VA/DOD Clinical Practice Guidelines

FOR THE MANAGEMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Provider Summary

Version 4.0 | 2026

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Department of Veterans Affairs
Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical trial and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of a particular clinical situation.

These guidelines are not intended to represent Department of Veterans Affairs nor TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 4.0 – 2026

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DOD) Evidence-Based Practice Work Group (EBPWG) was established in 2004, with a mission to use clinical and epidemiological evidence to improve population health within the Veterans Health Administration (VHA) and Military Health System (MHS) and develop clinical practice guidelines (CPGs) for the VA and DOD populations.(1) The development and updating of VA/DOD CPGs is funded by VA Evidence-Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based guidelines, including this CPG, is to guide providers in chronic obstructive pulmonary disease (COPD) management through pathways supported by evidence. This CPG is intended to provide health care providers with a practical framework by which to evaluate, treat, and manage COPD, address the individual needs and preferences of patients, and improve clinical outcomes.

In 2014, the VA and DOD published a CPG for the Management of Chronic Obstructive Pulmonary Disorder (2014 VA/DOD COPD CPG), which was based on evidence reviewed through February 2014. This was updated in 2021 using the same process, based on evidence reviewed from January 2014 through February 2020 (2021 VA/DOD COPD CPG). Since then, a growing body of research has expanded the general knowledge and understanding of the impact of COPD. Consequently, a recommendation to update the 2021 VA/DOD COPD CPG was initiated in July 2025 using published data from February 1, 2020, to December 5, 2025. The system-wide goal of evidence-based guidelines is to improve the patient's health and well-being. To that end, this CPG is intended to guide providers who care for patients along management pathways supported by evidence. These guidelines were written to emphasize the role of:

- Utilizing patient-centered care;
- Decreasing preventable complications and morbidity;
- Improving health outcomes and quality of life; and
- Using shared decision-making frameworks in patient collaboration efforts.

Scope of the CPG

This CPG is intended for use by general health care professionals who manage, co-manage, or otherwise provide outpatient care for adults with COPD.

Populations Included in this Guideline

This CPG is intended for adults (18 years or older) with COPD, who are eligible for outpatient care in the VA or DOD systems, including community care. This includes Veterans and Service members as well as their eligible adult dependents.

Recommendations

The following recommendations were made using a systematic approach considering four domains as per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach as detailed in the section on Methods and Appendix A in the full 2026 VA/DOD COPD CPG. These domains include the confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient or provider values and preferences, and other implications as appropriate (e.g., resource use, equity, acceptability, feasibility, subgroup considerations).

A. Key Takeaways/Highlights

1. Updated Algorithms;
    a. Including the initial assessment of COPD, pharmacologic and non-pharmacologic management of COPD, and outpatient management of COPD exacerbations
2. Updated Sidebars; and
    a. Including a guide to creating individualized management plans
3. Added 6 new recommendations, reviewed and replaced 3 recommendations, reviewed and amended 1 recommendation, carried over 2 recommendations that were reviewed and not changed, carried over 5 recommendations that were not reviewed and amended, and carried over 2 recommendations that were not reviewed and not changed from the 2021 VA/DOD COPD CPG
    a. Including a strong-for recommendation for long-acting beta 2-agonist/long-acting antimuscarinic agent (LABA/LAMA) dual therapy over monotherapy in patients with significant symptom burden
    b. More specific recommendations for who/when to prescribe systemic corticosteroids and/or antibiotics in patients with acute COPD exacerbations
    c. And the inclusion of telerehabilitation as a clinically effective alternative to in-person pulmonary rehabilitation

B. Evidence-Based Clinical Practice Recommendations with Strength and Category

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Diagnosis & Monitoring		1.	We suggest post-bronchodilator spirometry to confirm clinical diagnosis of chronic obstructive pulmonary disease (COPD)	Weak for	Reviewed, Not Changed
		2.	There is insufficient evidence to recommend using a multidimensional schema to diagnose chronic obstructive pulmonary disease (COPD)	Neither for nor against	Reviewed, New-added
		3.	There is insufficient evidence to recommend for or against any frequency of testing (i.e., spirometry, symptom questionnaires, electronic health technology) in patients with chronic obstructive pulmonary disease (COPD) to reduce exacerbations, reduce mortality, and/or improve quality of life	Neither for nor against	Reviewed, New-added

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Risk Reduction		4.	We recommend smoking cessation with a goal of sustained abstinence for prevention and risk reduction of chronic obstructive pulmonary disease (COPD). (see the VA/DOD Tobacco Use Treatment CPG)	Strong for	Reviewed, Not changed
		5.	We suggest against electronic nicotine delivery systems (ENDS) as an alternative to tobacco smoking cessation for the reduction of chronic obstructive pulmonary disease (COPD) risk and exacerbation. (see the VA/DOD Tobacco Use Treatment CPG)	Weak against	Reviewed, New-added
		6.	We suggest respiratory vaccinations with influenza, pneumococcal pneumonia, and coronavirus disease to reduce the risk of exacerbations of chronic obstructive pulmonary disease (COPD).	Weak for	Reviewed, New-replaced
Pharmacotherapy	Stable COPD	7.	We recommend inhaled long-acting muscarinic antagonists (LAMA) as initial therapy for patients with mild symptoms of chronic obstructive pulmonary disease (COPD)	Strong for	Not reviewed, Amended
		8.	In patients with moderate to severe symptom burden, we recommend initiating therapy with a long-acting beta-agonist and long-acting muscarinic antagonist (LABA/LAMA) over monotherapy	Strong for	Reviewed, New-added
Pharmacotherapy (cont.)	Stable COPD (cont.)	9.	In patients with chronic obstructive pulmonary disease (COPD) and a history of exacerbations requiring systemic corticosteroids and/or antibiotics in the past year, we recommend triple therapy with an inhaled corticosteroid, a long-acting beta-agonist, and a long-acting muscarinic antagonist (ICS/LABA/LAMA) for reducing exacerbations	Strong for	Reviewed, New-replaced
		10.	We recommend against long-acting beta agonists with inhaled corticosteroids (LABA/ICS) as standalone therapy for patients with chronic obstructive pulmonary disease (COPD)	Strong against	Not reviewed, Amended
		11.	In select patients on inhaled corticosteroid-containing therapy who have not had an exacerbation in the prior year and have blood eosinophil count <300 cells/μL, we suggest discontinuation of inhaled corticosteroid with careful monitoring	Weak for	Reviewed, Amended
		12.	In patients with chronic obstructive pulmonary disease (COPD), we suggest starting or continuing cardio-selective beta-blockers only in those who have a cardiovascular indication for beta-blockers (e.g., heart failure with reduced ejection fraction or recent myocardial infarction)	Weak for	Not reviewed, Not changed
	COPD Exacerbations	13.	In outpatients experiencing an acute chronic obstructive pulmonary disease (COPD) exacerbation, we suggest selectively prescribing a short course of systemic corticosteroids based on clinical exacerbation severity and patient characteristics	Weak for	Reviewed, New-added
		14.	In outpatients experiencing an acute chronic obstructive pulmonary disease (COPD) exacerbation, we recommend short-term antibiotics depending on patient characteristics	Strong for	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Other Management Interventions	Oxygen Therapy	15.	In outpatients with chronic obstructive pulmonary disease (COPD) and chronic severe resting hypoxemia or moderate resting hypoxemia with signs of chronic hypoxia-related cardiopulmonary or hematologic complications, we recommend providing long-term oxygen therapy	Strong for	Not reviewed, Amended
		16.	In outpatients with chronic obstructive pulmonary disease (COPD) and isolated exercise hypoxemia, we suggest against providing long-term oxygen therapy	Weak against	Not reviewed, Amended
	Rehabilitation	17.	We recommend offering pulmonary rehabilitation to stable, symptomatic patients on pharmacotherapy or post-hospitalization for chronic obstructive pulmonary disease (COPD) exacerbation	Strong for	Not reviewed, Amended
		18.	We suggest offering telepulmonary rehabilitation as a clinically effective alternative to in-person pulmonary rehabilitation	Weak for	Reviewed, New-added
	Tele-health	19.	We suggest offering telehealth support (e.g., telemonitoring and/or mobile applications)	Weak for	Not reviewed, Not changed

