REMOTE COPD PATIENT FOLLOW-UP DURING COVID-19 PANDEMIC RESTRICTIONS

Introduction

During the COVID-19 pandemic, the Global Initiative for Chronic Obstructive Lung Disease (GOLD) recognizes that there is a need for developing new approaches to interact with COPD patients. Remote consultations are superb tools to minimize the risk of transmitting coronavirus and will be necessary for some time. The systems put in place to facilitate remote consultations should also help increase the efficiency and capacity of the health care system into the future.

In this short document, GOLD provides guidance to support the remote interaction with COPD patients who are usually seen in primary or secondary care. The tool includes instructions on how i) to prepare for the remote visit; ii) to set up the visit agenda with the patient; and iii) provides a standardized checklist for follow-up of COPD patients whether in-person, by phone or in a virtual/online setting.

The principles of good record keeping and clinical practice should always apply: i) treat patients with dignity; ii) respect people's right to privacy and confidentiality; iii) listen to the patient's needs and act in their best interest; and iv) base your recommendations on the best available evidence.

Triage and prioritizing process

The process of triage should help decide: a.) whether to offer an in-person as opposed to a remote (telephone or virtual/online) consultation, and b.) who to prioritize.

Remote follow-up could be considered in the following situations:

- Patient or caregiver can understand the process and provide information clearly;
- Regular COPD follow-up or patient followed for a known condition;
- Medical records and laboratory test results are accessible to the healthcare professionals;
- Prescription and access to medication is possible and follow-up to the prescription can be arranged if necessary.

In-person follow-up should be prioritized in these situations:

- Patient and caregiver have difficulty providing information;
- Patient needs immediate attention due to the presence of severe medical symptoms;
- Changes in patient's symptoms require a differential diagnosis work-up with the need for a physical exam and/or laboratory testing;
- Patient treatment can only be given in person and cannot be given at home.

Prioritization of in-person visits should take into consideration the COPD patient disease severity (symptom burden and risk of exacerbations), recent emergency department visit and/or hospital admission, associated significant comorbidities, age, and/or living alone at home.

Consideration and instruction for remote COPD follow-up

Ensure documentation of the whole visit (in writing) as you would normally do for an in-person follow-up. The documentation should reflect that this is a remote follow-up (telephone or virtual/online) and should be specific about how the information was obtained.

1. ***Start the call by***
    a. Introducing yourself and, if necessary, any other health care professional(s) who may be with you (e.g., case manager, student, resident, etc.);
    b. Verifying who you are speaking with (patient name and date of birth), and patient consent to receive remote follow-up;
    c. If applicable, informing patient that the speakerphone is on;

2. ***Welcome the patient to the call***
    a. Verify technical issues;
    b. Ask the patient if (s)he can hear you well;
    c. Describe what to do if the connection fails;

3. ***Explain that this is a remote visit*** and give the reason why;

4. ***Check if there are others listening*** to the conversation, and if patient consents to all those present;

5. ***Set the agenda*** (agree on elements to be discussed, time allotted, etc.);

6. ***Conduct the follow-up visit*** using the instructions below in the COPD Follow-up Checklist and remember to keep the focus on the main issues raised by the patient;

7. ***End and summarize the visit***
    a. Ask the patient to summarize what the discussion and main issues have been, reinforce any action plan or intervention you have agreed upon (if any homework);
    b. Set up a date for follow-up;
    c. Agree upon ending the meeting.

References

1. Action Plan from the *Living Well with COPD* series. Bourbeau J, Nault D, Sedeno M et al. 2005. https://www.livingwellwithcopd.com/en/copd-treatment.html
2. Global Strategy for Diagnosis, Management and Prevention of COPD (2020 Report). Global Initiative for Chronic Obstructive Lung Disease. www.goldcopd.org

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Document prepared by: Dr. Jean Bourbeau, MD; Dr. Josianne Hamel Bourbeau, MD; Alexandre Joubert, RN, BSc; Maria Sedeno, BEng, MM

