GP MANAGEMENT PLAN / TEAM CARE ARRANGEMENTS - MBS ITEM No. 721 /723
(CHRONIC OBSTRUCTIVE PULMONARY DISEASE - COPD)

Date Prepared: <TodaysDate> **Proposed review date:**
Date Reviewed:
Date Reviewed:
Date Reviewed:

Patient Details	**GP DETAILS**
Name:<PtFullName> DOB:<PtDoB> Address: <PtAddress> Phone:<PtPhoneMob>	Name:<DrName> Address:<DrAddress> Phone:<DrPhone> Provider No:<DrProviderNo>

Current Problems List
<PMHActive>
Resolved Problems List
<PMHInactive>
Current Medications
<CurrentRx>
Allergies
<Reactions>
Immunisations
<Imm>
Smoking status / history

Social History:

Date of Confirmed Diagnosis of COPD Co-existing asthma yes / no

Summary:

	Date	
Post bronchodilator Spirometry (at either initial diagnosis or first available spirometry after diagnosis)		FEV_1/ FVC = FEV_1 = predicted %
CXR		Where?
Pulmonary Rehab		Where? When?
Last Pneumococccal vaccination		Next due / or now complete
Last influenza vaccination		Next due

Last BMD T score hip / spine		Next due
Home oxygen commenced		Last review Current prescription
Last specialist review		Next review
Significant co-morbidities		
Hospitalisations or ever ICU admission for COPD		

Biomedical data	**Initial GPMP Date**	**Review GPMP Date**	**Review GPMP Date**	**Review GPMP Date**	**Review GPMP Date**
BP					
Pulse					
Height					
Weight					
BMI					
Waist Circ.					
Activity levels (mins / week)					
Functional Capacity CAT / mMMR					
Exacerbations in last year					
FEV_1/ FVC (post bd)					
FEV_1 (post bd)					
FEV_1 % pred (post bd)					
Severity classification					
SaO_2 (if applicable)					
Depression score K10/DASS21 /HADS					
Smoking status					
Inhaler technique					
Action plan rev					

AKPS (if indicated)					

Resources:
http://lungfoundation.com.au/health-professionals/clinical-resources/copd/general-practice/

http://lungfoundation.com.au/health-professionals/guidelines/copd/copd-x-concise-guide-for-primary-care/

http://lungfoundation.com.au/health-professionals/clinical-resources/copd/primary-care-respiratory-toolkit/

Patient problems / needs / relevant conditions	**Goals and Recommendations**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
1. General			
Patient's understanding of their condition of COPD/Chronic Lung Disease	Patient to have a clear understanding of their condition and patient's role in management.	Patient education Lung Foundation Australia resources COPD On Line Patient Education http://www.cope.lungfoundation.com.au/ Better Living with Your Lung Disease – DVD Series http://lungfoundation.com.au/patient-support/living-with-a-lung-condition/self-management/ Better living with COPD – a patient guidehttp://lungfoundation.com.au/patient-support/copd/better-living-with-copd-a-patient-guide/ Lung Foundation Patient Information and Support Centre – 1800 654 301 Chronic Disease Self-Management Programs *A* Stepwise Management Guide to Stable COPD *will guide clinicians in COPD management* http://lungfoundation.com.au/health-professionals/guidelines/copd/stepwise-management-of-stable-copd/ consider referral to Respiratory Physician	GP Nurse Respiratory (nurse) Educator Lung Foundation Australia Respiratory Physician
2. Lifestyle			
Nutrition	Maintain healthy diet based on nutritional state	Patient education Assess nutritional state (under or overweight?) Frequent small meals can reduce dyspnoea	Patient to implement GP/Nurse to monitor Dietitian
Weight **Your weight**	Your target:	Monitor Review 6 monthly *Excessive weight loss is common with*	Patient to monitor GP/Nurse to review

