COPD annual cycle of care

The COPD annual cycle of care includes three practice appointments, one held every four months.

This document has been prepared by COORDINARE - SENSW PHN, in collaboration with the local health districts, general practitioners, respiratory team specialists, pharmacists, and allied health providers. Review of best practice literature has informed these recommendations.

Change to Participation in an annual cycle of care assists people living with COPD to better manage their condition.

The annual cycle of care appointments will include:

1. Preparation/review of management plans

- GP Management Plan (within Inca)
- COPD Action Plan (within Inca)
- Discuss Advance Care Planning

2. Health assessments

- Spirometry
- Review of medications
- Pulse Oximetry
- Vaccination status

3. Lifestyle discussions

- Physical activity
- Healthy eating
- Smoking cessation
- Emotional health

4. Referrals as indicated for

- Oxygen therapy
- Bone densitometry
- Sleep apnoea assessment
- Pharmacist home medication review

Cycle of care checklist guide for adults

When	Check
Every 4 months	
	Inhaler technique / medication check
	Smoking cessation
	Pulse oximetry
	Blood pressure
	Weight
	Emotional health - the K10 Survey
	Physical activity education
	Offer Pulmonary Rehab if beneficial
	Symptom control assessment - the CAT Survey. Is home oxygen required?
Every 12 months	**Above plus:**
	Spirometry test to classify severity of COPD according to FEV1 results
	Mild – 60-80% predicted
	Moderate - 40-59% predicted
	Severe - <40% predicted
	Consider bone densitometry
	Consider Pharmacist Home Medication Review
	Vaccinations: Are the following vaccines indicated?
	Influenza
	COVID
	Pneumonia
	Shingles
	Pertussis (private vaccine)
	Sleep apnoea assessment
	Review of COPD Action Plan and GP Management Plan
	Discuss Advance Care Planning

Cycle of care

Review of medications/ Inhaler technique	Every 4 months	Check appropriate use of medications and inhaler technique.
Smoking	Every 4 months	Promote and support smoking cessation. Check maintenance of non-smoking status for patients who have previously quit smoking.
Pulse oximetry	Every 4 months	Consider referral to a respiratory specialist for further assessment for long term oxygen therapy assessment if: ● Sa02 < 92% in room air (when COPD is stable) ● FEV1 < 30% predicted ● Cyanosis ● Polycythemia ● Peripheral oedema ● Raised JVP
Blood pressure	Every 4 months	Ideal target - < 130/80 mmHg
Healthy eating review	Every 4 months	Discuss a healthy eating plan. Obesity in patients with COPD is associated with sleep apnoea, CO^2 retention, and cor pulmonale.
Emotional health	Every 4 months	Discuss emotional health and well-being. Patient should complete a Quality-of-Life survey. Discuss End of Life Care Plan/Advanced Care Planning, as and when appropriate.
Physical activity **Exercise tolerance**	Every 4 months	Encourage at least 30 minutes of moderate physical activity, five or more days a week, 2-3 sessions with resistance training, and minimize time sitting. Offer pulmonary rehabilitation if patient has had hospital admission. 6-minute walk tolerance test.
COPD symptom control	Every 4 months	Check patient's understanding of their COPD self-management plan. Is home oxygen required?
Medication review	Every 12 months	Consider referral for a Home Medication Review by a pharmacist.
Spirometry test	Every 12 months	Assess disease progression and response to therapy.
Osteoporosis	Every 12 months	Minimise risk factors for osteoporosis and consider bone densitometry. Correct any deficiency in vitamin D status.
Vaccinations	Every 12 months	Ensure appropriate vaccinations are up to date.
Sleep apnoea	Every 12 months	Discuss sleep quality and patterns. Consider referral to a sleep apnoea clinic.
COPD Action Plan and GP Management Plan	Every 12 months	Review to ensure these plans are appropriate and up to date.
Advance Care Planning	Every 12 months	Check to see if patient has an Advance Care Plan loaded onto My Health Record – if not, discuss further.

More information and support

Algorithm - Managing Exacerbations

https://lungfoundation.com.au/resources/managing-exacerbations-algorithm/

Head to Health Hub

1800 372 000 (option 2)

Lung Foundation

https://lungfoundation.com.au

Healthdirect

1800 022 222

Better Living with COPD

Better living with COPD - Lung Foundation Australia

Pharmacy delivery service

https://www.findapharmacy.com.au/our-services/delivery-services

Support groups

https://lungfoundation.com.au/patients-carers/support-services/peer-support/

Sleepiness Scale

Epworth Sleepiness Scale - Sleep Services Australia

Sleep Apnoea

One-on-one peer support

https://lungfoundation.com.au/patients-carers/support-services/peer-support/peer-connect/

