QUALITY STANDARDS

Placemat for Chronic Obstructive Pulmonary Disease

This document is a resource for health care providers and summarizes content from the ***Chronic Obstructive Pulmonary Disease*** quality standard. It can be used to support health care providers in the provision of care but does not override their responsibility to make decisions with patients after considering each patient's unique circumstances.

Care for People With COPD

Quality Statement (QS) 1: Diagnosis Confirmed With Spirometry

People clinically suspected of having COPD have spirometry testing to confirm diagnosis within 3 months of developing respiratory symptoms.

COPD is clinically suspected when **at least 1 respiratory symptom** (e.g., persistent shortness of breath that worsens with activity or exercise; chronic cough; regular sputum production) ***and*** **1 risk factor for COPD** (e.g., current or past tobacco smoking; exposure to second-hand smoke; exposure to occupational lung irritants; childhood factors such as low birth weight) are present.

To confirm a diagnosis of COPD, administer or order spirometry testing within 3 months of a person developing respiratory symptoms. Spirometry is the only way to accurately measure airflow obstruction. Ensure that spirometry testing is performed before and after the administration of an inhaled bronchodilator.

QS 2: Comprehensive Assessment

People with COPD have a comprehensive assessment to determine the degree of disability, risk of acute exacerbation, and presence of comorbidities near the time of diagnosis and on an annual basis. The severity of airflow limitation, as initially determined by spirometry testing to confirm diagnosis, is reassessed when people's health status changes.

Perform a comprehensive assessment (e.g., medical history; physical exam; evaluation and documentation of the severity of airflow limitation; degree of disability; and risk of acute exacerbation) with people who have COPD near the time of their diagnosis and then at least once a year thereafter, to guide the development of an individualized care plan.

Consider additional assessments, referral to specialized care, or both, when the severity of symptoms seems disproportionate to the severity of airflow limitation or when comorbidities are suspected. Additional assessments may include arterial blood gases or pulse oximetry; blood testing; alpha-1 antitrypsin deficiency testing; chest x-ray; or sputum cytology.

QS 3: Goals of Care and Individualized Care Planning

People with COPD discuss their goals of care with their future substitute decision-maker, their primary care provider, and other members of their interprofessional care team. These discussions inform individualized care planning, which is reviewed and updated regularly.

Actively engage people with COPD and their substitute decision-maker to discuss goals of care. These discussions and the comprehensive assessment inform individualized care planning.

The health care needs of people with COPD can change over time and may require care from an interprofessional care team.

Ontario Health

QS 4: Education and Self-Management

People with COPD and their caregivers receive verbal and written information about COPD from their health care professional and participate in interventions to support self-management, including the development of a written self-management plan.

Provide interventions to support self-management for people with COPD and their caregivers, and work with them to create a written self-management plan.

Educate people with COPD and their caregivers on how the disease will progress, what treatments are available, and what they can do to care for themselves.

Consider discussing topics such as the nature and progression of COPD, managing acute exacerbations, medication options, smoking cessation, and the importance of stress and anxiety management.

Provide education and self-management information verbally and in written form, including information about and referrals to local respiratory education and exercise programs.

QS 5: Promoting Smoking Cessation

People with COPD are asked about their tobacco smoking status at every opportunity. Those who continue to smoke are offered pharmacological and nonpharmacological smoking-cessation interventions.

At each encounter with a person with COPD, discuss their tobacco-smoking status and the importance of smoking cessation.

For those who have stopped smoking, offer additional interventions or support to maintain smoking cessation.

For those who still smoke or who have started smoking again, use motivational interviewing techniques to encourage them to consider stopping.

Offer appropriate smoking-cessation interventions in alignment with the person's readiness for change and with their care plan (see page 5 for relevant resources).

Treatment and Vaccinations

QS 6: Pharmacological Management of Stable COPD

People with a confirmed diagnosis of COPD are offered individualized pharmacotherapy to improve symptoms and prevent acute exacerbations. Their medications are reviewed at least annually.

Provide clear instructions about when and how to properly use the medication and its delivery system, including inhaler technique and use of a spacer, if applicable.