BMI **Waist**	Ideal: BMI 25-28 kg/m^2 *A slightly higher BMI is acceptable in COPD*	*advanced COPD* *Obesity in patients with COPD is associated with sleep apnoea, CO2 retention, and cor pulmonale.*	
Physical activity **current activity level:**	Your target: General recommendation: Exercise at least 30 minutes walking or equivalent 5 or more days per week http://www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines	Patient exercise routine Pulmonary Rehabilitation for moderate to severe COPD *(see below under self-management)* *Find the closest one to you:* http://lungfoundation.com.au/patient-support/living-with-a-lung-condition/pulmonary-rehabilitation-2/pulmonary-rehabilitation-programs-2/ Referral to Pulmonary Maintenance Exercise Program (post PR) e.g. Lungs In Action http://lungsinaction.com.au	GP/practice nurse to monitor. Pulmonary Rehabilitation Programme Referral to Chronic Disease Self-Management Programs Exercise Physiologist Exercise group
Smoking **Cigarettes/day:** **Pack years:**	Complete cessation	Smoking cessation strategy: Consider: - Quitline - Medication - Lung Age estimator and pack years calculator http://lungfoundation.com.au/health-professionals/clinical-resources/copd/primary-care-respiratory-toolkit/ Behavioural support/counselling	Patient to manage GP/Nurse to monitor and support Quitline referral Smoking cessation clinic Pharmacist referral / support
Alcohol intake **current drinks/day**	Your target: Ideal: ≤ 2 standard drinks per day with at least one alcohol-free day per week	Reduce alcohol intake Patient education	Patient to manage GP/Nurse to monitor and support DASSA – Drug and Alcohol Service of SA
3. Medication			
Medication review	Pharmacotherapy to optimise function and prevent exacerbations. Good adherence and device use Prevent adverse medication effects	Check optimal drug therapy *(refer to pharmacotherapy section of* ***Stepwise Management of COPD*** ahttp://lungfoundation.com.au/health-professionals/guidelines/copd/stepwise-management-of-stable-copd/ Review adherence Check and correct device use LFA videos and inhaler technique fact sheets http://lungfoundation.com.au/patient-support/copd/inhaler-technique-fact-sheets Understanding the use of medications including: **- Inhaled Bronchodilators** for symptom relief and to increase exercise capacity	GP Practice nurse Respiratory (nurse) Educator Pharmacist Home Medication Review (Accredited pharmacist)

		- Maintenance Medications /long acting bronchodilators (LABAs and/or LAMAs) to improve exercise capacity, reduce breathlessness and reduce risk of exacerbations **- Inhaled corticosteroids** in patients with severe COPD AND ≥2 exacerbations in the last 12 months, to reduce risk of exacerbations **- Oral Bronchodilators** (low dose Theophylline) to reduce breathlessness (monitor for adverse effects and drug interactions) Ensure patient has **exacerbation medications /emergency pack** readily available – details as per Action Plan, including short course oral steroids and antibiotics	
4. Biomedical			
Spirometry Your spirometry : (post bd) **FVC: litres** **% predicted** **FEV_1: litres** **% predicted** **FEV_1/FVC:** **Severity assessment when stable:** Mild Mod Severe http://lungfoundation.com.au/health-professionals/guidelines/copd/stepwise-management-of-stable-copd/ Exacerbations in last 12 months: Date: Hospitalised? Yes / No Date: Hospitalised? Yes/ No	Confirm diagnosis and monitor lung condition COPD defined as **Post bd FEV1/FVC<0.7** **Post bd FEV_1<80% predicted)** If the FEV_1 response to bronchodilator is: • > 400 mL, strongly consider asthma or asthma / COPD overlap. • < 400 mL (but ≥ 200 mL and ≥ 12%), consider co-existing asthma with COPD depending on history and pattern of symptoms.	Record results of spirometric tests at diagnosis (absolute and percentage of predicted) Perform and record spirometric measurements annually for mild / moderate COPD and twice yearly for severe COPD (a loss of 500mls over 5 years will identify patients with rapidly progressing disease who may need specialist referral and investigation)	GP Nurse Respiratory Function Laboratory Respiratory specialist or physician
Pulse Oximetry **Date:**	Assess tissue oxygen levels	Referral to Respiratory Specialist for further assessment and need for long term oxygen therapy (LTOT): SaO2 < 92% in room air (when	GP Nurse

