

OPTIMIZED COPD CARE CHECKLIST

Patient Name: _____

Date: __/__/____

Optimizing inhaler therapy

Step 1: Clinical Check (Complete during visit)

1. Diagnosis Confirmation

- ☐ COPD diagnosis documented.
- ☐ Spirometry on file (**Date:** __/__/____).
- ☐ Smoking/Exposure history documentation (tobacco, vaping, cannabis, occupational).

2. Symptom Assessment - Identify symptoms impacting quality of life (check all that apply):

- ☐ Breathlessness with activity.
- ☐ Declining exercise tolerance or fatigue.
- ☐ Chronic cough and sputum.
- ☐ Wheezing or chest tightness.
- ☐ Sleep disruption due to respiratory symptoms.
- ☐ Increasing frequency of rescue inhaler use.
- ☐ Other: _____

3. Exacerbation History (Past 12 Months)

- ☐ **Moderate:** Worsening symptoms requiring systemic corticosteroids and/or antibiotics. Count: ____
- ☐ **Severe:** Event requiring an Emergency Department (ED) visit and/or hospitalization. Count: ____

4. Current Maintenance Therapy

- ☐ **Monotherapy** (LAMA or LABA).
- ☐ **Triple therapy** (ICS/LAMA/LABA).
- ☐ **Dual therapy** (LAMA/LABA).
- ☐ **Other:** _____

5. Therapy Verification

- ☐ Optimal treatment for risk level. **High risk:** ≥ 2 moderate OR ≥ 1 severe exacerbation in the past 12 months.
- ☐ Inhaler technique checked (observed during visit).
- ☐ Adherence assessed.
- ☐ Access assessed (cost, coverage, medication availability).

Moderate exacerbation: Systemic corticosteroids and/or antibiotics | **Severe exacerbation:** ED visit and/or hospitalization

6. Biomarkers - Blood eosinophils value available (4 to 6 weeks away from prednisone treatment)

- ☐ **Highest value:** _____ Date: __/__/____
- ☐ **Most recent stable value:** _____ Date: __/__/____

Step 2: Clinical status

- ☐ **Not stable** - Optimize therapy.
- ☐ **Stable** (No exacerbations, low symptom burden and stable FEV₁).

Step 3: Book a reassessment

- ☐ **If not stable:** Reassess within 1 month.
- ☐ **If stable:** Reassess in 6 to 12 months.

Optimizing therapy to achieve the lowest possible disease activity

Step 4: Refer high-risk patients

Refer to respirology for assessment when the patient is currently on triple therapy (ICS/LAMA/LABA) AND has:

- ☐ High symptom burden.
- ☐ ≥ 1 moderate OR ≥ 1 severe exacerbation in the past 12 months.

Referral should include:

- ☐ Current COPD medications and inhaler devices.
- ☐ Exacerbation history (dates and severity).
- ☐ Date triple therapy was initiated.
- ☐ Key comorbidities and smoking status.
- ☐ Spirometry date and key values.
- ☐ Most recent eosinophil count (and prior if available).

References: Canadian Thoracic Society. Pharmacotherapy in Stable COPD. 2023; Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2026 Report.

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RESPIRATORY THERAPIST'S ROLE IN ADVANCED COPD MANAGEMENT

1. Device and technique audit

Observe

and document inhaler technique at every contact, not just at initiation.

Advocate

for **single inhaler** (triple or double) therapy where feasible; patients on 2 or more devices are at substantially higher risk of critical errors.

Assess

for dexterity issues, cognitive barriers, incorrect breath timing, and inadequate inspiratory flow.

Flag

PRN use, device switching, or refill gaps inconsistent with adherence.

Document

persistent errors clearly: confirmed adherence is a prerequisite for biologic referral.

Measure BEC during stable period

Post-prednisone: 4 to 6 weeks

If BEC <300:
Repeat and optimize care

Check adherence, inhaler technique, comorbidities, and therapy

If BEC ≥300:
Refer to respiratory

Consider PR and optimize pharmacotherapy

Additional warning signs

- Increasing breathlessness.
- Increasing rescue inhaler use without changes to maintenance therapy.

⚠ **Flag to primary care clinician and escalate through your site's referral pathway. Do not normalize recurring exacerbations.**

3. Eosinophil count: key facts

≥300cells/μL

Strong type 2 signal; highest likelihood of biologic response

150-300cells/μL

Supportive signal, especially if persistent across multiple readings

- Flag if no BEC on file before referral is initiated.
- Values during exacerbation or post-prednisone (4-6 weeks) may be artificially low, note in documentation.

5. Patient education

□ Before Biologics initiation

- Biologics are add-on therapies. They do not replace inhalers.
- **Dupilumab**: subcutaneous injection (300 mg) every 2 weeks.
- **Mepolizumab**: subcutaneous injection (100 mg) every 4 weeks.
- Confirm PSP access for injection training and coverage navigation.
- **Explain the treatment target**: disease stability (no exacerbations, controlled symptom burden, and stable FEV₁).