[a] For additional information, please refer to **Determining Recommendation Strength and Direction** in the full CPG.

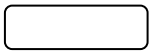
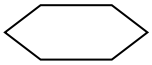
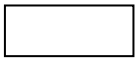
[b] For additional information, please refer to **Recommendation Categorization** in the full CPG

Algorithm

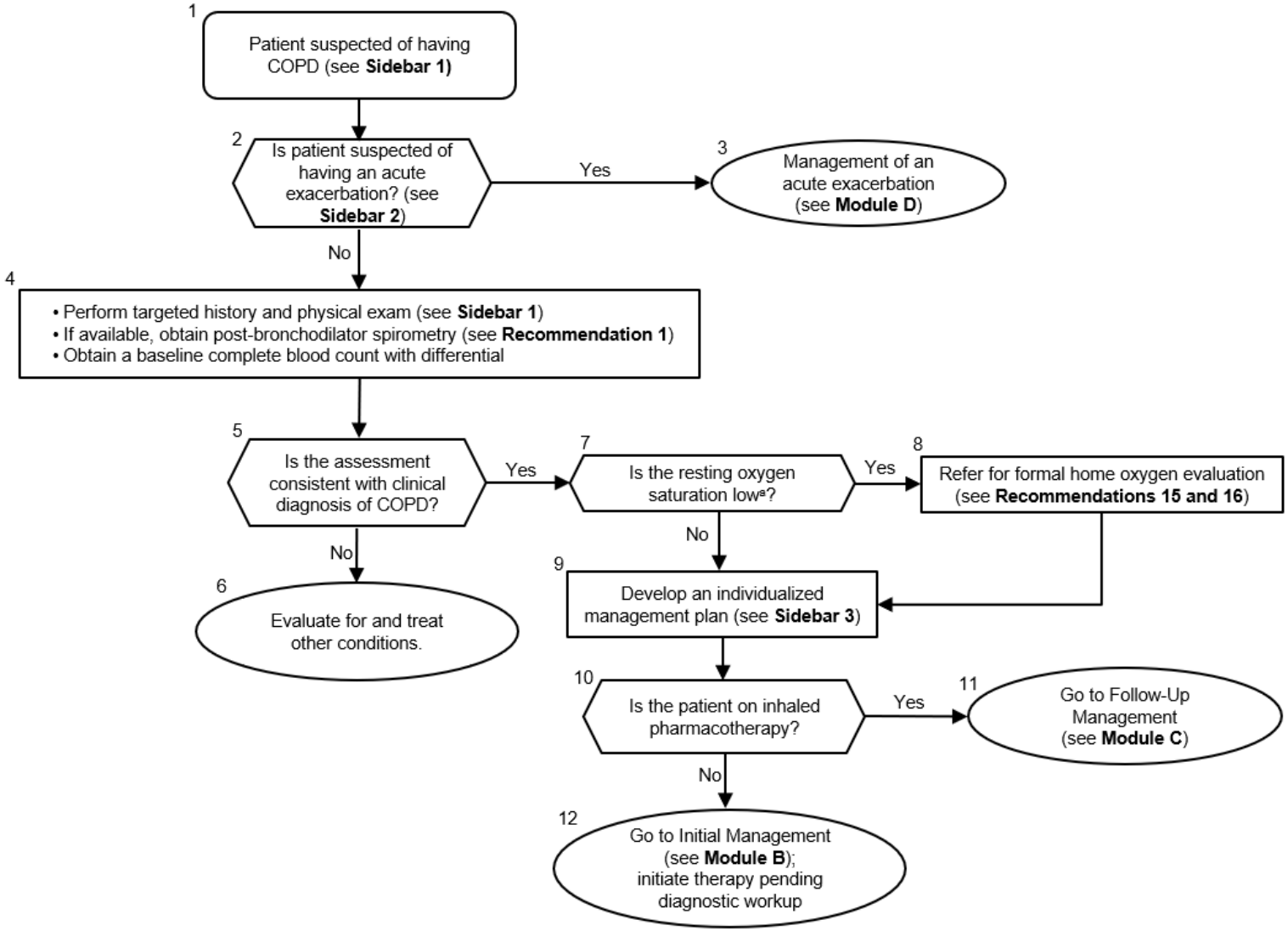
This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision-making process used in COPD management. This algorithm format represents a simplified flow of the management of patients with COPD, helping to foster efficient decision-making by providers. It includes:

- An ordered sequence of steps of care;
- Recommended observations and examinations;
- Decisions to be considered; and
- Actions to be taken.