Your Oxygen saturation level (SaO2) today:		stable) FEV_1<30% predicted Cyanosis Polycythaemia Peripheral oedema Raised JVP Consider referral for assessment: FEV_1 30 – 49% predicted Patient education – LFA Home Oxygen resources (e.g. Home Oxygen Booklet; equipment checklists, oxygen prescription and goal setting, power blackout action plan) http://lungfoundation.com.au/patient-support/living-with-a-lung-condition/oxygen Assess fitness to fly (if required) - *Patients with advanced or unstable disease might require specialist assessment and high altitude simulation tests (HAST) , particularly if SaO2 is 88% or lower* http://copdx.org.au/copd-x-plan/p-prevent-deterioration/p10-oxygen-therapy/p101-fitness-to-fly/ Patient fact sheet: http://lungfoundation.com.au/wp-content/uploads/2013/12/Fitness-to-Fly.pdf	Respiratory Physician Lung Foundation Australia
Assess the impact of COPD on the person's life **Date:** **CAT: /40** http://www.catestonline.org/ **mMRC Dyspnoea scale** **Grade :** (see Table 2 below)	Monitor long term course of disease, early detection of deterioration, and affect on activities of daily living **CAT COPD Assessment Tool** (Impact on QOL): 5-9 Low 10-20 Medium >20 High >30 Very High	Monitor for the impact of COPD including the degree of breathlessness and affect on activities of daily living	GP Pulmonary Physiotherapist Exercise physiologist Occupational Therapy Pulmonary Maintenance Exercise Program Respiratory Physician
Blood pressure **Your BP:**	Your target: Ideal: < 130/80 mm Hg	Check every 6 months	GP Nurse
Osteoporosis **Vitamin D:** **BMD date & result:** .	Maintain healthy bones *Patients with COPD are at increased risk of fracture due to the disease itself, the use of high dose corticosteroids and co-existing risk factors such as immobilisation, reduced muscle mass and other factors*	Minimise risk factors for osteoporosis and consider monitoring bone density (two yearly). Correct any deficiency in vitamin D status Advice re adequate calcium intake / sun exposure / exercise http://www.osteoporosis.org.au/resources	GP Nurse Dietitian Pharmacist Endocrinologist / Specialist Physician

		Manage osteoporosis according to current guidelines http://www.osteoporosis.org.au/healthcare-professionals	
5. Prevent Deterioration			
Immunisation **Your current vaccination status:** **Influenza – Pneumococcal-**	Maintain immunisation and prevent complications from influenza and pneumococcal disease	Influenza vaccine every year Pneumococcal vaccine – initial vaccine then booster after 5 years depending on age and ATSI status see table 3, page 9 http://lungfoundation.com.au/health-professionals/guidelines/copd/copd-x-concise-guide-for-primary-care/	GP Practice nurse
Home Oxygen	Yes ☐ No ☐ Date commenced:	Consider need for home oxygen (see above under pulse oximetry) Ambulatory oxygen for those on LTOT who want to continue therapy outside the home Short burst oxygen only for episodes of severe breathlessness relieved by other treatments Patient education – LFA Home Oxygen resources (e.g. Home Oxygen Booklet; equipment checklists, oxygen prescription and goal setting, power blackout action plan) http://lungfoundation.com.au/patient-support/living-with-a-lung-condition/oxygen	Respiratory Specialist Respiratory nurse specialist Home oxygen supplier Lung Foundation Australia
6. Develop self-management plan			
Pulmonary rehab	Yes ☐ No ☐ Date referred: Maintain recommended physical activity levels	Assess need for pulmonary rehab, particularly in moderate to severe disease Provide information to patient about PR http://lungfoundation.com.au/wp-content/uploads/2014/02/Pulmonary-Rehab-Fact-Sheet-Feb-2015.pdf Refer to suitable PR program http://lungfoundation.com.au/patient-support/living-with-a-lung-condition/pulmonary-rehabilitation-2/pulmonary-rehabilitation-programs-2/ Assess need for re- referral	GP Practice nurse Respiratory Specialist Pulmonary rehab

