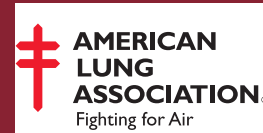


Chronic Obstructive Pulmonary Disease (COPD) Care Management Assessment



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: _____

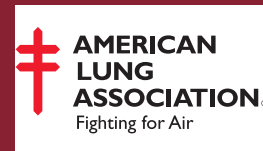
Have you seen a pulmonologist (lung doctor) for your COPD in the past 12 months?

- 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

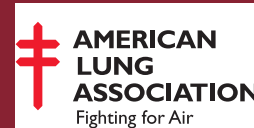
Have you ever smoked the following on a regular basis?

- 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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