Pulmonary Specialist Health Coach Consultation (PuSHCon) Study: Health Coach Consultation Form for Patients with Chronic Obstructive Pulmonary Disease (COPD) and/or Asthma

Background and Description

The Pulmonary Specialist Health Coach Consultation (PuSHCon) COPD and Asthma study is a randomized controlled trial of health coaching funded by the National Heart, Lung, and Blood Institute (NHLBI). A health coach works with a pulmonary nurse practitioner to help patients receive guideline based care and improve the self-management of their chronic lung condition.

How to use this form

This form is designed to guide staff in gathering information from patients with chronic obstructive pulmonary disease (COPD) and/or Asthma in order to assist in assessment by a clinician. This information can be given to a primary care provider or pulmonary specialist as a needs assessment for treatment changes or additional evaluation. The questions on this form are answered by both interviewing a patient and reviewing their chart. Information should be confirmed from both sources whenever possible.

Helpful tools

On page seven coaches will find the CAT (COPD Assessment Test) and mMRC Dyspnea Scale, which is used with COPD patients. On page nine coaches will find both The GINA Asthma Assessment, which is used with Asthma patients, and a form to screen patients for obstructive sleep apnea. We also suggest using a color inhaler guide so that patients may point out which inhalers they are taking. A good one is available for purchase from the Asthma & Allergy Network or you can ask your site's pulmonary department for suggestions.

UCSF Center for Excellence in Primary Care

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care. To learn more about the PuSHCon Study, or for information about health coach training for your staff, please visit us at https://cepc.ucsf.edu/.

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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

PuSHCon Health Coach Consultation Form

Patient Demographics **(include in chart review)**

MRN		Primary Care Clinic	
Name		PCP	
DOB		Pulmonologist	
Gender		Primary Language	
Payer			

Agenda Setting and Developing Rapport

Tell me about a typical day for you. Active, debilitated, homebound?

_____
_____
_____
_____
_____
_____

What do you do for fun? What types of physical activities do you enjoy doing?

_____
_____
_____
_____
_____
_____

What are your goals for working with a health coach?

_____
_____
_____
_____
_____
_____

Are you feeling at your baseline/normal today? What feels different than normal today? (→seek care and reschedule if not feeling well)

_____
_____
_____
_____
_____
_____

History of Present Respiratory Illness **(include in chart review)**

Respiratory Symptoms:

What respiratory symptoms do you have?

☐ Cough

- ☐ Occurs during the day ☐ Occurs at night
- ☐ Sputum production with cough ☐ Blood in cough
- ☐ All the time ☐ Comes and goes

☐ Shortness of breath

- ☐ Occurs during the day ☐ Wakes me up at night (→ OSA screen)

☐ Wheezing

☐ Chest tightness

☐ Other Respiratory Symptoms:_____

What respiratory symptom(s) bother you the most?_____

How long ago did you start experiencing this symptom?_____

Has it worsened overtime? ☐ Yes ☐No ☐ Gradually ☐ Acutely

When and how often does this symptom occur? _____

What medicines have you found to be most helpful in relieving your resp. symptoms?_____

What activities do you have difficulty doing because of your symptom(s)?

_____

If you experience SOB, (→ mMRC)

How far can you walk on flat ground before stopping from SOB?_____

If unlimited, can you walk at the same pace as your peers? ☐ Yes ☐No

Additional Symptom Questions:

Have you recently experienced any of the following? (Constitutional)

☐ Fever
☐ Chills
☐ Weight loss
☐ Night sweats

Do you experience any of the following symptoms? (Allergic)

☐ Stuffy nose
☐ Runny nose
☐ Itchy nose
☐ Sneezing
☐ Mucus draining into throat
☐ Itchy/watery eyes

Is there a seasonal pattern to your symptoms? ☐ Yes ☐No
When? ☐ Fall ☐ Winter ☐ Spring ☐ Summer

How bothersome are these symptoms? ☐ Mild ☐ Moderate ☐ Severe

How many days in a week do you have these symptoms? _____days

If you have seasonal allergies/hay fever, what makes your allergies worse?