The algorithm is a step-by-step decision tree. Standardized symbols are used to display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed.(2) Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

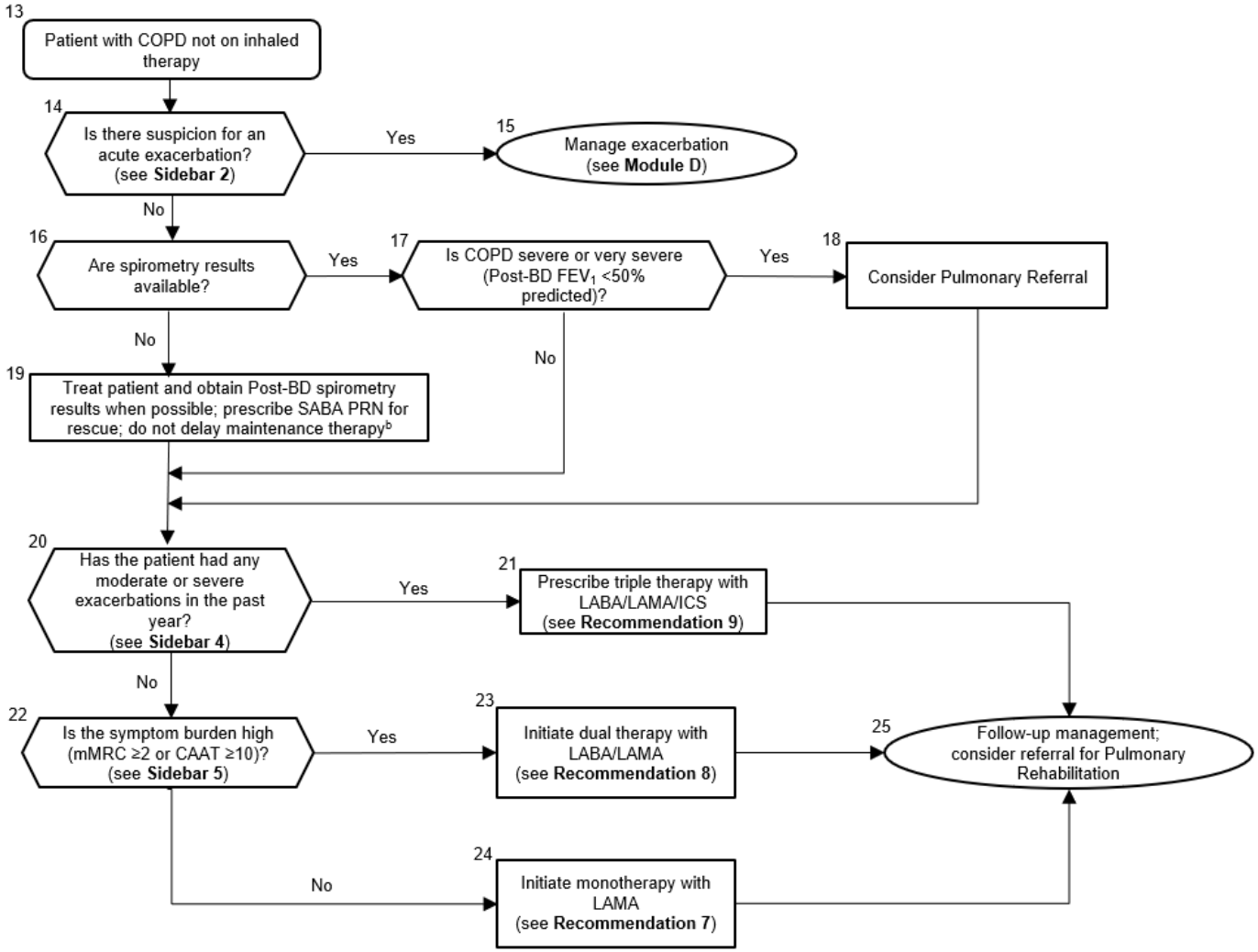
Shape	Description
	Rounded rectangles represent a clinical state or condition.
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered "Yes" or "No".
	Rectangles represent an action in the process of care.
	Ovals represent a link to another section within the algorithm

Module A: Assessment of COPD



Abbreviations: COPD: chronic obstructive pulmonary disease

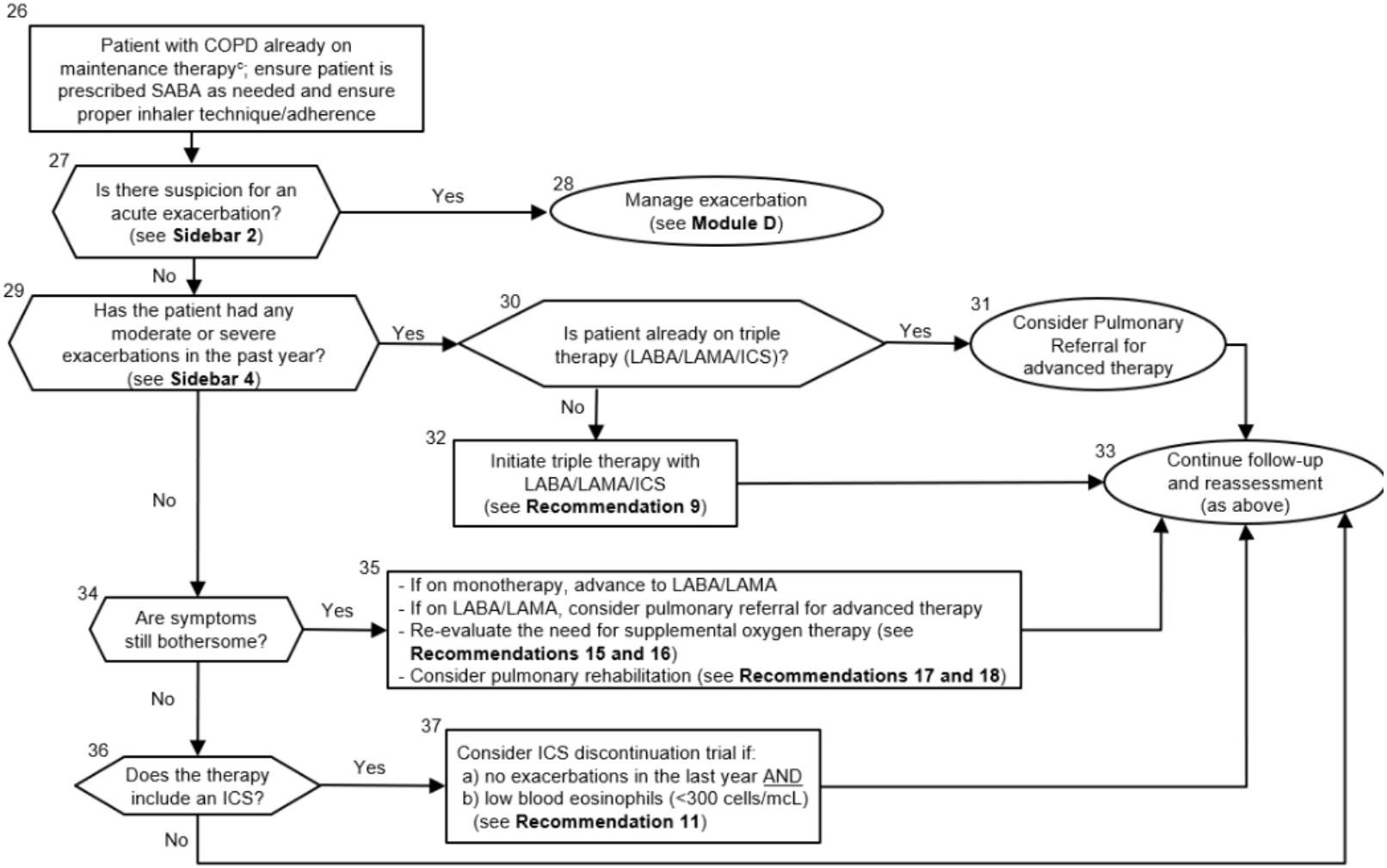
Module B: Initial Management of COPD



[b]: COPD exacerbations are treatment failures and exacerbations can result in disease progression

