



COPD Checklist:

A Tool for Optimizing Patient Care

Diagnosis and Classification¹

Consider **COPD** diagnosis in patients with dyspnea, chronic cough or sputum production, frequent lower respiratory tract infections, and/or a history of exposure to risk factors.*

Confirm Diagnosis¹:



Initial Assessment¹:

- Spirometry with **post-bronchodilator** FEV₁/FVC <0.7 is required
- Pre-bronchodilator spirometry can be used to **exclude** COPD diagnosis

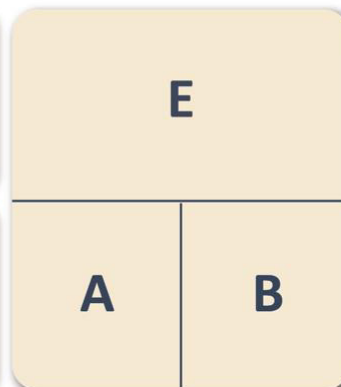
- FEV₁ → Determine GOLD Stage 1-4
- Assess symptoms (mMRC/CAAT) & exacerbation history/risk → GOLD A, B, E
- Blood eosinophil count
- Alpha-1 antitrypsin deficiency (AATD)
- Smoking status
- Comorbidities

GRADE	FEV ₁ (% predicted)
GOLD 1	≥ 80
GOLD 2	50-79
GOLD 3	30-49
GOLD 4	< 30

EXACERBATION HISTORY¹ (PER YEAR)

One or more (≥ 1) moderate or severe exacerbations in the previous year

Zero (0) moderate or severe exacerbations in the previous year



mMRC 0-1
CAAT < 10

mMRC ≥ 2
CAAT ≥ 10

SYMPTOMS



A late diagnosis of COPD contributes to a high symptom burden¹



Targeting disease activity at earlier stages has the potential to minimize disease progression¹

*Risk Factors = tobacco smoking, inhalation of toxic particles and gases from household and outdoor air pollution, other environmental and host factors (including abnormal lung development and accelerated lung aging)

COPD=chronic obstructive pulmonary disease; CAAT = chronic airways assessment test; FEV₁ = forced expiratory volume in 1 second; FVC=forced vital capacity; GOLD = global initiative for chronic obstructive lung disease; mMRC = modified medical research council

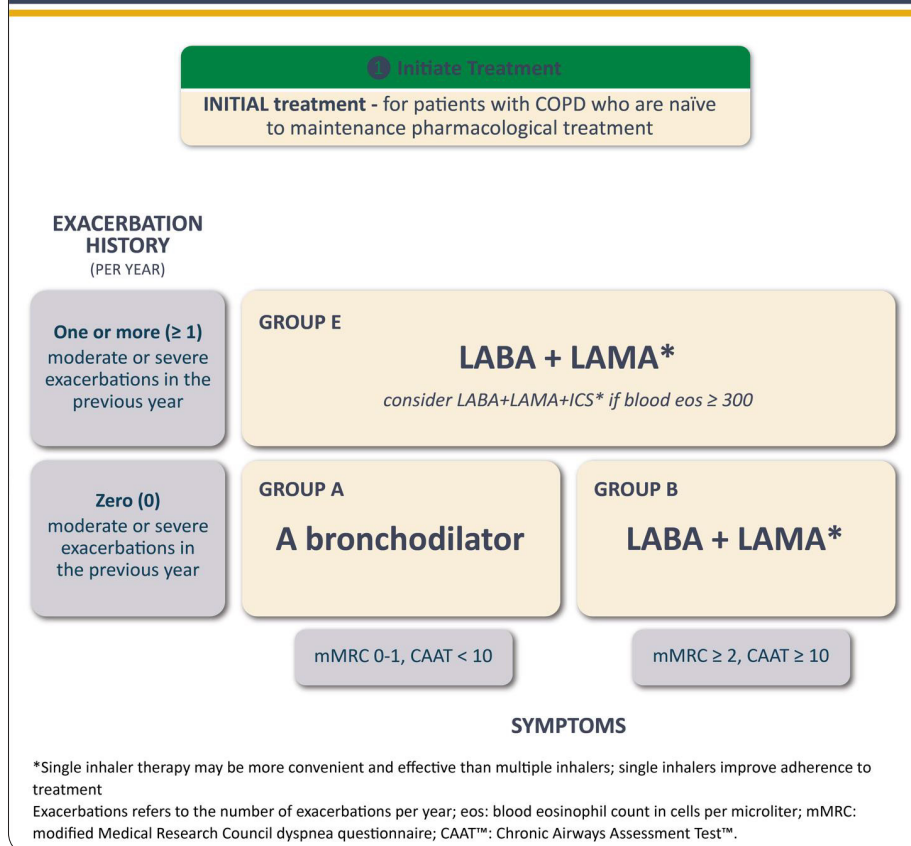
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STRATEGIES FOR INITIAL MANAGEMENT¹