☐Tree pollen
☐Grass pollen
☐Animal dander
☐Weed pollen
☐Mold
☐Dusts/dust mites

Do you experience any of the following symptoms? (Reflux)

Bitter taste in your mouth with your cough? ☐ Yes ☐No
A feeling of heartburn? ☐ Yes ☐No
Heartburn worse after eating? ☐ Yes ☐No
Trouble swallowing? ☐ Yes ☐No

Do you feel like your reflux symptoms are under control? ☐ Yes ☐No

How many times in a week do you have these symptoms? _____ times

History of Present Respiratory Illness – Health Coach Notes

NOTES FROM Chart Review:

NOTES FROM PT INTERACTION:

Screening Tools

CAT - SCORE _____

For each question, select the number that best describes how you feel.

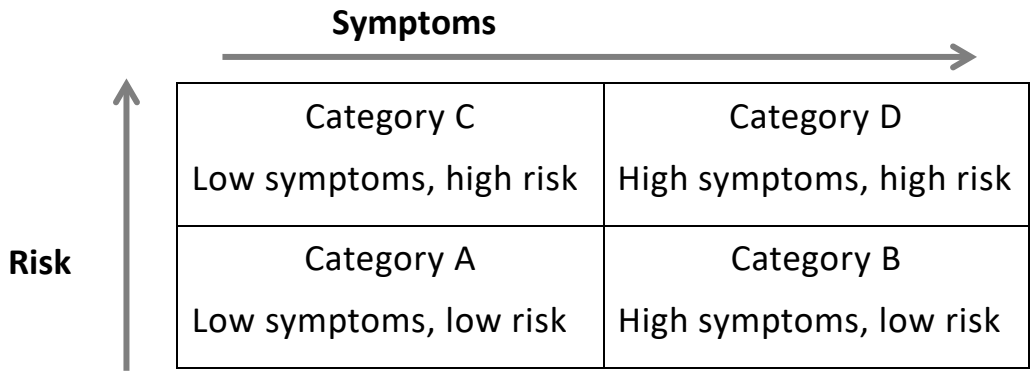
1	I never cough	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	I cough all the time
2	I have no phlegm (mucus) in my chest at all	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	My chest is completely full of phlegm (mucus)
3	My chest does not feel tight at all	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	My chest feels very tight
4	When I walk up a hill or one flight of stairs I am not breathless	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	When I walk up a hill or one flight of stairs I am very breathless
5	I am not limited doing any activities at home	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	I am very limited doing activities at home
6	I am confident leaving my home despite my breathing condition	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	I am not at all confident leaving my home because of my breathing condition
7	I sleep soundly despite my breathing condition	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	I don't sleep soundly because of my breathing condition
8	I have lots of energy	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	I have no energy at all

mMRC - SCORE _____

Grade	Description of Breathlessness
0	"I only get breathless with strenuous exercise."
1	"I get short of breath when hurrying on level ground or walking up a slight hill."
2	"On level ground, I walk slower than people of the same age because of breathlessness or have to stop for breath when walking at my own pace."
3	"I stop for breath after walking about 100 yards or after a few minutes on level ground."
4	"I am too breathless to leave the house, or I am breathless when dressing."

If **mMRC is ≥ 2 OR CAT ≥ 10**, the symptoms are high. Otherwise, symptoms are low.
Use the tables below to determine GOLD classification category A-D

GOLD classification category (A, B, C, D)	
Degree of symptoms based on mMRC or CAT	☐Low ☐High
Degree of risk based on frequency of exacerbations	☐Low ☐High



GINA Asthma Assessment

In the past 4 weeks, have you had:

Daytime symptoms more than twice a week? ☐ Yes ☐ No	Well controlled =None of these	Partly controlled =1-2 of these	Uncontrolled =3-4 of these
Any night waking due to asthma? ☐ Yes ☐ No			
Rescue medicine needed more than twice/week? ☐ Yes ☐ No			
Any activity limitations due to asthma? ☐ Yes ☐ No			

