Ensuring Safe Transitions of Care in Patients with CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Transition of Care Checklist

The use of standardized comprehensive checklists throughout the continuum of care for COPD ensures that essential domains of care are not lost during transitions. This document includes key components of a care checklist to be used during the different stages of stable and acute COPD care management.

Acute Care COPD Exacerbation

Patient presents to the hospital with an acute exacerbation of COPD (AECOPD). Follow the different phases of managing patients from admission through discharge.

Admission Phase

- ☐ Confirm COPD exacerbation
- ☐ Determine level of acute care
  - O Respiratory failure; non-invasive positive pressure ventilation (NIPPV), Invasive mechanical ventilation
- ☐ Review patient symptoms/prodromes
  - O Triggers
  - O Sick contacts
  - O Action Plan followed
  - O Anxiety/Depression screen
- ☐ Exacerbation Review
  - O Review and discuss with patient symptoms for acute vs gradual exacerbations
  - O What actions did patient take prior to coming to hospital?
  - O Number of exacerbations in prior 12 months
- ☐ Utilize short-acting bronchodilators to stabilize patient
- ☐ Implement COPD order sets
  - O Steroids strategy
  - O Antibiotic strategy
  - O Determine O2 saturation goals
- ☐ Review Respiratory Protocols
  - O Review time restrictions for short acting bronchodilators in relation to timing of long-acting bronchodilators
  - O Review conversion to as needed rescue medications
- ☐ Perform daily action planning
  - O Promote symptom recognition
  - O Monitor changes
- ☐ Ancillary assessments
  - O Nutritional needs
  - O Asses for physical and occupational therapy

Ensuring Safe Transitions of Care in Patients with CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Stabilization & Discharge Planning

- ☐ Verify last pulmonary function testing
- ☐ Pulmonary consult as indicated
- ☐ Provide nicotine replacement therapy if needed
- ☐ Daily action planning
  - O promote symptom recognition/subtle changes
- ☐ Institute mobility protocol
- ☐ Institute oral health protocol
- ☐ Titrate O2 with protocol
  - O Document clear goals to maintain recommended O2 saturations.
- ☐ Address co-morbidities that impact breathlessness
  - O CAD, HF, Anemia, deconditioning/myopathy, pain, sedating medications, anxiety/depression
- ☐ Address co-morbidities that may be impacted by AECOPD (Diabetes mellitus, anxiety/depression, insomnia, coronary artery disease, heart failure, atrial fibrillation)
- ☐ Determine patient driven-educational needs * link to Guide to Device Selection
- ☐ Involve patient in defining what 'stable" feels like in the context of their disease
- ☐ Review/address vaccinations
- ☐ Identify durable medical equipment/home health equipment needs
- ☐ Consult physical therapy for mobility/appropriate level of care post discharge
- ☐ Consult occupational therapy for upper extremity strength, energy conservation, breathing and cough techniques
- ☐ Swallow studies for swallow evaluation
- ☐ Social work consult for durable medical equipment needs/level of post discharge care/family support
- ☐ Determine who is responsible for inhaler education at your clinic/facility
- ☐ Pulmonary rehabilitation consult as indicated

Discharge

- ☐ Determine appropriate level of care for patient's recovery needs
- ☐ Exertional oxygen assessment/assessment for home oxygen
- ☐ Review home COPD device regimen to determine if still appropriate
- ☐ Perform cognitive and functional assessment and relation to appropriate device use **Link to Guide to

Device Selection

- ☐ Provide patient education and counseling on role of long acting and short acting medications
- ☐ Provide Inhaler education and teach back
- ☐ Assess inhaler technique and concerns with inhaled medications
- ☐ Determine who will be administering inhaled medications if patient needs assistance and train caregiver
  - O Speak with facility staff about competencies for inhalers and nebulized medications.
- ☐ Discuss potential changes in health status that may impact ability to use COPD medication devices
  - O Predict any new or anticipated cognitive or functional concerns that will affect ability to use treatment modalities (Assess at follow-up)