Abbreviations: BD: bronchodilator; CAAT: COPD Airways Assessment Test; COPD: chronic obstructive pulmonary disease; FEV1: forced expiratory volume in 1 second; ICS: inhaled corticosteroid; LABA: long-acting beta-agonist; LAMA: long-acting muscarinic antagonist; mMRC: Modified Medical Research Council Dyspnea Scale; PRN: pro re nata; SABA: short-acting beta-agonist

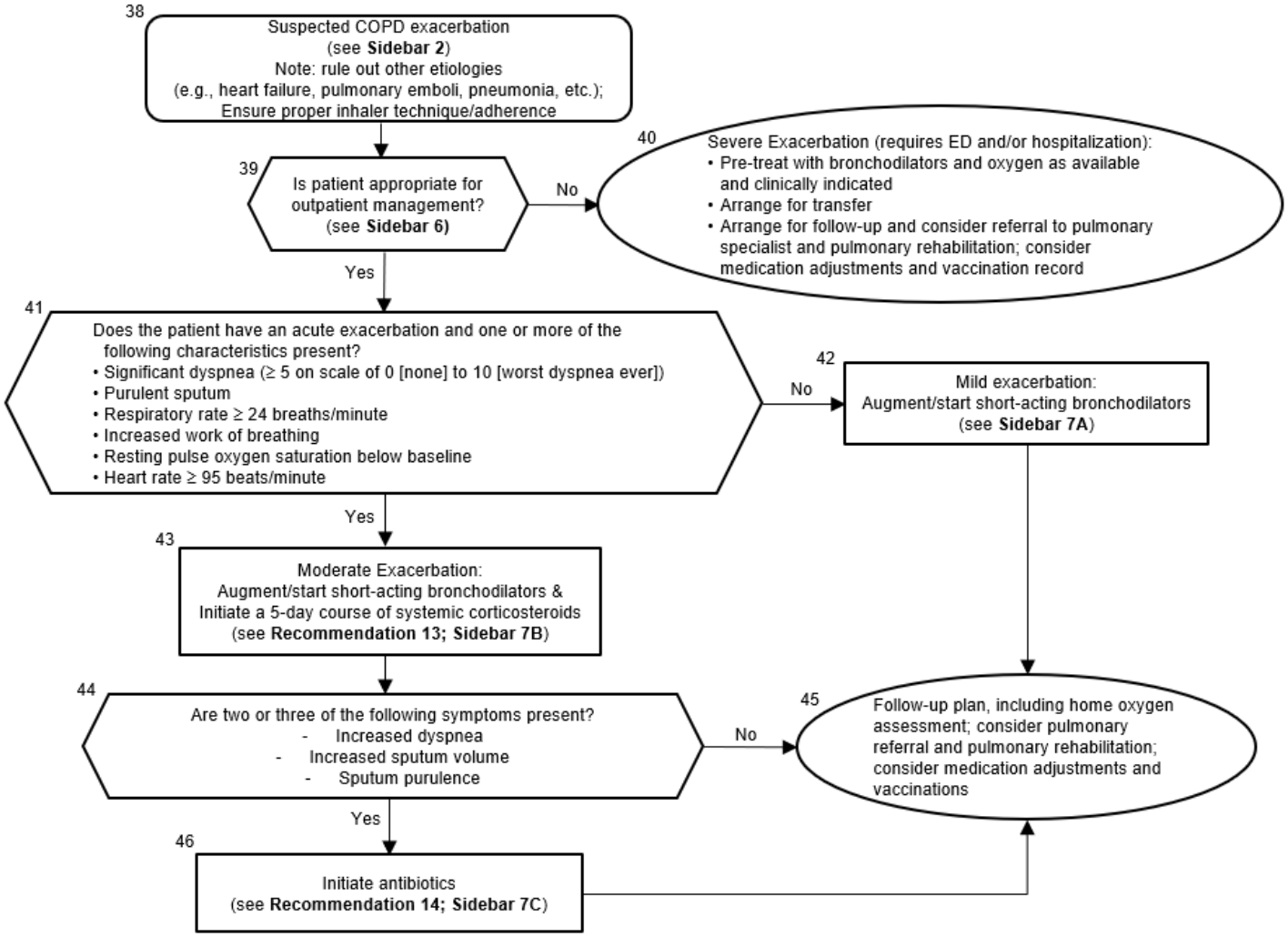
Module C: Follow Up Management of COPD



[c]: Stable patients on ICS/LABA, should be switched to either LABA/LAMA or triple therapy based on moderate/severe exacerbations and EOS ≥ 300 (see **Recommendation 8 and 9** narratives for details)

Abbreviations: COPD: chronic obstructive pulmonary disease; ICS: inhaled corticosteroid; LABA: long-acting beta-agonist; LAMA: long-acting muscarinic antagonist; mcL: microliter; SABA: short-acting beta-agonist

Module D: Management of Acute COPD Exacerbations



Abbreviations: COPD: chronic obstructive pulmonary disease; ED: emergency department

Sidebar 1: Definition of COPD

COPD is a respiratory condition associated with progressive decline in exercise tolerance and quality of life and increased mortality. In addition to genetic predisposition like alpha-1 antitrypsin deficiency, COPD results from long-term exposure to noxious stimuli including but not limited to cigarette smoking, biomass fuel, etc. Physiologically, the expiratory flow limitation is not fully reversible in COPD. Pathologically, COPD is an inflammatory condition encompassing a wide variety of findings including alveolar wall destruction, small airways disease, and mucus gland hypertrophy. The symptoms of COPD include one or more of the following:

- Shortness of breath (progressive)
- Chronic cough
- Chronic sputum production regardless of purulence
- Chronic Wheezing
- Fatigue
- Episodes of acute flares or worsening known as exacerbations
- Consider other conditions that may present similarly

Abbreviations: COPD: chronic obstructive pulmonary disease

Sidebar 2: When to Suspect an Acute COPD Exacerbation

Increased respiratory symptoms (i.e., increased shortness of breath, increased sputum volume, and/or sputum purulence — a change in sputum color from the patient's usual clear or white baseline to yellow or green) over a few days (<2 weeks) beyond the usual day-to-day variability and not fully explained by other differential diagnoses (e.g., heart failure, pulmonary emboli, pneumonia, etc.)