Obstructive Sleep Apnea
(Indicated if c/o of nighttime dyspnea)

1. Do you ever fall asleep during the day without expecting to (i.e. while reading or watching TV)?	☐Yes ☐ No
2. Do you snore?	☐Yes ☐ No
3. Do you ever wake up feeling short of breath?	☐Yes ☐ No
4. Do you ever wake up feeling like you're choking?	☐Yes ☐ No
5. Have you or anyone else noticed that you stop breathing while you're sleeping?	☐Yes ☐ No
6. Do you feel sleepy when you first wake up or during the day even if you got a full nights' sleep?	☐Yes ☐ No
7. Have you ever nodded off while driving?	☐Yes ☐ No

Smoking History **(include in chart review)**

Do you currently smoke? ☐ Yes ☐No

Did you smoke in the past? ☐ Yes ☐No

Chart Review Notes:

☐ Current ☐ Former ☐ Never Quit Date:_____

A. How many years did/have you smoke(d) for? _____
B. How many packs, on average, did you smoke per day? _____
   Pack years = A x B: _____

Do you smoke within 30 minutes of waking up? ☐ Yes ☐No

Do you smoke anything else? ☐ Yes ☐No
☐ Marijuana ☐ Crack cocaine ☐ Amphetamines ☐E-cigarettes ☐ Other, specify:
_____

Is there anything else you have smoked in the past such as: ☐ Yes ☐No
☐ Marijuana ☐ Crack cocaine ☐ Amphetamines ☐E-cigarettes ☐ Other, specify:
_____

If you currently smoke anything, would you be interested in quitting within the next 30 days? ☐ Yes ☐No

Summary of Smoking Cessation Attempts **(include in chart review)**

Have you tried to quit before? ☐ Yes ☐No

Type of Cessation Support	Prescribed by Doctor (EHR)	Patient Attempted	Effect
NRT patches (21,14,7)	☐ Yes ☐No	☐ Yes ☐No	
NRT PRN (gum, lozenges) (4, 2)	☐ Yes ☐No	☐ Yes ☐No	
NRT patch + PRN	☐ Yes ☐No	☐ Yes ☐No	
Wellbutrin (buproprion)	☐ Yes ☐No	☐ Yes ☐No	
Chantix (varenicline)	☐ Yes ☐No	☐ Yes ☐No	
Cessation support (classes, 1-800-NoButts, etc.)	☐ Yes ☐No	☐ Yes ☐No	

Respiratory Trigger History

What do you notice makes your breathing worse?
☐ Strong smells/fumes
☐ Rapid changes in the weather
☐ Extreme hot or cold temperatures
☐ Stress
☐ Exercise
☐ Viral infections
☐ Smoke
☐ Laughing or crying hard
☐ Aspirin or NSAIDS
☐ Being at work
☐ Being at home
☐ Other triggers? _____

Do you have food allergies? ☐ Yes ☐No

Allergies Listed in EMR:

Allergies Listed by Patient:

Have you noticed that your breathing is better when you are outside of your home?
☐Better ☐ Worse ☐No difference

Exposure/Environmental History

Have you been exposed to a lot of second-hand smoke such as another smoker in the house or a wood burning stove? ☐ Yes ☐No

Type	Length of Exposure

See social history for occupational exposures.

Does anyone smoke in your house currently? ☐ Yes ☐No

Do you have carpeting in your home? ☐ Yes ☐No

Do you have pets? ☐ Yes ☐No
What type? _____

Do your pets live inside the house or outside? ☐ Inside ☐ Outside

Do you have allergies to pets? ☐ Yes ☐No

Does your house have roaches? ☐ Yes ☐No

Does your house have mice? ☐ Yes ☐No

Can you see or smell mold in your home? ☐ Yes ☐No

Do you use feather bedding (pillow or comforter)? ☐ Yes ☐No

Exacerbation History **(include in chart review)**

Has the patient had **2 or more COPD exacerbations in the past year** requiring prednisone OR antibiotics OR a hospitalization? ☐ Yes ☐ No

NOTE: An exacerbation or flare up is when your breathing symptoms get a lot worse quickly. Usually people go to their MD/NP, urgent care, ED, and may be prescribed prednisone.