International Primary Care Respiratory Group

https://www.ipcrg.org/desktophelpers

Respiratory Care Nurse

1800 654 301

Quitline

13 78 48

Lungs in Action

Lungs in Action - Lung Foundation Australia

Get Healthy Service

https://www.gethealthynsw.com.au/

Active & Healthy

https://www.activeandhealthy.nsw.gov.au/

HealthPathways

ACT and Southern NSW

Username: together
Password: forhealth

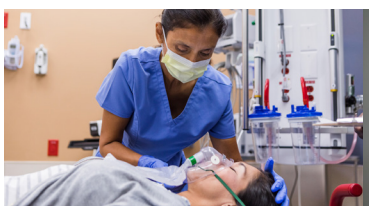
Illawarra Shoalhaven

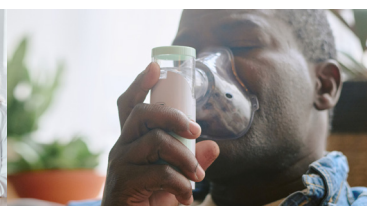
Username: connected
Password: 2pathways

Top tips

- Schedule the remaining two four monthly appointments prior to the – first appointment. These appointments are very important for assessing your patient's health and risks of COPD-related complications.
- Follow up the scheduled appointments via a phone call a week out.
- Introduce the person to their practice contact.

Notes



Care pathway flowchart

Early Diagnosis

General Practice
COPD Patients and Patients at Risk

Initial COPD GP Clinic Workshop

Respiratory Scientist
Spirometry Testing
Diagnosis

Practice Nurse
Clinical Assessments
CoCo Program Info

General Practitioner
Review Clinical Results and Spiro Diagnosis

External Providers
Smoking Cessation
Healthy Eating
Exercise Program

Diagnosed with COPD?
NO
YES

Agrees to Program
NO
YES

Signs Consent Form
NO
YES

Review Again in 12 Months

Initial Patient GP Meeting
GPMP and Action Plan

Practice Nurse
- Inhaler Technique
- Medication Check
- Pulse Oximetry
- Blood Pressure
- Weight
- Emotional Health
- Advance Care Planning
- Physical Activity Education
- Symptom Control
- Vaccinations
- Sleep aponea
- Bone density

General Practitioner
Preparation of GP Management Plan and Action Plan

Discuss completion of Advance Care Planning

Refer to Pulmonary Rehab (if req)

Invite Care Team to Review GPMP

COPD Action Plan

Patient reaches YELLOW Level Calls Practice Contact

Patient reaches ORANGE Level Urgent Mtg with GP - Consider referring to VeCC

Patient reaches RED Level Call Ambulance

VeCC
(Virturally Enhanced Community Care)

Direct admission to inpatient

Care in the Community

Ongoing Annual Cycle of Care

4th month

Practice Nurse

- **Inhaler Technique**
- **Medication Check**
- **Pulse Oximetry**
- **Blood Pressure**
- **Weight**
- **Emotional Health**
- **Physical Activity Education**
- **Symptom Control**
- **Follow up completion of Advance Care Planning**

General Practitioner

- Review of Clinical Assessments
- Review GPMP
- Review Action Plan
- Refer to Pulmonary Rehab (if req)

8th month

Practice Nurse

- **Inhaler Technique**
- **Medication Check**
- **Pulse Oximetry**
- **Blood Pressure**
- **Weight**
- **Emotional Health**
- **Physical Activity Education**
- **Symptom Control**

General Practitioner

- Review of Clinical Assessments
- Review GPMP
- Review Action Plan
- Refer to Pulmonary Rehab (if req)

12th month

Practice Nurse

- **Inhaler Technique**
- **Medication Check**
- **Pulse Oximetry**
- **Blood Pressure**
- **Weight**
- **Emotional Health**
- **Physical Activity Education**
- **Symptom Control**
- **Lung Function**
- **Vaccinations**
- **Sleep Apnoea**
- **Bone Density**
- **Wellbeing and Patient Engagement Questionnaire**

General Practitioner

- Review of Clinical Assessments
- Redo GPMP
- Redo Action Plan
- Refer to Pulmonary Rehab (if req)

Respiratory Specialists – Monthly Practice Meeting

Complex Cases (1st Year of Practice Involvement ONLY)

Severe COPD Patients – Fortnightly Practice Nurse Call
Moderate COPD Patients – Every Two Months Practice Nurse Call

Hospitalisation

LHD based Transition of Care – Hospital to Community
LinkMyCare – COPD Nurse Manages Patient's transition back into Community

- **Refer to VeCC if appropriate**
- **Refer to Pulmonary Rehab**
- **Mgt with GP within 72 Hrs of Discharge**
- **Refer to RCCP if appropriate**

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