Abbreviations: COPD: chronic obstructive pulmonary disease

Sidebar 3: Individualized Management Plan

Assess symptom burden with a Patient-Reported Outcome Measure – CAAT (3,4) and/or mMRC
Assessment and management of modifiable risk factors

- Tobacco smoking and cessation (see **Recommendations 4 and 5** and **VA/DOD Tobacco Use Treatment CPG**)
- Vaccination (see **Recommendation 6**)
- Nutrition (malnutrition)
- Activity/Exercise
- Mental health
- Substance use including alcohol
- Air Quality
- Housing insecurity

Additional management considerations

- Patient and/or caregiver education and support (for example see **Background F** *in the full CPG*; refer to Veterans Health Library)
- Management of co-occurring conditions that may worsen COPD (see **CPG pg. 8**)
- Lung cancer screening as appropriate
- Pharmacological management (see **Module B and Module C**)
- Oxygen therapy (see **Recommendations 15 and 16**)
- Refer for in-person or tele-pulmonary rehabilitation (see **Recommendations 17-18**)
- Telehealth support tools (see **Recommendation 19**)

Sidebar 3: Individualized Management Plan
• Complimentary and Integrative Health support based on patient preferences • Palliative Care

Abbreviations: CAAT: COPD Airways Assessment Test; COPD: chronic obstructive pulmonary disease; CPG: clinical practice guideline; DOD: Department of Defense; mMRC: Modified Medical Research Council Dyspnea Scale; VA: Department of Veteran Affairs

Sidebar 4: Severity of Prior Acute COPD Exacerbations
History of acute exacerbation of COPD within the last year treated in the following manner: • History of Mild Exacerbation: Symptoms managed with inhaled bronchodilators alone. (**See Algorithm Box 42**) • History of Moderate Exacerbation: Treatment included systemic corticosteroids and/or antibiotics. (**See Algorithm Box 43**) • History of Severe Exacerbation: Management required hospitalization or emergency room visit. Severe exacerbations may also require additional ventilatory support including non-invasive ventilation or mechanical ventilator support. (**See Algorithm Box 40**)

Abbreviations: COPD: chronic obstructive pulmonary disease

Sidebar 5: mMRC Dyspnea Scale	
Grade	**Description of Breathlessness**
Grade 0	I only get breathless with strenuous exercise
Grade 1	I get short of breath when hurrying on level ground or walking up a slight hill
Grade 2	On level ground, I walk slower than people of the same age because of breathlessness, or I have to stop for breath when walking at my own pace on the level
Grade 3	I stop for breath after walking about 100 yards or after a few minutes on level ground
Grade 4	I am too breathless to leave the house or I am breathless when dressing

Abbreviation: mMRC: Modified Medical Research Council Dyspnea Scale

Sidebar 6: Criteria for Possible Admission to ED, Hospital, or ICU*
• In the opinion of the evaluating healthcare professional, inpatient or emergency department management is warranted • Accessory muscle use or retractions • Severe tachypnea or respiratory distress • Acute, aberrant vitals (e.g., hypotension, severe tachycardia, etc.) • Failure to respond to initial outpatient therapy • Hypoxemia or hypercapnia compared to baseline • Inability to complete ADLs due to acute symptoms • Inability to take oral medications • Altered mental status • Presence of severe underlying COPD and/or serious co-occurring medical conditions

*Use clinical judgement

Abbreviations: ADLs: activities of daily living; ED: emergency department; ICU: intensive care unit

Sidebar 7: Pharmacologic Treatment of Acute COPD Exacerbations in Outpatients

7a. Adjust bronchodilator therapy

- Augment (consider scheduling for a few days) short-acting bronchodilator therapy with SABA (e.g., albuterol, levalbuterol), then change back to as needed ***and***
- Start or change maintenance inhalers to triple therapy with ICS/LABA/LAMA (Boxes 21 & 30) [do NOT use maintenance inhalers for relief of acute symptoms and do NOT use more than usual dose approved by the FDA]

7b. Systemic corticosteroids (see **Recommendation 13**)

- Start a short course of prednisone 40 mg daily or equivalent (recommended duration is 5 days but may extend to 14 days as clinically indicated). (5)

7c. Antibiotics (see **Recommendation 14**)

- Start a short (3-10 days) course of an antibiotic: choice based on local resistance patterns and prior patient culture data to cover, at minimum, *S. pneumoniae*, *H. influenzae*, *M. catarrhalis*
- Consider adding coverage for *Pseudomonas* and other Gram-negative rods if Post-BD FEV_1 <50% predicted, recent antibiotic use, recent or frequent hospitalizations, or history of infection or colonization with resistant organisms (6,7)

Abbreviations: BD: bronchodilator; COPD: chronic obstructive pulmonary disease; FEV_1: forced expiratory volume in 1 second; ICS: inhaled corticosteroid; LABA: long-acting beta 2-agonist; LAMA: long-acting muscarinic antagonist; mg: milligram; SABA: short-acting beta 2-agonist

Appendix A: Pharmacotherapy*

*Refer to current product information for additional prescribing information.

Table H-1. Short-Acting Beta 2-agonist (SABA) Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held Devices	Albuterol ProAir Respiclick	DPI	90 mcg	2 inhalations every 4-6 hours as needed (Max: 2 inhalations every 4 hours)	200
	Albuterol ProAir HFA Proventil HFA Ventolin HFA	MDI			
	Levalbuterol Xopenex HFA	MDI	45 mcg	1 or 2 inhalations every 4-6 hours as needed (Max: 2 inhalations every 4 hours)	
Nebulizers	Albuterol sulfate solution	Neb	2.5 mg/3 mL	Inhale contents of 1 vial every 6-8 hours as needed over 5-15 minutes (Max: 10 mg/day)	30
	Levalbuterol solution Xopenex	Neb	0.63 mg/3 mL	Inhale contents of 1 vial every 6-8 hours as needed for 3 doses/day (Max: 3.75 mg/day)	25
			1.25 mg/3 mL		

Abbreviations: DPI: dry powder inhaler; HFA: hydrofluoroalkane; mcg: microgram; MDI: metered-dose inhaler; mg: milligram; mL: milliliter; Neb: nebulized solution; SABA: short-acting beta 2-agonist

Table H-2. Short-Acting Muscarinic Antagonist (SAMA)(8) Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held Devices	Ipratropium Atrovent HFA	MDI	17 mcg	2 inhalations 4 times/day (Max: 12 inhalations/day)	200
Nebulizers	Ipratropium bromide solution	Neb	500 mcg/25 mL	Inhale contents of 1 vial every 6-8 hours (Max: 2000 mcg/day)	30

Abbreviations: HFA: hydrofluoroalkane; mcg: microgram; MDI: metered-dose inhaler; mg: milligram; mL: milliliter; Neb: nebulized solution; SAMA: short-acting muscarinic antagonist

Table H-3. SABA + SAMA(8) Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held Devices	Ipratropium/Albuterol Combivent Respimat	SMI	20/100 mcg	1 inhalation 4 times/day (Max: 6 inhalations/day)	120
Nebulizers	Ipratropium/Albuterol solution DuoNeb	Neb	0.5/3 mg/3 mL	Inhale contents of 1 vial (3 mL) every 6 hours (Max: 3/18 mg/day)	30