If 'yes' the patient is high risk. If 'no', the patient is low risk.

Date	Type of visit (ED, outpt, UC)	Reason for visit	Prescribed prednisone?	Prescribed antibiotics?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

1. Have you ever been intubated (needed a tube to help you breathe)? ☐ Yes ☐ No
2. Have you ever received BiPaP (a mask) during an exacerbation? ☐ Yes ☐ No
3. Have you ever been in the ICU for a respiratory exacerbation? ☐ Yes ☐ No
4. Have you ever been hospitalized overnight for your asthma? ☐ Yes ☐ No

Hospitalizations, ED, and UC Visits found in Chart Review

Date (up to 2 years ago)	ED or Hosp or UC	Reason

Prednisone/ABX Prescriptions found in Chart Review

Date (up to 2 years ago)	Prednisone or antibiotic	Reason

Pulmonary History/Medical History **(include in Chart Review)**

Breathing Conditions

☐ COPD Date of Diagnosis _____
☐ Asthma Date of Diagnosis _____
☐ ACOS Date of Diagnosis _____
☐ Hx of respiratory sx during childhood
☐ Allergic rhinitis
☐ Chronic Sinusitis
☐ Other lung conditions (i.e. bronchiectasis, chronic infection):
_____

Mental Health Conditions

☐ Depression
☐ Anxiety
☐ Other mental health conditions (i.e. Schizophrenia, PTSD):
_____

Other Relevant Conditions

☐ Obesity (BMI ≥ 30) BMI_____
Date BMI calculated _____
☐ Diabetes ☐ Pre-Diabetes
☐ Obstructive Sleep Apnea
☐ Prescribed CPAP
Are you using it? ☐ Yes ☐ No
Nights per week_____ Hours per night____
☐ Osteoporosis
☐ GERD
☐ Food allergy and anaphylaxis
☐ Chronic Pain
☐ MSK condition interfering with activity

Heart Conditions

☐ Coronary artery disease
☐ Congestive heart failure
☐ Atrial fibrillation
☐ Other cardiovascular conditions:
_____

What other medical problems make your breathing worse?

_____
_____
_____
_____
_____

What medical problems make it hard for you to do everything your doctor/NP recommends?

_____
_____
_____
_____
_____

What other potentially relevant medical problems are in the EMR?

_____
_____
_____
_____
_____

Past COPD Care & Maintenance **(include in chart review)**

Vaccination	Date of last dose	Indication for COPD patients*
Last flu shot		Every year
PPSV23 (Pneumovax ® 23)		o One dose followed by booster after patient turns 65. o If vaccinated before age 65, wait at least 5 years before booster. o If due but patient also needs a PCV13, PCV13 takes priority. o PPSV23 and PCV13 should be given 12 months apart.
PCV13 (Prevnar 13®)		Only for patients 65 and up unless patient has a condition compromising the immune system. See CDC guidelines for list of qualifying conditions.

Programs Noted in Chart Review:

Program	Participated in the past?	If hasn't participated, willing to be referred?	Effect:
Breathing Class	☐Yes ☐ No	☐Yes ☐ No	
COPD Class	☐Yes ☐ No	☐Yes ☐ No	
Pulmonary rehabilitation Often only available for Medicare recipients, but consider prior authorization for other insurance plans. PFTs need to show FVC, FEV1, and/or DLCO <65% within 1 year of referral. Chest x-ray also often required.	☐Yes ☐ No	☐Yes ☐ No	
Other physical therapy	☐Yes ☐ No	☐Yes ☐ No	
Home assessment (for patients with asthma symptoms)	☐Yes ☐ No	☐Yes ☐ No	

Social/Occupational History

What jobs have you had in the past?

_____

_____

Have you been exposed to dusts and fumes while working in past jobs? If yes,

Type	Length of Exposure	Protective Gear Used?
		☐ Yes ☐No ☐ Sometimes
		☐ Yes ☐No ☐ Sometimes

Where do you live? Who do you live with?

