Developing Person-Centered **Treatment Plans for COPD**

Person-centered treatment plans built on the latest clinical evidence not only enhance care and drive positive outcomes. They also ensure that each individual is engaged and their wishes and preferences are respected. At the recent PALTmed Annual Meeting, a session on Clinical Hits for 2026 addressed how to create effective, targeted, personalized treatment plans for COPD.

COPD: Common, Complex, and Costly

Chronic Obstructive Pulmonary Disease (COPD) is a significant problem for older adults. It affects approximately 20% of long-stay nursing home residents; and one study showed that more than half of residents with heart failure also had COPD.

Allison Lange, MD, instructor at the University of Colorado Anschutz Medical Campus, explained why COPD is so problematic in post-acute and long-term care. She observed that it increases the risk of cognitive dysfunction, causes frequent hospitalizations and ER visits, causes dyspnea (shortness of breath or breathing discomfort), and comes with an average of six comorbidities including cardiovascular disease, metabolic disorders, osteoporosis, and lung infections. Clearly, this condition can have a negative impact on overall health and quality of life. It can also increase cost of care.

"COPD is a heterogeneous disease, the symptoms of which are primarily cough, shortness of breath, and sputum production. These symptoms are generally due to two abnormalities – abnormal inflammation of the airways or chronic bronchitis and/or alveolar abnormalities.," said Lange.

Spirometry and the GOLD Standard

According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD), "The GOLD international COPD guidelines, as well as national guidelines, advise spirometry as the gold standard for accurate and repeatable measurement of lung function. Evidence is emerging that when spirometry confirms a COPD diagnosis, doctors initiate more appropriate treatment. Spirometry is also helpful in making a diagnosis in patients with breathlessness and other respiratory symptoms and for screening in occupational environments."

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It can be challenging to diagnose COPD in older adults, Lange observed. These individuals often have comorbidities with similar symptoms so these signs may be misattributed to those conditions. Also, when individuals are sedentary and inactive, they may not exhibit obvious signs of dyspnea. At the same time, even when an individual has dyspnea, this may be caused by heart failure, anemia, pulmonary embolism, deconditioning, arrhythmias, or pneumonia.

Inhalers and Other Medications

Even when the diagnosis is made, there are challenges to COPD medication use. Incorrect inhaler use, as well as polypharmacy, can lead to ER visits or hospitalizations. It is important, Lange noted, to provide appropriate teaching on inhaler use and change the inhaler type as necessary. It is important to avoid unnecessary use of inhaled corticosteroids (ICS) due to the risk of pneumonia and fractures.

The type of inhaler used for COPD matters, Lange stressed. To make an appropriate recommendation:

- ✓ Consider soft mist inhalers (SMIs) + spacer
- ✓ Use a metered-dose inhaler (MDI) + spacer for ICS

Lange referenced other medications that can be used to manage COPD. These include:

- ✓ Revefenacin, a nebulized once-daily long-acting muscarinic antagonist (LAMA); LAMAs promote smooth muscle relaxation, decreased glandular secretion, and does not affect heart rate
- ✓ Azithromycin, an antibiotic used to treat various bacterial infections; By controlling inflammation and modulating immune responses, it can help reduce the frequency of COPD exacerbations
- ✓ Roflumilast can help reduce flare-ups in those with severe COPD, especially those with a history of exacerbations
- ✓ Prednisone, a corticosteroid that helps reduce airway inflammation can be used for a maximum of 5 days; it is usually started in the hospital or ER for exacerbations

Pulmonary rehab can be useful, said Lange, noting that it improves dyspnea, exercise capacity, and quality of life. It is covered by Medicare Part B in outpatient settings, but it isn't covered in long-term care. Other beneficial interventions for long-term care residents include smoking cessation and staying up to date on vaccinations.

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