



HOME HEALTH

Pulmonary Services

Our pulmonary clinical delivery model utilizes a patient-centered approach in providing the education and tools necessary for improved self-management of a patient's disease. The multidisciplinary team assists with in-home recovery following an acute episode and assists patients with minimizing the potential loss of function and debility associated with exacerbation of chronic conditions.

Left unmanaged, these patients may be at risk of developing further complications such as pneumonia or further aggravation of COPD or chronic asthma. Simultaneous treatment of co-morbidities can reduce the frequency and intensity of pulmonary exacerbations, aiding the patient in controlling symptoms in the home setting.

Pulmonary Symptom Management

- Appropriate inhaler use; use of MDIs and/or spacers
- Improved breathing techniques through education on pursed-lip and diaphragmatic breathing
- Pulse oximetry to monitor oxygen concentration levels
- Reduction in anxiety through education and practice on diversion techniques
- Energy conservation techniques to improve in-home functioning
- Address nutritional needs

Prevalence

- An estimated 35 million Americans are living with chronic lung diseases such as chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, asthma, restrictive lung disease and cystic fibrosis.
- National medical costs for COPD are projected to increase from \$32.1 billion in 2010 to \$49.0 billion in 2020.
- COPD is the only disease with an increasing rate of mortality.
- In each year since 2000, more women have died from COPD than men.

Resources:

1. Centers for Disease Control
2. American Lung Association

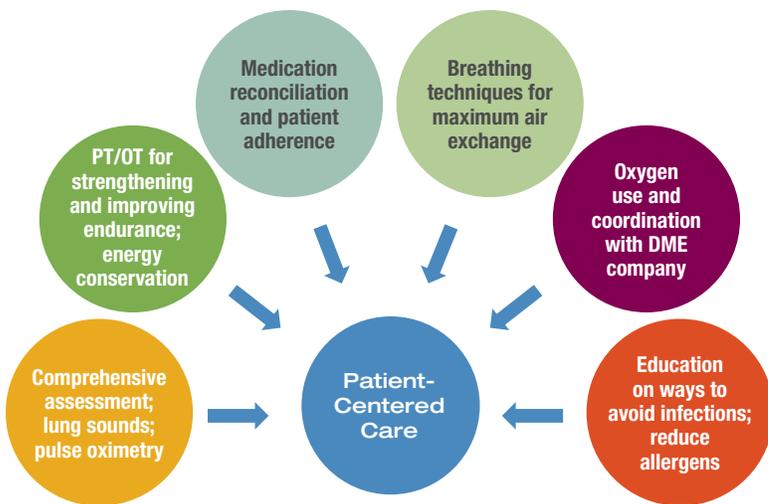
Diagnoses We Support:

- COPD
- Acute/chronic bronchitis
- Emphysema
- Asthma
- Cystic fibrosis
- Upper respiratory infections
- Pneumonia
- Lung cancer
- Oxygen dependent

For more information, please call

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Pulmonary Clinical Delivery Model

Proven Results for Patients and Families

- Ability to better manage their condition
- Positive behavior changes that reduce contributing factors in exacerbations
- Ability to better manage their medications
- Safer at home
- Improved care coordination and access to services
- Lower risk of hospitalization
- Smooth transition to self-care with plan for physician follow up and link to community resources

Every Patient, Every Visit

As ordered by the physician

Skilled Nursing

- Comprehensive assessment
- BP, pulse, respirations, lung sounds, blood glucose or pulse oximetry or PT/INR labs, when ordered
- Drug regimen review
- Risk for hospitalization assessed each visit
- Zone Tools for early symptom recognition
- Identify barriers to care

Teaching and Training

- Goal-directed plan of care
- Patient-centered education on disease process, diet, medications and symptom management
- Teach-Back method for improved retention
- Patient engagement to encourage ongoing self management
- Perform and educate on treatments (e.g., wound care, IVs)

Therapy Services

- Fall prevention, safety in ambulation, ADLs
- Individualized home exercise program (HEP) to increase strength and endurance, thereby improving function

- Energy conservation
- Use of assistive devices
- Cognition evaluation and treatment
- Recommendations for home and leisure modifications

Risk Management and Customized Teaching Plan

- Risk factors drive a clinical care delivery model best suited for each patient
- Collaboration on individual patient education and interventions following skilled assessments
- Automatic review and notification of potential medication contraindications or interactions
- Ability to monitor 30-day rehospitalizations

Integrated Discharge Plan and Care Coordination

- Comprehensive discharge plan with appropriate community resources and physician follow-up in place
- Fast, safe, efficient transfer between settings
- Follow-up calls post-home health discharge for questions or additional needs