□ After Biologics initiation

- Monitor exacerbations, symptoms, rescue inhaler use, adherence, and FEV₁.
- Aim for minimum exacerbations, ideally 0, lowest symptom burden, and no FEV₁ decline.
- Reassess if symptoms worsen, exacerbations persist, or disease stability is not achieved.
- Older adults or dexterity-limited patients may need repeat injection training or caregiver support.

6. Contact Prompts - Every Visit, High-Risk Patients

- 👤 Any exacerbations since last visit? Dates and treatment used?
- 👁 Inhaler technique directly observed and documented this visit?
- 📄 Respiriology referral initiated and sent?

- 💊 Maintenance inhaler used every day as prescribed?
- 📈 BEC on file from a stable period?
- 💉 **If on biologics**: Any new side effects experienced? Changes in symptoms, lung function, or breathlessness?

✅ **Key Abbreviations**: BEC: Blood eosinophil count | PR: Pulmonary rehabilitation | PRN: As needed | PSP: Patient support program

References: Canadian Thoracic Society. Pharmacotherapy in Stable COPD. 2023; Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2026 Report.

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One exacerbation is too many in COPD, it is a warning signal.

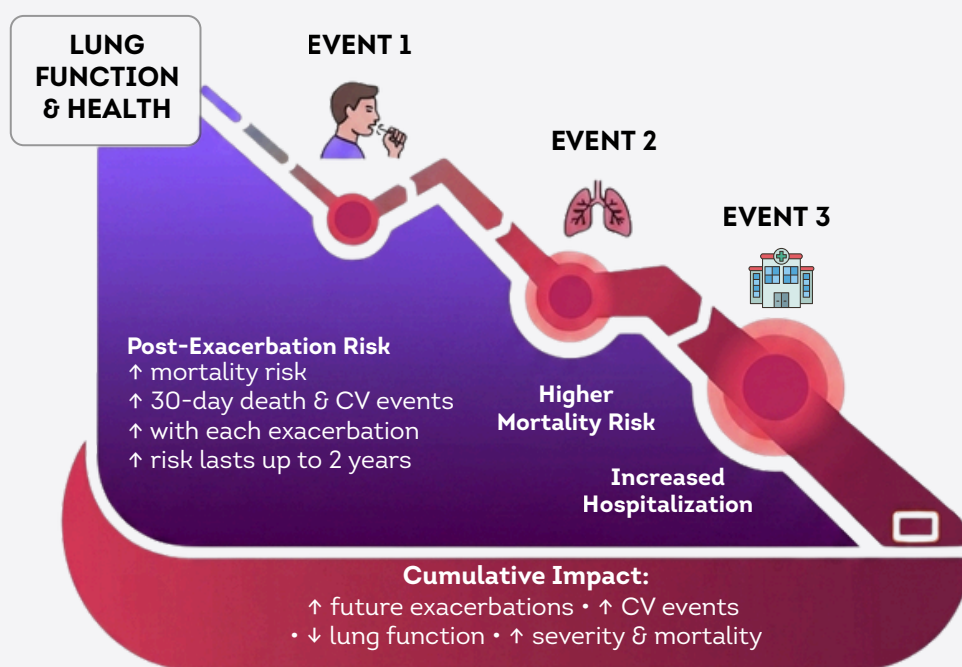
Do not normalize it.

Moderate Event

Requires oral steroids/antibiotics

Severe Event

Requires ER visit and/or hospitalization



ASSESSMENT FOR ADVANCED CARE

When to assess: Exacerbations despite optimized pharmacological management with triple therapy (LAMA/LABA/ICS), indicate a need for assessment for advanced therapy including the possibility of biologics.

Assess for advanced therapies, including biologics, or refer to a respirologist where appropriate.

SPECIALIST EVALUATION: Enables assessment for advanced therapies, including biologics.

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Key Clinical Flow (COPD Advanced Management Pathway)

Identify → Optimize → Confirm risk → Phenotype → Initiate → Monitor

1. Confirm the right COPD patient

- ☐ COPD diagnosis confirmed (spirometry on file where available).
- ☐ Symptoms and disease burden documented (baseline for follow-up).

2. Optimize inhaled therapy

- ☐ On triple therapy (LABA/LAMA/ICS): Single inhaler when feasible.
- ☐ Adherence confirmed and device technique appropriate (rule out: PRN use, incorrect device, dexterity issues).

3. Confirm exacerbation risk (despite optimized therapy)

Exacerbation definitions:

- Moderate exacerbations require systemic corticosteroids with or without antibiotics.
- Severe exacerbations involve an emergency room visit and/or hospitalization.

- ☐ **Document:** Number, dates, severity, treatments in the past 12 months - Extend to 24 months if needed.

High-risk (GOLD-aligned, for biologics): ≥ 2 moderate OR ≥ 1 severe exacerbation in past 12 months.

4. Phenotype Type 2 inflammation (eosinophils)

- ☐ **Blood eosinophils (BEC):** Capture baseline + repeat values (trends matter).