Take a stepwise approach to prescribing medications, according to findings from a comprehensive assessment and the person's individualized care plan:

- All people with COPD: Offer a short-acting, fast-onset inhaled bronchodilator for immediate symptom relief
- People with mild COPD: Offer a long-acting inhaled bronchodilator – either a long-acting anti-muscarinic (LAMA) or a long-acting beta-2-agonist (LABA)
- People with moderate to severe COPD without frequent or severe exacerbations and without features of asthma: Offer dual long-acting bronchodilator therapy (i.e., LAMA/LABA) as initial maintenance pharmacotherapy
- People who have COPD and concomitant asthma: Initial maintenance pharmacotherapy should include an inhaler that combines a LABA and an inhaled corticosteroid of low to moderate dose

Further pharmacotherapy should be individualized based on symptom severity and the frequency and severity of acute exacerbations according to current treatment recommendations.

Review medications at least annually.

QS 7: Vaccinations

People with COPD are offered influenza, pneumococcal, and other vaccinations, as appropriate.

Offer influenza vaccination annually to people with COPD, as well as pneumococcal and up-to-date COVID-19 vaccinations based on their age and individual risk factors, as outlined in National Advisory Committee on Immunization statements.

Offer other vaccinations, such as the Tdap (dTap/dTPa) vaccine (for people with COPD who were not vaccinated against pertussis in adolescence) and zoster vaccinations (for people aged 50 years and older).

Encourage caregivers and family members to receive appropriate vaccinations.

QS 8: Specialized Respiratory Care

People with a confirmed diagnosis of COPD are referred to specialized respiratory care when clinically indicated, after receiving a comprehensive assessment and being offered treatment in primary care. This consultation occurs in accordance with the urgency of their health status.

Refer people with COPD to specialized respiratory care if clinically indicated. Clinical indications include accelerated decline in lung function, hypercapnia, onset of pulmonary hypertension, and the need for further treatment (e.g., long-term oxygen therapy, surgery, or pulmonary rehabilitation; see pages 34–35 of the quality standard for further indications).

Confirm a person's diagnosis of COPD with spirometry and perform a comprehensive assessment before considering referral to specialized care.

If you are a primary care provider: In the referral, include spirometry results, comprehensive assessment results, the person's individualized care plan, the person's self-management plan, and the clinical indication for referral.

If you are a specialist in respiratory care: Communicate with the person's primary care provider to inform them of the timing of the referral response.

QS 9: Pulmonary Rehabilitation

People with moderate to severe, stable COPD are referred to a pulmonary rehabilitation program if they have activity or exercise limitations and breathlessness despite appropriate pharmacological management.

Discuss the option of pulmonary rehabilitation with people who have moderate to severe, stable COPD if they have activity or exercise limitations and breathlessness despite appropriate pharmacological management. Offer referral to a program as appropriate.

QS 10: Management of Acute Exacerbations of COPD

People with COPD have access to their primary care provider or a health care professional in their care team within 24 hours of the onset of an acute exacerbation.

Explain to people with COPD the signs and symptoms of an acute exacerbation.

Give people with COPD the name and contact information of a person on their care team who they can contact within 24 hours of the onset of an acute exacerbation.

During an acute exacerbation or a suspected exacerbation, obtain a complete history to help determine the cause of the worsening symptoms.

Timely access to support with structured management may prevent the need for acute care, but more severe exacerbations require an emergency department visit or hospital admission.

QS 14: Long-Term Oxygen Therapy

People with stable COPD who have clinical indications of hypoxemia receive an assessment for and, if needed, treatment with long-term oxygen therapy.

Screen people with COPD using oximetry to determine if their arterial blood gases should be measured to assess the need for long-term oxygen therapy.

Offer long-term oxygen therapy to people with stable COPD who have severe resting hypoxemia.

Clinical indications include very severe airflow obstruction (FEV_1 < 30%); bluish discoloration of the skin or mucous membranes; hematocrit > 55%; physical exam findings suggestive of heart failure; a resting oxygen saturation of ≤ 92% (see page 52 of the quality standard for further indications).

Educate people on long-term oxygen therapy and their caregivers on the proper and safe use of oxygen.