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COPD Follow-Up Checklist

In-person Follow-up □ **Phone Follow-up** □ **Virtual/online Follow-up** □

Date: YYYY / MM / DD **Diagnosis:**

1. BASELINE SYMPTOMS – Breathlessness on a regular day: mMRC /4

Daily sputum production: □ no □ yes, color: Regular cough □ no □ yes

Recent change in symptoms □ no □ yes

If yes, since when:

□ Sputum color: □ Sputum volume ↑ = ↓

□ Dyspnea ↑ = ↓ □ Fatigue ↑ = ↓

□ Cough ↑ = ↓ □ Other

□ Signs of hypercapnia **CAT: /40**

Maintenance Medication and adherence:

□ SABA □ LABA/LAMA

□ LABA □ LABA/ICS

□ LAMA □ ICS/LABA/LAMA

□Other:

Non pharmacological Rx:

O2: CPAP: BIPAP :

2. COVID-19 – If patient is feeling unwell, check other symptoms: □ Fever____ □ Sore throat □ Anosmia □ Others________

Contact with someone COVID-19 positive? □ no □ yes Tested for COVID-19? □ no □ yes If yes □ positive □ negative

3. WRITTEN ACTION PLAN – no □ yes □

Instruction and any additional treatment: ___________________________________

Last time it has been used (date):

4. RECENT ADMISSIONS AND EMERGENCY VISITS

Hospital/ER	Where	Date	Length	Reason (Dx)

Comments:

5. COPD Self-management (healthy behaviors) – Integrated (patient has used it in his daily life)**?**

Smoke-free environment	yes	no	cannot tell
Medication adherence	yes	no	cannot tell
Prevention/management of exacerbations	yes	no	cannot tell
Breathing control	yes	no	cannot tell
Stress management	yes	no	cannot tell
Physical activity and exercise	yes	no	cannot tell
Other _____________	yes	no	

Comments and what patient should prioritize based on his/her need:

6. MAIN ISSUES

1.	***2.***	***3.***

7. SUMMARY, INTERVENTIONS & PLAN

(healthcare professional name & signature)

Instructions for using the COPD Follow-Up Checklist

1. Intro
    a. Identify dates, Dx and whether this follow-up is being done in-person, by phone or remotely.
2. Section 1 – Baseline symptoms
    a. Go over the patient symptoms and whether there have been change in dyspnea, cough, sputum volume and color (from least to most purulent: mucous; mucopurulent; purulent).
    b. Identify maintenance pharmacological and non-pharmacological treatment and whether the patient is observing treatment as prescribed.
3. Section 2 – COVID-19
    a. Assess whether the patient has any symptoms of COVID-19 and would need to be tested. Have at hand local numbers where the patient can be referred to for testing and treatment.
    b. If the patient has already been tested identify when the results will be obtained, or whether the result was positive or negative. If positive, is there a follow-up test planned, and dates.
    c. Verify patient is practicing COVID-19 precautions (face masks, hand washing, social distancing, or shielding if necessary).
4. Section 3 – Action Plan
    a. Describe if the patient already has a written action plan. See example of an action plan from the Living well with COPD program [1]. Describe if the education for this action plan has already been done. Describe if the written action plan includes a prescription to be self-administered at home or whether the patient need to call his contact person / physician to obtain the prescription. Describe when it was used the last time and if used appropriately.
5. Section 4 – Recent Admissions and ER visits
    a. Write down recent admissions and ER visits, dates and where they took place.
6. Section 5 – COPD Self-Management behaviors
    a. Go over each of the self-management behaviors described in the list. You should cover what is pertinent to the patient treatable traits (dyspnea and/or exacerbation) [2]. Describe whether the patient has integrated these strategies in their daily life (yes), not at all (e.g. for example it has not been discussed or not applicable), and whether the patient is unsure “Cannot tell”.
7. Section 6 – Main issues
    a. Identify with the patient the main issues of the call. Up to a maximum of 3 items that can be covered for the duration of the call. Avoid to cover too many issues in one visit.
8. Section 7 – Summary, Intervention and Plan
    a. Finalize by describing the interventions done during the remote visit, the ones to be put in place, and agreed by the patient, the plan, including whether the patient needs to be referred to other services, healthcare professionals, etc. and when the next follow-up will take place (describe whether will it be in-person or remote).