Practical thresholds:

- ≥ 300 cells/ μ L: Strong Type 2 signal.
- ≥ 150 cells/ μ L: Supportive signal (especially if persistent or with prior exacerbations).

At least one elevated value can support risk stratification in context.

5. Identify and address competing drivers (do not delay optimization)

- ☐ **Consider:** cardiac disease / heart failure, GERD, OSA, anemia, deconditioning, infection.
- ☐ Treat in parallel, but do not normalize recurrent exacerbations.

6. Consider other guideline add-ons

- ☐ **For patients still exacerbating on triple therapy:** consider macrolide maintenance, roflumilast, mucolytics, and **pulmonary rehabilitation** when appropriate.

7. Confirm initiation readiness

- ☐ Baseline documented: Spirometry, symptoms/QoL, exacerbation history, eosinophils.
- ☐ Vaccination status, smoking status, comorbidities, current meds.
- ☐ Patient discussion: Expected benefits, risks, injections, adherence plan.
- ☐ Access planning: Coverage, PSP, documentation package.

8. Monitor and define response (specialist-owned)

- ☐ **Define “response” upfront:**
 - ↓ exacerbations, ↑ lung function, ↑ quality of life.
- ☐ Set reassessment timepoint.
- ☐ Establish clear continuation vs stopping rules.

References: Canadian Thoracic Society. Pharmacotherapy in Stable COPD. 2023; Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2026 Report.

Candidate ID → Eosinophil phenotype → Evidence Snapshot → Alternatives

Candidate Identification - The Biologic Candidate

Clinical Profile

Persistent exacerbations despite optimized single inhaler triple therapy with a clear Type 2 inflammatory signal.

Prerequisite

Patient still exacerbating despite optimal single inhaler triple therapy and "eosinophilic phenotype" before biologics are considered.

Eosinophil Phenotype- Identification and Interpretation of Blood Eosinophil Count (BEC)

Intermittent eosinophilia in COPD may be missed by a single BEC screening. Three BEC assessments over 12 months increases detection, and combining historical and prospective BEC values may improve biologic eligibility assessment.

≥300 cells/μL - High Response Likelihood:

BEC ≥300 cells/μL is a strong indicator of Type 2 inflammation and is associated with a higher likelihood of response to biologic therapy. Even a single measurement at this level may help identify COPD patients likely to benefit from biologics.

100-299 cells/μL - Possible Response:

Patients in this range may also respond to biologic therapy, although the association is less pronounced. Because BEC can fluctuate due to exacerbations and corticosteroid use, repeat measurements may be considered.

Biologics Evidence Snapshot - Approved Agents & Trial Data

Dupilumab: BOREAS and NOTUS enrolled patients with chronic bronchitis; MATINEE enrolled patients with COPD regardless of chronic bronchitis status.

Dupilumab - BOREAS & NOTUS Phase III Trials

up to 52 weeks

↓ Reduction in moderate/severe exacerbations: BOREAS 0.70 [95% CI 0.58, 0.86] | NOTUS 0.66 [95% CI 0.54, 0.82].

📈 **Lung function:** FEV₁ statistically significant improvement in both trials.

🔥 **Quality of life (QoL):** SGRQ

BOREAS: Statistically significant improvement. LS mean difference, -3.4; 95% CI, -5.5 to -1.3; P=0.002.

NOTUS: LS mean difference, -3.4; 95% CI, -5.8 to -0.9.

Mepolizumab - MATINEE Phase III Trial

up to 104 weeks

↓ Reduction in moderate/severe exacerbations 0.79 [95% CI: 0.66, 0.94] and exacerbations leading to emergency department visit and/or hospitalization 0.65 [95% CI: 0.43, 0.96].

📈 **Lung function:** FEV₁ no significant difference between treatment groups.

🔥 **Quality of life (QoL):** SGRQ reduction not statistically significant -2.3 [95 % CI -4.6, 0.1].

In the absence of comparative effectiveness trials, biologic therapy can only be individualized using indirect data comparisons. Shared decision-making should consider T2 biomarkers, injection frequency, administration route, patient preference, adverse effects, and potential outcomes.

📍 **Dupilumab:** 300 mg subcutaneous injection every 2 weeks.

📍 **Mepolizumab:** 100 mg subcutaneous injection every 4 weeks.

📅 Monitoring and reassessment

Monitor early for adherence, injection support, symptoms, rescue inhaler use, exacerbations, and safety. Assess response over 6 to 12 months, guided by disease stability and local criteria.

GOLD 2026 Clinical Alternatives - For Patients Not Meeting Biologic Criteria

Macrolides: Long-term macrolide therapy for patients with frequent exacerbations and non-eosinophilic profile.

Roflumilast: PDE-4 inhibitor for chronic bronchitis phenotype with FEV₁ <50% and frequent exacerbations.

✅ **Important to combine pharmacotherapy with non-pharmacotherapy, pulmonary rehabilitation as a key adjunctive therapy.**

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