- ☐ Assess durable medical equipment needs including oxygen, nebulizer devices/nebulizer medications, nasal intermittent mandatory ventilation (NIMV)
- ☐ Review insurance coverage/verification of inhaled medications
  - O Formulate plan for alternative medication selection if not covered or affordable for patient
- ☐ Ensure a COPD short acting quick relief/rescue medication is ordered
- ☐ Ensure a COPD long acting/maintenance medication is ordered
- ☐ Review Action Plan
- ☐ Verify patient has a working nebulizer if nebulized medications are ordered
- ☐ Verify portable oxygen availability for transport if patient is oxygen dependent
- ☐ Schedule follow-up appointments as appropriate

Chronic Care

Patient discharges from hospital to home, Assisted Living Facilities (ALF), or Skilled Nursing Homes (SNF). Follow Phase I for immediate follow-up needs and Phase II for stable chronic care management.

Phase I: Post-Hospital Discharge Follow-up

- ☐ Provide medication reconciliation
- ☐ Apply GOLD Treatment Strategies/Evidence Based Treatment Strategies
- ☐ Symptom assessment/Strategy Review
  - O Action Plan-importance of early symptom recognition
  - O Review Action Plan
  - O COPD assessment test (CAT)
  - O Modified British Medical Research Council (mMRC) questionnaire
  - O Modified Borg scale (MBS)
  - O Symptom Diary
- ☐ Provide continued patient education and counseling on role of long acting and short acting medications
- ☐ Assess inhaler technique and concerns with inhaled medications
- ☐ Perform cognitive and functional assessment and relation to appropriate device use **Link to Guide to Device Selection
- ☐ Assess for changes in delivery device/medication
- ☐ Manage co-morbidities
- ☐ Assess goals of care/Advanced Directives
- ☐ Ensure vaccinations are up-to-date
- ☐ Evaluate for nicotine cessation/second hand exposure avoidance
- ☐ Evaluate durable medical equipment care/concerns/issues
- ☐ Assess home health care needs and plan to start if needed
- ☐ Address nutritional concerns
- ☐ Apply Transitional Care Management (TCM) Codes for Medicare patients (99495 and 99496)

Phase II: Chronic Care Management

- ☐ Continue to monitor for any COPD exacerbations
- ☐ Apply GOLD Treatment Strategies/Evidence Based Treatment Strategies
- ☐ Monitor for change in symptoms
- ☐ Provide continued patient education and counseling on role of long acting and short acting medications
- ☐ Review inhaler technique and assess for changes in delivery device/medication
- ☐ Perform cognitive and functional assessment and relation to appropriate device use **Link to Guide to Device Selection
- ☐ Review all medications and provide medication reconciliation at each visit
- ☐ Review Action Plan
- ☐ Symptom & Strategy Review
  - O Review Action Plan
  - O COPD assessment test (CAT)
  - O Modified British Medical Research Council (mMRC) questionnaire
  - O Modified Borg scale (MBS)
- ☐ Assess inhaler technique at every visit
- ☐ Perform cognitive and functional assessment and relation to appropriate device use
- ☐ Discuss and address medication access concerns/affordability issues
- ☐ Continue to evaluate durable medical equipment care/concerns
- ☐ Ensure vaccinations are up-to-date
- ☐ Assess need for resting and exertional oxygen assessment
- ☐ Address caregiver concerns & provide education resources
- ☐ Assess if patient is a pulmonary rehabilitation candidate
- ☐ Manage co-morbidities that impact COPD
- ☐ Nicotine Cessation/2nd hand exposure avoidance
- ☐ Monitor impact of hypoxia/hypercapnia
- ☐ Promote physical activity
- ☐ Screen for alpha-1 antitrypsin deficiency
- ☐ Screen as appropriate for lung cancer
- ☐ Bone density tests per guidelines
- ☐ Consider sleep study
- ☐ Assess for Advanced Care Planning