Abbreviations: mcg: microgram; mg: milligram; mL: milliliter; Neb: nebulized solution; SABA: short-acting beta 2-agonist; SAMA: short-acting muscarinic antagonist; SMI: slow mist inhaler

Table H-4. Long-Acting Beta 2-Agonist (LABA) Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held Devices	Indacaterol Arcapta Neohaler	DPI	75 mcg	Inhale contents of 1 capsule once daily (Max: 300 mcg/day)	30
	Olodaterol Striverdi Respimat	SMI	2.5 mcg	2 inhalations once daily (Max: 5 mcg/day)	60
	Salmeterol Serevent Diskus	DPI	50 mcg	1 inhalation twice daily (Max: 100 mcg/day)	60
Nebulizers	Arformoterol solution Brovana	Neb	15 mcg/2 mL	Inhale contents of 1 vial twice daily (Max: 30 mcg/day)	60
	Formoterol solution Perforomist	Neb	20 mcg/2 mL	Inhale contents of 1 vial twice daily (Max: 40 mcg/day)	60

Abbreviations: DPI: dry powder inhaler; LABA: long-acting beta 2-agonist; mcg: microgram; mg: milligram; mL: milliliter; Neb: nebulized solution; SMI: slow mist inhaler

Table H-5. Long-Acting Muscarinic Antagonists (LAMA) Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held Devices	Aclidinium Tudorza Pressair	DPI	400 mcg	1 inhalation twice daily (Max: 800 mcg/day)	60
	Tiotropium Spiriva Handihaler	DPI	18 mcg	Inhale contents of 1 capsule once daily (Max: 18 mcg/day)	30
	Tiotropium Spiriva Respimat	SMI	2.5 mcg	2 inhalations once daily (Max: 5 mcg/day)	60
	Umeclidinim Incruse Ellipta	DPI	62.5 mcg	1 inhalation once daily (Max: 62.5 mcg/day)	30
Nebulizers	Revefenacin solution Yupelri	Neb	175 mcg/3 mL	Inhale contents of 1 vial once daily (Max: 175 mcg/day)	30

Abbreviations: DPI: dry powder inhaler; mcg: microgram; mL: milliliters; Neb: nebulized solution; SMI: slow mist inhaler

Table H-6. LAMA + LABA Products

Product		Delivery	Strength	Dosing	Doses per Unit
Hand-held devices	Aclidinium/Formoterol Duaklir Pressair	DPI	400/12 mcg	1 inhalation twice daily (Max: 2 inhalations/day)	60
	Glycopyrrolate/Formoterol Bevespi Aerosphere	MDI	9/4.8 mcg	2 inhalations twice daily (Max: 4 inhalations/day)	120

Product		Delivery	Strength	Dosing	Doses per Unit
	Tiotropium/Olodaterol Stiolto Respimat	SMI	2.5/2.5 mcg	2 inhalations once daily (Max: 2 inhalations/day)	60
	Umeclidinium/Vilanterol Anoro Ellipta	DPI	62.5/25 mcg	1 inhalation once daily (Max: 1 inhalation/day)	30

Abbreviations: DPI: dry powder inhaler; LABA: long-acting beta 2-agonist; LAMA: long-acting muscarinic antagonist; mcg: microgram; MDI: metered-dose inhaler; mg: milligram; mL: milliliter; SMI: slow mist inhaler

Table H-7. Inhaled Corticosteroids (ICS) Products*

Product		Delivery	Strength	Dosing	Potency of Steroid	Doses per Unit
Hand-held devices	Beclomethasone Qvar RediHaler	Breath-actuated MDI	40 mcg	1 or 2 inhalations twice daily	Low	120
			80 mcg	1 or 2 inhalations twice daily (Max: 320 mcg twice daily)	Low/Med/ High	
	Budesonide Pulmicort Flexhaler	DPI	90 mcg	1 or 2 inhalations twice daily	Low	60
			180 mcg	1 or 2 inhalations twice daily (Max: 720 mcg twice daily)	Low/Med/ High	120
	Ciclesonide Alvesco HFA	MDI	80 mcg	1 or 2 inhalations twice daily	Low/Med	60
			160 mcg	1 or 2 inhalations twice daily (Max: 320 mcg twice daily)	Med/High	
	Fluticasone furoate Arnuity Ellipta	DPI	100 mcg	1 or 2 inhalations once daily (Max: 200 mcg/day)	Low/High	30
			200 mcg	1 inhalation once daily (Max: 200 mcg/day)	High	
	Fluticasone propionate ArmonAir Digihaler Flovent Diskus	DPI	55 mcg	1 or 2 inhalations twice daily	Low	60
			113 mcg	1 or 2 inhalations twice daily (Max: 223 mcg twice daily)	Low/Med	
			232 mcg	1 inhalation twice daily (Max: 223 mcg twice daily)	Med	
			50 mcg	1 or 2 inhalations twice daily	Low	
			100 mcg	1 or 2 inhalations twice daily	Low/Med	
			250 mcg	1 or 2 inhalations twice daily (Max: 1000 mcg twice daily)	Med/High	
	Fluticasone propionate Flovent HFA	MDI	44 mcg	1 or 2 inhalations twice daily	Low	120
			110 mcg	1 or 2 inhalations twice daily	Low/Med	
			220 mcg	1 or 2 inhalations twice daily (Max: 880 mcg twice daily)	Med/High	
	Mometasone Asmanex HFA Asmanex Twisthaler	MDI	100 mcg	1 or 2 inhalations twice daily	Low	120
			200 mcg	1 or 2 inhalations twice daily (Max: 800 mcg/day)	Med/High	
		DPI	110 mcg	1 or 2 inhalations daily	Low	60

Product		Delivery	Strength	Dosing	Potency of Steroid	Doses per Unit
			220 mcg	1 or 2 inhalations daily (Max: 440 mcg/day)	Low/Med	
Nebulizers	Budesonide suspension Pulmicort	Neb	0.25 mg/2 mL	Inhale contents of 1 respule once daily	Low	30
			0.5 mg/2 mL	Inhale contents of 1 or 2 respules once or twice daily	Med/High	

*Not to be used alone in COPD; use in combination with LAMA and LABA (as triple therapy in one or two inhalers)
Abbreviations: DPI: dry powder inhaler; HFA: hydrofluoroalkane; mcg: microgram; Med: medium; MDI: metered-dose inhaler; mg: milligram; mL: milliliter; Neb: nebulized solution

Table H-8. ICS + LABA devices recommended for use with LAMA (See Table H-5). Products*

