



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

E

A

B

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

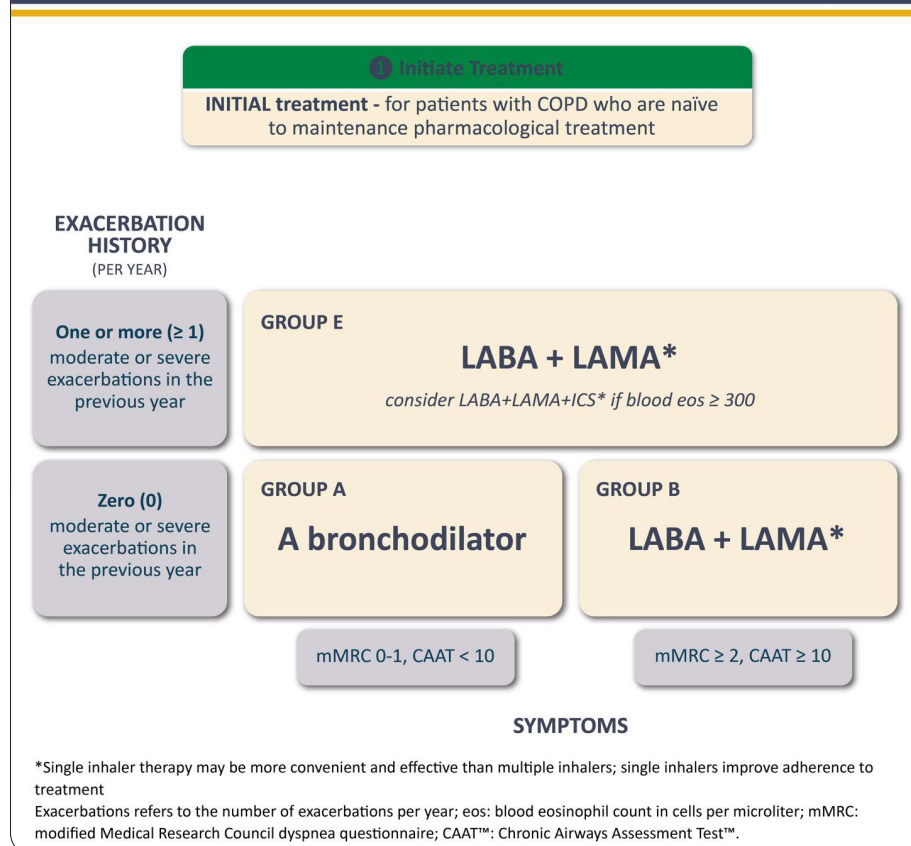
COPD Checklist: A Tool for Optimizing Patient Care

STRATEGIES FOR INITIAL MANAGEMENT¹

Smoking Cessation	☐ Assess/offer pharmacotherapy and/or counseling
Vaccines	☐ Annual influenza ☐ Covid-19 ☐ Pneumococcal ☐ RSV ☐ Tdap ☐ Shingles
Exercise/Lifestyle	☐ Adequate sleep ☐ Healthy diet/exercise ☐ Pulmonary Rehab Consult/Referral (GOLD B & E)
Initiate Pharmacotherapy	☐ Treat based on symptoms & exacerbation history See “Initial Pharmacological Treatment” [figure 3.8] below ☐ All patients should be prescribed short-acting bronchodilators for symptom relief ☐ LABA+LAMA+ICS is recommended in Group E patients with blood eos ≥ 300 ☐ Provide instruction or video on proper inhaler technique
Patient Education	☐ Provide/educate on COPD Action Plan ☐ Self-management strategies → avoid triggers; how to manage symptoms; breathlessness/stress management
Manage Comorbidities	☐ 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

COPD Checklist: A Tool for Optimizing Patient Care

FOLLOW-UP ASSESSMENT: PREVENTION AND TREATMENT OF EXACERBATIONS

Pharmacological¹

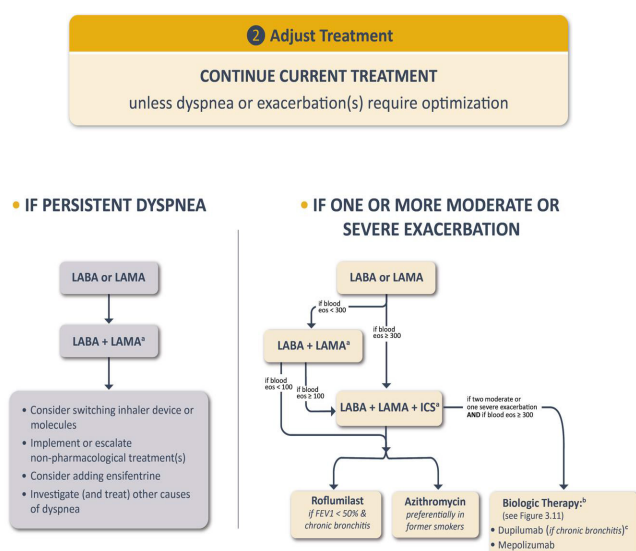
- ☐ **Exacerbation history** since last assessed & current symptoms (mMRC or CAAT)
 - Assess dose/frequency of rescue medications
 - Adjust pharmacological therapy, as appropriate - See "Follow-up Pharmacological Treatment" [figure 3.9] below
 - Patients hospitalized for exacerbations: Consider initiation 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



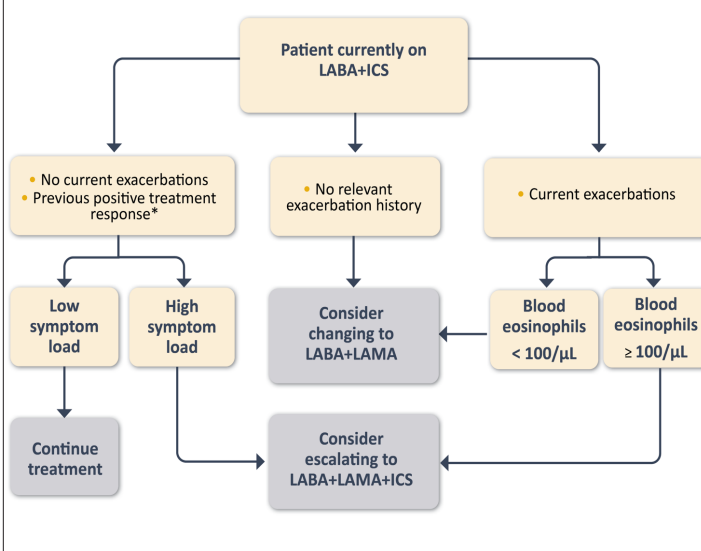
^aSingle inhaler therapy may be more convenient and effective than multiple inhalers; single inhalers improve adherence to treatment.

^bListed in order of approval in the US.

^cPatient-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

COPD Checklist: A Tool for Optimizing Patient Care



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

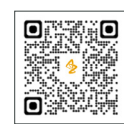


Timely follow-up and evaluation after an exacerbation can help reduce the risk of future adverse impacts on the patient



Patients with COPD require routine re-evaluation to proactively assess their disease progression, comorbidities, and treatment

HCP RESOURCES TO HELP PATIENTS

COPD Foundation Education Materials	American Lung Association – COPD Device Tutorials	American Lung Association – COPD Action Plan	NIH Breathing Better Handout	CDC Tobacco Cessation – How to Quit	AZ&Me Helping Patients Access AstraZeneca Medicines	COPD Discharge Checklist
						

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