_____

_____

Tell me about people who support you in your life. How do they support you? IHSS?

_____

_____

Social Needs Screening (if indicated)

Do you run out of food before you have money to buy more?

_____

Are you worried about having a place to stay?

_____

_____

Are there problems at your home such as pests, mold, water leaks, other?

_____

_____

Are you able to get to your medical appointments?

_____

_____

Are the electric gas or water companies threatening to shut off services?

_____

_____

Are you struggling to find or keep work?

_____

_____

Family History **(include in chart review)**

Do you have a first degree relative that has been diagnosed with a chronic lung disease, like asthma and or COPD?

☐Yes ☐ No

Family Member	Condition

Family History Noted in Chart Review:

Medication Reconciliation **(include in chart review)**

Medication	**How Prescribed** **(days per week, times per day, puffs per time)**	**How taken by Patient** **(ALL: days/wk, times/day, puffs/time CONTROLLER: how many days used as Rxed in last 7 days)**	**HC Notes (e.g. barriers to adherence)**
SABA			
ProAir (Albuterol) ☐ HFA ☐ Respiclick			
Ventolin (Albuterol) ☐			
Proventil (Albuterol) ☐			
Xopenex (Levalbuterol) ☐			
SAMA			
Atrovent (Ipratropium) ☐			
SABA/SAMA			
Combivent ☐ (Albuterol/Ipratropium)			
LABA			
Arcapta Neohaler ☐ (Indacaterol)			
Serevent Diskus ☐ (Salmeterol)			
Striverdi Respimat ☐ (Olodaterol)			
LAMA			
Spiriva (Tiotropium) ☐ Handihaler ☐ Respimat			
Incruse (Umeclidinium) ☐			

Tudorza (Aclidinium) ☐			
Other:			

LABA/LAMA			
Anoro Ellipta ☐			
Bevespi Aerosphere ☐			
Stiolto Respimat ☐			
Utibron Neohaler ☐			

ICS Only			
QVAR 80/40mcg ☐			
Pulmicort 180/90mcg ☐			
Flovent 220/110/44mcg ☐			
Arnuity Ellipta ☐ 100/200mcg			
Other:			

ICS/LABA			
Advair Diskus Dose: ☐100/50 ☐250/50 ☐500/50			
☐ Advair HFA Dose: ☐45/21 ☐115/21 ☐230/21			
Air Duo Respiclick Dose: ☐ 55/14 ☐ 113/14 ☐ 232/14			
☐ Dulera Dose: ☐100/5 ☐200/5			
☐ Symbicort Dose: ☐80/4.5 ☐160/4.5			
☐ Breo Dose: ☐100/25 ☐200/25			

Other			

ICS/LABA/LAMA			
Trelegy Ellipta ☐			

Other Relevant Medications			
Montelukast (Singulair) ☐			
Fluticasone nasal spray ☐ (Flonase)			
Roflumilast ☐			
Chronic Azithromycin ☐			
Propranolol ☐ Indication:			
Theopylline ☐			
Proton Pump Inhibitor: _____			
H1 Blocker: _____			

Durable Medical Equipment			
Nebulized Medication: ☐ Albuterol ☐ Ipratropium ☐ DuoNeb ☐ Budesonide ☐ Arformoterol ☐ Formoterol Baseline use:			
Acapella Valve ☐			
Home O2 ☐ LPM continuous LPM with exertion LPM during sleep			

Notes re: use/adherence: _____			

Are you having difficulty getting your oxygen and/or the supplies? ☐ Yes ☐ No

_____

_____

What other breathing medications do you take?

Medication	**Purpose**	**How Rxed**	**How taken by Patient** **(ALL: days/wk, times/day, puffs/time CONTROLLER: how many days used as Rxed in last 7 days)**

NEEDS PFTS ☐ YES ☐NO

Date Scheduled

Patient Notified ☐ Yes ☐NO

Visioning Question: If we could have an impact on your breathing symptoms, what would life look then?