Product		Delivery	Strength	Dosing	Potency of Steroid	Doses per Unit
Hand-held devices	Budesonide/ Formoterol Symbicort Breyna authorized generic	MDI	80/4.5 mcg	2 inhalations twice daily	Low	120
			160/4.5 mcg	2 inhalations twice daily (Max: 320/9 mcg twice daily)	Med	
	Fluticasone furoate/ Vilanterol Breo Ellipta	DPI	100/25 mcg	1 inhalation once daily	Low	30
			200/25 mcg	1 inhalation once daily (Max: 200/25 mcg daily)	High	
	Fluticasone propionate/ Salmeterol Advair Diskus Wixela Inhub Authorized generic	DPI	250/50 mcg	1 inhalation twice daily (Max: 250/50 mcg twice daily) (FDA approved for this dose)	Med	60
Hand-held devices (cont.)	Fluticasone propionate/ Salmeterol Advair HFA	MDI	45/21 mcg	2 inhalations twice daily	Low	120
			115/21 mcg	2 inhalations twice daily	Med	
			230/21 mcg	2 inhalations twice daily (Max: 460/42 mcg twice daily)	High	
	Mometasone/ Formoterol Dulera	MDI	100/5 mcg	2 inhalations twice daily	Med	120
			200/5 mcg	200/5 mcg: 2 inhalations twice daily (Max: 400/10 mcg twice daily)	High	

*Must be used with LAMA in COPD (as triple therapy)
Abbreviations: DPI: dry powder inhaler; HFA: hydrofluoroalkane; ICS: inhaled corticosteroid; LABA: long-acting beta 2-agonist; LAMA: long-acting muscarinic antagonist; mcg: microgram; MDI: metered-dose inhaler; mg: milligram; mL: milliliter

Table H-9. ICS + LABA + LAMA Products

Product		Delivery	Strength	Dosing	Potency of Steroid	Doses per Unit
Single Inhalers	Budesonide/ Glycopyrrolate/ Formoterol fumarate Breztri Aerosphere	MDI	160/9/4.8 mcg	2 inhalations twice daily	Med	120
	Fluticasone furoate/Vilanterol/ Umeclidinium Trelegy Ellipta	DPI	100/25/62.5 mcg	1 inhalation once daily	Low	30
	Beclomethasone dipropionate / Formoterol fumarate / Glycopyrrolate Trimbow	MDI	86/4.9/10.6/86 mcg	2 inhalations twice daily	Medium	120
Multiple Inhalers*	Fluticasone furoate Arnuity Ellipta + Tiotropium/ Olodaterol Stiolto Respimat	DPI	100 mcg	1 inhalation once daily	Low	30
		SMI	2.5/2.5 mcg	2 inhalations once daily		60
	Fluticasone propionate Flovent Diskus + Umeclidinium/ Vilanterol Anoro Ellipta	DPI	100 mcg	1 or 2 inhalations twice daily	Low/Med	60
		DPI	62.5/25 mcg	1 inhalation once daily		30
	Mometasone Asmanex Twisthaler + Tiotropium/ Olodaterol Stiolto Respimat	DPI	220 mcg	1 or 2 inhalations daily	Low/Med	60
		SMI	2.5/2.5 mcg	2 inhalations once daily		60

*Based on individual formularies, cost, and preferences, triple therapy may be achieved by using a single inhaler (LABA+LAMA+ICS) or by using a 2-drug fixed-dose combination (LAMA+LABA preferred in COPD) + a single inhaler (ICS preferred in COPD) (e.g., see below [NOT an all-inclusive list])

Abbreviations: COPD: chronic obstructive pulmonary disease; DPI: dry powder inhaler; ICS: inhaled corticosteroid; LABA: long- acting beta 2-agonist; LAMA: long-acting muscarinic antagonist; mcg: microgram; SMI: slow mist inhaler

Table H-10. Comments by Drug Class*

Drug Class	Comments
Beta 2-Agonists	LABAs increase the risk of asthma-related death; do not use as monotherapy in asthma
	May cause palpitations, chest pain, rapid heart rate, increased blood pressure, tremor, nervousness
	Decreases in potassium levels have occurred

Drug Class	Comments
	SABAs are used for acute treatment of bronchospasm; LABAs are used for chronic treatment of bronchospasm
	Indacaterol: capsules are for oral inhalation only; capsules should not be swallowed; administer using supplied inhalation device only
Muscarinic Antagonist Agents	Use with caution in patients with narrow angle glaucoma, prostatic hyperplasia, or bladder neck obstruction
	Caution patients against getting product in eyes; temporary blurred vision may result
	For relief of dry mouth, suggest use of saliva substitute, practice of good oral hygiene, rinsing of mouth after inhalation; instruct patient to take sips of water frequently, suck on ice chips or sugarless hard candy, or chew sugarless gum
	Tiotropium: capsules are for oral inhalation only; capsules should not be swallowed; administer using supplied inhalation device only
Inhaled Glucocorticoids	Rare instances of glaucoma, increased intraocular pressure, and cataracts have been reported
	Increased risk of pneumonia
	Advise patients to rinse mouth after inhalation to reduce risk of oral fungal infections (e.g., oropharyngeal candidiasis)

Note: Each drug class has agents available in a dry powder formulation, appropriate for patients with adequate inspiratory flow. Dry powder formulations contain lactose and small amounts of milk proteins; do not use in patients with severe hypersensitivity to milk proteins.

* Table not intended as a comprehensive list of all warnings, precautions, and risks. Abbreviations: LABA: long-acting beta 2-agonist; SABA: short-acting beta 2-agonist

Appendix B: Standardized Questionnaires

Standardized questionnaires may help clinicians assess symptom burden. Two commonly used questionnaires are the mMRC and the CAT. The mMRC is a simple tool that can be used to assess dyspnea in multiple medical conditions.(3) The CAAT is a more complex questionnaire that is specific to COPD.(4)