		Assess need for referral to maintenance exercise program (e.g. Lungs In Action http://lungsinaction.com.au)	
Psychosocial and mental health issues	Prevention and early detection of psychosocial problems, support for patient and extended family	Lung Foundation Australia has a range of educational resources for patients & carers and contacts for local support groups and can be contacted toll-free on 1800 654 301 Regular review with nurse to support patient with health education, advocacy and referral to other health providers as necessary, encourage carers/family to attend appointments if patient is willing Consider screening for depression/anxiety using assessment tool if appropriate - Kessler Psychological Distress Scale (K10) - Depression Anxiety Stress Scale 21 (DASS 21) http://www.gppaustralia.org.au/sites/default/files/services/mh/DASS%2021%20with%20Scoring%20Sheet.pdf - Hospital anxiety and depression scale (HADS) http://www.scalesandmeasures.net/files/files/HADS.pdf	LungNet National Support Network – 1800 654 301 Nurse Closing the Gap Chronic Disease Management Programs GP Psychologist / Mental Health Clinician
Family / Carer support	Maintain communication and support for carers and family members if applicable	Encourage carer/family involvement with management if patient willing Refer to carer's advocacy/support groups as appropriate Referral to agencies providing assistance in the home as required/AACAT referral	GP Nurse Access 2 home care Home Assist/local council Carer support organisations
7. Manage exacerbations			
COPD Action Plan (Copy attached)	Yes ☐ No ☐ Early detection and management of exacerbations	Develop COPD Action Plan with patient and / or carer http://lungfoundation.com.au/health-professionals/clinical-resources/copd/copd-action-plan/ Review at least annually and after each exacerbation, ED visit or hospitalisation to review and optimize medication regime, and lung function and consider need for Pulmonary Rehabilitation Ensure current ambulance subscription Have COPD Action Plan (and current list of medicines) readily available to	Patient / carer GP Nurse Specialist Respirator Nurse Practitioner

		show emergency services	
8. Identify and manage co-morbidities			
Sleep apnoea	Consider sleep apnoea	Assess for symptoms http://www.sleep.org.au/documents/item/78 Consider using screening tools such as ESS http://www.sleepapnoeanz.org.nz/the_epworth_sleepiness_scale.shtml online form http://www.sleepservices.com.au/patients/epworth-sleepiness-scale	GP Specialist referral Sleep unit
Management of co-morbidities *These may include* *Cardiac disease* *Heart failure* *Sleep-related breathing disorders* *Diabetes* *Anxiety and depression* *Osteoporosis*	Early detection and management of conditions	Further review and assessment as required	GP Specialist
9. Supportive or palliative care needs			
	Identify those late in the clinical course of COPD who require supportive or palliative care Three triggers that suggest that patients are nearing the end of life are: 1. The Surprise Question: 'Would you be surprised if this patient were to die in the next 6 – 12 months? 2 General indicators of decline - deterioration, increasing need or choice for no further active care. 3 Indicators of severe COPD (low FEV_1, decreased functional capacity) Australian Karnofsky Performance Status (KPS) scale – decreasing numbers indicate reduced performance http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/do	Discussion of end of life wishes with patient / family / carer → Advance Care Planning http://www.advancecaredirectives.sa.gov.au/forms-and-guides Specialist Palliative Care and Advance Care Planning Advisory Services (Decision Assist) for GPs and aged care staff 1300 668 908 (available 24/7) http://www.caresearch.com.au/caresearch/tabid/2583/Default.aspx Consider referral to palliative care services / specialist .	GP Palliative Care Australia Local Palliative Care Service Palliative Care Physician (private)

	c/uow129188.pdf		

Team Care Arrangements

Provider Name	Treatment/Service	Goals	No. of visits

Copy of GP Management Plan offered to patient? <<Copy of GPMP offered to patient?>>

Copy / relevant parts of the GP Management Plan supplied to other providers? <<Copy of GPMP supplied to other providers?>>

GP Management Plan added to the patient's records? <<GPMP added to patient's records?>>

Date service was completed: <<Date service completed>>

Proposed Review Date: <<Proposed review date (recommended 6 months)>>

I have explained the steps and any costs involved, and the patient has agreed to proceed with the plan. <<Steps and costs explained, patient agreed>>

GP's Signature: x_____ Date: <<Miscellaneous:Date>>

GP Name: <<Doctor:Name>>

Table 1: COPD Severity

Based on FEV1%of predicted post-bronchodilator

Mild	60-80%
Moderate	40-59%
Severe	<40%

Table 2: Modified Medical Research Council (mMRC) Dyspnoea Scale for grading the severity of breathlessness during daily activities

Grade 0	I only get breathless with strenuous exercise
Grade 1	I get short of breath when hurrying on level ground or walking up a slight hill2On level ground
Grade 2	I walk slower than people of the same age because of breathlessness, or I have to stop for

	breath when walking at my own pace on the level
Grade 3	I stop for breath after walking about 100 metres or after a few minutes on level ground
Grade 4	I am too breathless to leave the house or I am breathless when dressing or undressing