Smoking Cessation	<input type="checkbox"/> Assess/offer pharmacotherapy and/or counseling
Vaccines	<input type="checkbox"/> Annual influenza <input type="checkbox"/> Covid-19 <input type="checkbox"/> Pneumococcal <input type="checkbox"/> RSV <input type="checkbox"/> Tdap <input type="checkbox"/> Shingles
Exercise/Lifestyle	<input type="checkbox"/> Adequate sleep <input type="checkbox"/> Healthy diet/exercise <input type="checkbox"/> Pulmonary Rehab Consult/Referral (GOLD B & E)
Initiate Pharmacotherapy	<input type="checkbox"/> Treat based on symptoms & exacerbation history See “Initial Pharmacological Treatment” [figure 3.8] below <input type="checkbox"/> All patients should be prescribed short-acting bronchodilators for symptom relief <input type="checkbox"/> LABA+LAMA+ICS is recommended in Group E patients with blood eos ≥ 300 <input type="checkbox"/> Provide instruction or video on proper inhaler technique
Patient Education	<input type="checkbox"/> Provide/educate on COPD Action Plan <input type="checkbox"/> Self-management strategies → avoid triggers; how to manage symptoms; breathlessness/stress management
Manage Comorbidities	<input type="checkbox"/> Explore and manage the following: Cardiovascular disease (arterial HTN, CAD, HF, arrhythmias, and cardiovascular risk factors) skeletal muscle dysfunction, osteoporosis, metabolic syndrome, lung cancer, depression/anxiety → these influence health status, hospitalization & mortality

Initial Pharmacological Treatment¹

Figure 3.8



PREVENTING COPD EXACERBATIONS IS KEY¹:

- Exacerbations of COPD worsen airflow obstruction, disease progression, **rates of hospitalization and readmission, and risk of death**
- Exacerbations increase **risk of major adverse cardiovascular events**, especially in first 30 days
- **5-year mortality rate after hospitalization for COPD exacerbation ~50%**

Arterial HTN = arterial hypertension; CAD = coronary artery disease; COPD = chronic obstructive pulmonary disease; eos = blood eosinophil count in cells/ μ L; HF = heart failure; ICS = inhaled corticosteroid; LABA = long-acting beta₂-agonist; LAMA = long-acting muscarinic antagonist

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FOLLOW-UP ASSESSMENT: PREVENTION AND TREATMENT OF EXACERBATIONS

Pharmacological¹

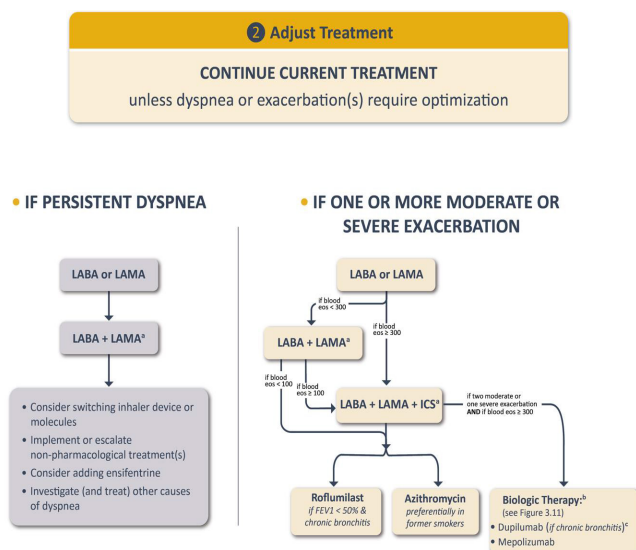
- Exacerbation history** since last assessed & current symptoms (mMRC or CAAT)
 - Assess dose/frequency of rescue medications
 - Adjust pharmacological therapy, as appropriate - See "Follow-up Pharmacological Treatment" [figure 3.9] below
 - Patients hospitalized for exacerbations: Consider initiation of LABA+LAMA+ICS, if blood eos ≥ 100
 - Consider biologics (≥ 2 moderate or 1 severe exacerbation on LABA+LAMA+ICS AND blood eos ≥ 300)
- Inhaler technique & adherence**
 - Single inhaler therapies may be more effective & improve adherence
 - Assess inhaler technique/adherence prior to concluding current therapy insufficient

Non-pharmacological¹

- Management of comorbidities**
 - Investigate CV risk factors in all COPD patients and treat according to guidelines
- Spirometry** (at least annually) - do not withhold maintenance therapies
- Imaging** for worsening symptoms/frequent exacerbations – CXR, CT scan
- Annual lung cancer screening** (50-80 y/o with 20 pack-year history who currently smoke or quit in last 15 years)
- Need for **oxygen** or other non-pharmacological interventions (NIV, surgical intervention, palliative care)
- Initial & ongoing management:**
 - COPD Action Plan – review/update at each visit
 - Pulmonary rehabilitation for GOLD B & E
 - Vaccination (influenza, COVID-19, Pneumococcal, RSV, Tdap, Shingles)
 - Smoking status – discuss cessation/offer pharmacotherapy at every visit for current smoker

