number of years smoked: \_\_\_\_\_  
 Enter pack years: \_\_\_\_\_  
 Quit date: \_\_\_\_\_

- Cigars  
 No  
 Yes  
 Number of cigars per day: \_\_\_\_\_  
 Number of cigars per week: \_\_\_\_\_  
 Number of years smoked: \_\_\_\_\_  
 Quit date: \_\_\_\_\_

- Pipe  
 No  
 Yes  
 Occasionally  
 Frequently  
 Number of years smoked: \_\_\_\_\_  
 Quit date: \_\_\_\_\_

# Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



## Do you currently use tobacco products?

- No  
 Yes (if yes, complete a, b, and c)  
**a. Which tobacco products do you use?**  
 (check all that apply)

- Cigarettes  
 Cigars  
 Pipe  
 Chew  
 Snuff

## b. Have you tried to quit using tobacco products in the past?

- Yes  
 No

## c. Are you interested in quitting using tobacco products in the near future?

- Yes  
 No

## Are you exposed to second-hand smoke on a regular basis?

- No  
 Yes  
 Work  
 Home  
 Social functions

## Do you own a scale?

- No  
 Yes

## If yes, do you weigh yourself?

- No  
 Yes

## a. How often?

- Daily                       Every other day  
 Weekly                       Monthly  
 Less frequently than monthly

## b. Do you contact your doctor if you have sudden increases or decreases in your weight?

- Yes  
 No

## How many meals do you eat per day?

- Three meals                       Two meals  
 One meal                       Frequent small servings  
 Irregular meal times

## How would you describe your weight?

- Normal  
 Over  
 Under

## What is your weight?

Enter weight: \_\_\_\_\_

## What is your height?

Enter height: \_\_\_\_\_

## Have you noticed a change in your appetite in the past six months?

- Increase  
 Decrease  
 No change

## Do you have any of the following that make it difficult to eat a complete meal?

- Poor or no appetite  
 Feel full before meal is complete  
 Shortness of breath  
 Choking sensations when eating or drinking liquids

## What diet are you to follow? (check all that apply)

- Regular                       High calorie  
 Low calorie                       Low salt  
 Low fat  
 Other: \_\_\_\_\_

## Who is responsible for your daily meal preparation?

- Self     Spouse  
 Caregiver  
 Other: \_\_\_\_\_

## Have you recently had a healthcare practitioner discuss your diet with you?

- No  
 Yes  
 Doctor                       Nurse  
 Dietitian                       At pulmonary rehabilitation

## Do you have a pillbox or other medication organizer?

- Yes  
 No

# Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



Do you keep a list of all your prescription and over-the-counter medications with you?

- Yes  
 No

Do you have a prescription plan or plan that covers the cost of your medications?

- Yes  
 No

What "rescue" medications do you take for your COPD (medications that you take to help catch your breath when your usual symptoms worsen)?

List medications: \_\_\_\_\_

What "maintenance" medications do you take for your COPD (medications that you take every day to help maintain control of your COPD)?

List medications: \_\_\_\_\_

Do you take your maintenance medications every day or only when your COPD symptoms get worse?

- Every day  
 Only on certain days

Please explain why you only take your medications on certain days.

- Forget  
 Don't think I need it every day  
 Can't afford my medicine  
 Forget to refill my prescription  
 Side effects

Do you use oxygen?

- No  
 Yes (if yes, complete a, b, c, and d)

a. LPM: \_\_\_\_\_

b. Frequency

- Intermittent  
 With meals  
 With shortness of breath  
 With activity  
 Continuous  
 Only during sleep

c. Delivery method

- Nasal cannula       Mask  
 Tracheostomy  
 SCOOP (transtracheal oxygen catheter)

d. Do you have a portable oxygen system for traveling?

- Yes  
 No

When did you have your last flu shot?

- Less than 1 year ago  
 More than 1 year ago  
 I never had a flu shot  
 I did have a flu shot in the past, but I stopped getting them

Please explain (barriers):

- Did not know I needed it       Flu shot causes flu  
 Doesn't work       General excuse  
 Access and cost       Vaccine shortage  
 Afraid of pain       Allergy to vaccine and/or eggs

Have you had a pneumonia shot?

- No  
 Yes  
Date initial: \_\_\_\_\_  
Date booster: \_\_\_\_\_

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