**Fig 1: Intervention**

**Nurse role:**

1. **1st Home visit**
   Nurse assess patients which includes activities of daily living, quality of life measures, confirmation of diagnosis and evaluation of the severity of COPD by performing spirometry before and after bronchodilator, assessment of smoking and immunisation status and assessment of patients' understanding of their condition and management. During this visit nurse identifies specific management issues for patients and provides standardised education.

2. **Care plan preparation and implementation**
   Nurse initiates the preparation of the care plan (see care plan below), tailored to patient's needs based on COPDX guidelines. Nurse meets with patient's GP to discuss the care plan and organise an appointment for patient with GP for completion of the plan. Nurse works with GP and other health professionals to implement the plan. This includes facilitating referral and teamwork to other relevant services e.g. smoking cessation program, pulmonary rehabilitation physiotherapist, pharmacist, and specialist physician. Nurse organises an appointment for patient at 4 months for a GP review.

3. **2nd home visit**
   During this consultation nurse reviews patient's understanding of the care plan, motivation and progress on implementation of each of the elements of the plan.

4. **Telephone calls**
   Nurse proactively telephone patients fortnightly after the 1st home visit and monthly after the 2nd home visit to check understanding and to motivate the uptake of the plan and address barriers to implementation. Nurse is available for patient initiated telephone calls over the six-month intervention period.

5. **Hand-over of care**
   At six months the nurse provides a written report on implementation of the plan for the GP and patient and handover care to the GP and other members of the care team.

**GP role:**

1. **Care plan preparation and implementation**
   GPs meet with the nurse to discuss the care plan and then have a consultation with patient to finalise the plan. Patient, nurse and other health professionals involved in the patient's care are provided with copies of the completed plan by the GP. The GP sees the patient to ensure implementation of certain aspects of the care plan eg medication management, immunisation. The GP visits vary depending on individual patient needs.

2. **Review**
   At four months GP reviews the overall management of the patient.