Follow-up Pharmacological Treatment¹

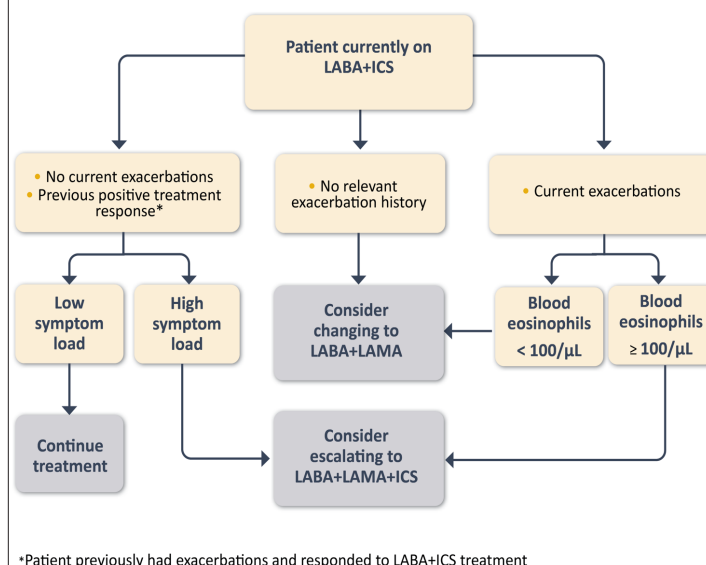
Figure 3.9



¹Single inhaler therapy may be more convenient and effective than multiple inhalers; single inhalers improve adherence to treatment.
²Listed in order of approval in the US.
³Patient-reported history of chronic bronchitis (chronic productive cough) for 3 months in the year up to screening, absent other known causes. Consider de-escalation of ICS if pneumonia or other considerable side-effects. In case of blood eosinophils ≥ 300 cells/ μ L de-escalation is more likely to be associated with the development of exacerbations.

Management of Patients Currently on LABA+ICS¹

Figure 3.12



*Patient previously had exacerbations and responded to LABA+ICS treatment

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Focused Patient Education¹






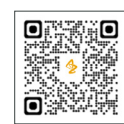

- ✓ Encourage patients to quit smoking and direct them to resources to help them quit (including pharmacotherapy)
- ✓ Encourage vaccination and review barriers, partner on potential solutions
- ✓ Promote physical activity with all patients and discuss benefits of pulmonary rehabilitation, when appropriate
- ✓ Identify/minimize exposure to triggers (ie, smoke, pollution, chemicals)
- ✓ Provide COPD Action Plan and self-management strategies
- ✓ Manage comorbidities
- ✓ Educate on Pharmacotherapy:
 - Provide instruction/demonstrate proper inhalation techniques for all inhalers
 - Explain role of maintenance vs rescue medication(s)
 - Encourage adherence to maintenance medication(s)
 - Base inhaler choice on access, cost, efficacy and patient preference
 - Minimize number of device types & number of inhalers



Quality Standards for COPD Care²

-  Early and accurate diagnosis of COPD is vital to improving management and outcomes, yet over half of those with the condition are undiagnosed
-  Patient and caregiver education is essential to effective self-management and shared decision-making, with the potential to improve clinical outcomes
-  Implementing treatment regimens aligned to clinical evidence and streamlining referral pathways benefit patient care
-  Timely follow-up and evaluation after an exacerbation can help reduce the risk of future adverse impacts on the patient
-  Patients with COPD require routine re-evaluation to proactively assess their disease progression, comorbidities, and treatment

HCP RESOURCES TO HELP PATIENTS

<p>COPD Foundation Education Materials</p> 	<p>American Lung Association – COPD Device Tutorials</p> 	<p>American Lung Association – COPD Action Plan</p> 	<p>NIH Breathing Better Handout</p> 	<p>CDC Tobacco Cessation – How to Quit</p> 	<p>AZ&Me Helping Patients Access AstraZeneca Medicines</p> 	<p>COPD Discharge Checklist</p> 
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References: 1. Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2026 GOLD Report and Pocket Guide. Global strategy for prevention, diagnosis and management of COPD: 2026 Report. Accessed January 7, 2026. <https://goldcopd.org/2026-gold-report-and-pocket-guide/>. 2. Bhutani M, Price DB, Winders TA, et al. Quality Standard Position Statements for Health System Policy Changes in Diagnosis and Management of COPD: A Global Perspective. *Adv Ther.* 2022;39(6):2302-2322. doi:10.1007/s12325-022-02137-x