Reassess the need for continued oxygen therapy 60 to 90 days following initiation of treatment, and then at least once a year thereafter.

Follow-Up and Palliative Care

QS 11: Follow-Up After Hospitalization for an Acute Exacerbation of COPD

People with COPD who have been hospitalized for an acute exacerbation have an in-person follow-up assessment within 7 days after discharge.

Follow up with people with COPD within 7 days of discharge after they have been hospitalized for an acute exacerbation.

In the follow-up assessment, include a review of current comorbidities and medications, as well as barriers to coping, and provide ongoing education about COPD as needed (see pages 43–44 of the quality standard for additional components of the follow-up assessment).

If follow-up with specialized care is needed, ensure that this occurs within 30 days of discharge.

QS 12: Pulmonary Rehabilitation After Hospitalization for an Acute Exacerbation of COPD

People who have been admitted to hospital for an acute exacerbation of COPD are considered for pulmonary rehabilitation at the time of discharge. Those who are referred to a pulmonary rehabilitation program start the program within 1 month of hospital discharge.

Consider pulmonary rehabilitation for people with COPD who are being discharged from hospital for an acute exacerbation.

People who are referred should begin the program within 1 month of discharge from hospital.

QS 13: Palliative Care

People with COPD and their caregivers are offered palliative care support to meet their needs.

Ensure that people with COPD and their caregivers have access to individualized interprofessional care that includes an early palliative approach to care to help them achieve the best possible quality of life as their illness progresses.

Assess people with COPD to determine whether they would benefit from additional palliative care services.

Perform and document a comprehensive, holistic assessment that considers the person's diagnosis; disease progression; functional decline; treatment preferences; pain and other symptoms; and other effects on the person's full range of needs.

Palliative care also helps people with a progressive, life-threatening illness and their family to prepare for and manage end-of-life-choices, the process of dying, and coping with loss and grief.

Resources

- *Chronic Obstructive Pulmonary Disease* quality standard and patient guide bit.ly/3P9N8Gh
- Clinical practice guidelines on COPD available from the Canadian Thoracic Society cts-sct.ca/guideline-library
- Clinical tools such as the COPD Care Map for Primary Care, Initial Assessment and Follow-Up; the My COPD Action Plan and the Spirometry Interpretation Guide available from the Lung Health Foundation hcp.lunghealth.ca
- COPD Assessment Test and the Modified Medical Research Council Dyspnea Scale for the assessment of dyspnea catesonline.org, bit.ly/45hyXot
- Existing programs and resources at Ontario Health can be leveraged to further disseminate and support uptake of the quality standard, including Quorum, Quality Improvement Plans (QIPs) and QBP Connect quorum.hqontario.ca, bit.ly/46IzRvv, bit.ly/3rF6xHd

Resources and programs for smoking cessation

- The STOP Program, provided by the Centre for Addiction and Mental Health, can connect individuals to free smoking-cessation medication and counselling nicotinedependenceclinic.com/en/stop/home; camh.ca
- The Nicotine Dependence Clinic at the Centre for Addiction and Mental Health offers several specialized outpatient treatments for anyone who wants to quit or reduce their tobacco use bit.ly/46ETTH7
- The Ottawa Model for Smoking Cessation is an evidence-based process that uses principles of knowledge translation and organizational change to implement systematic approaches to smoking cessation in health care settings ottawamodel.ottawaheart.ca
- The Registered Nurses' Association of Ontario developed a clinical best practice guideline, Integrating Tobacco Interventions into Daily Practice, to help nurses and other health care providers in all care settings support individuals who use tobacco bit.ly/3sUR3yZ

Resources for health care professionals

- RESPTREC (the Respiratory Training and Educator Course) is delivered by the Lung Health Institute of Canada and the Lung Association; RESPTREC also provides a COPD Medication Brochure for health care professionals resptrec.org
- The COPD primary care program is an evidence-based education and management program; the program's tools and resources are aligned with the latest Canadian Thoracic Society guidelines hcp.lunghealth.ca/clinical-programs/
- Online webinars and modules, clinical tools and resources, workshops, and conferences for health care providers are available through the Lung Health Foundation hcp.lunghealth.ca

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