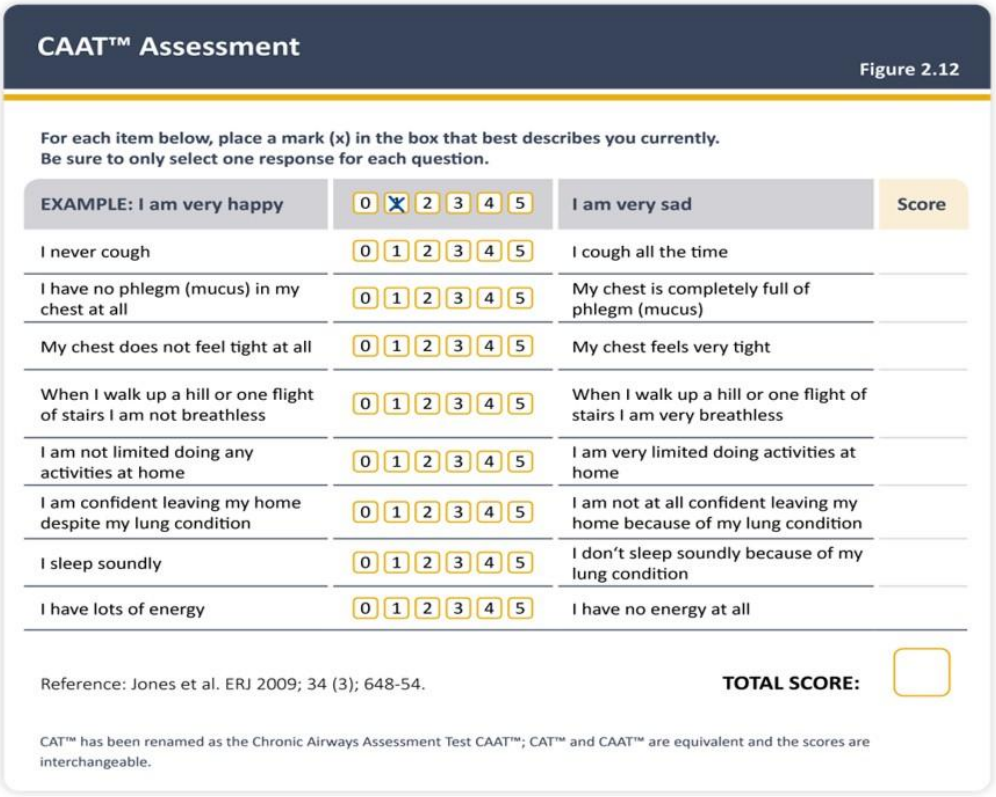
A. Modified Medical Research Council Questionnaire

Table I-1. mMRC (3)

Grade	Description of Breathlessness
Grade 0	I only get breathless with strenuous exercise
Grade 1	I get short of breath when hurrying on level ground or walking up a slight hill
Grade 2	On level ground, I walk slower than people of the same age because of breathlessness, or I have to stop for breath when walking at my own pace on the level
Grade 3	I stop for breath after walking about 100 yards or after a few minutes on level ground
Grade 4	I am too breathless to leave the house or I am breathless when dressing

B. COPD Airways Assessment Test

Figure I-1. CAAT (4)



CAAT™ Assessment

Figure 2.12

For each item below, place a mark (x) in the box that best describes you currently.
Be sure to only select one response for each question.

EXAMPLE: I am very happy	0 X 2 3 4 5	I am very sad	Score
I never cough	0 1 2 3 4 5	I cough all the time	
I have no phlegm (mucus) in my chest at all	0 1 2 3 4 5	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	0 1 2 3 4 5	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	0 1 2 3 4 5	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing any activities at home	0 1 2 3 4 5	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	0 1 2 3 4 5	I am not at all confident leaving my home because of my lung condition	
I sleep soundly	0 1 2 3 4 5	I don't sleep soundly because of my lung condition	
I have lots of energy	0 1 2 3 4 5	I have no energy at all	

Reference: Jones et al. ERJ 2009; 34 (3); 648-54.

TOTAL SCORE:

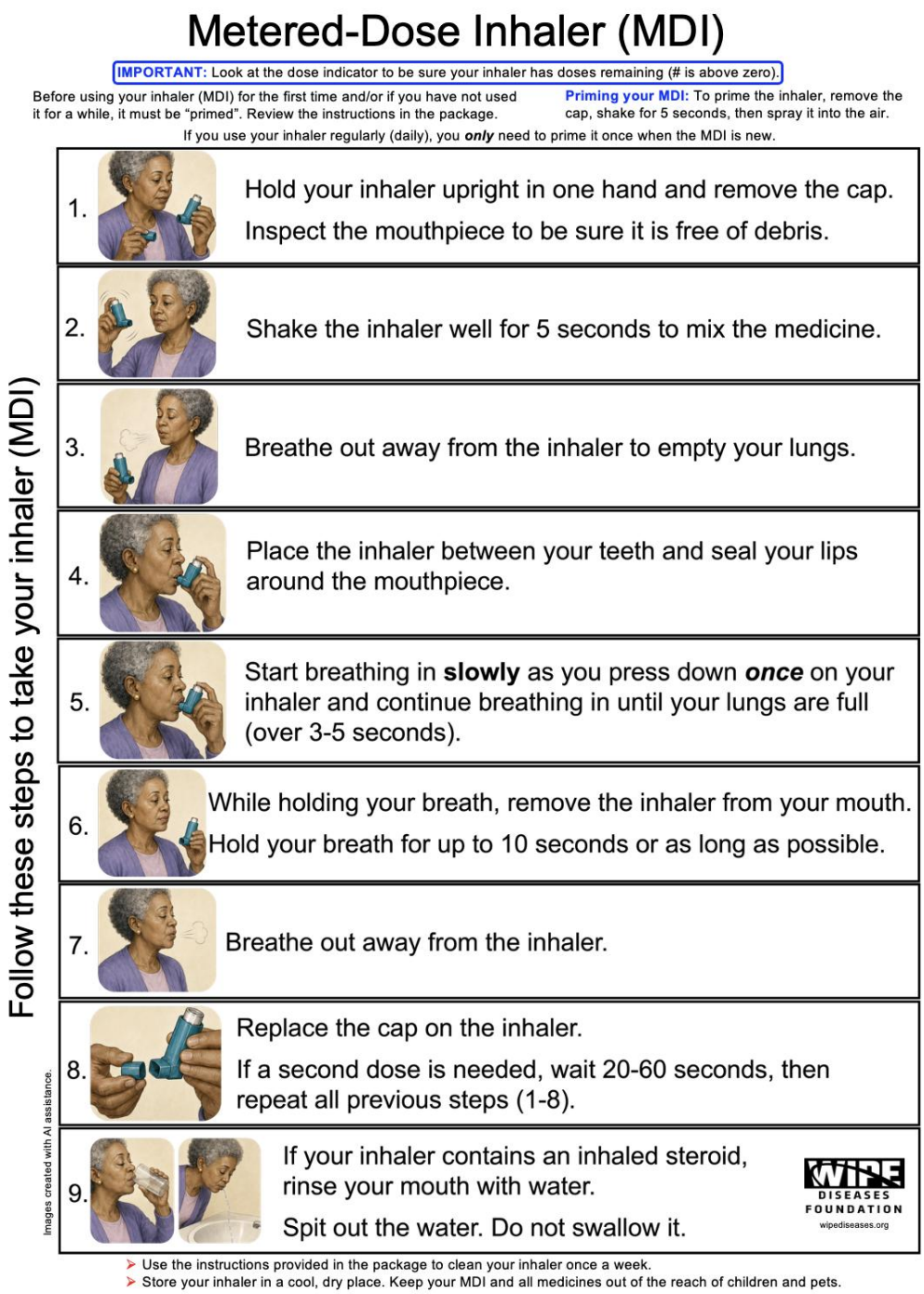
CAT™ has been renamed as the Chronic Airways Assessment Test CAAT™; CAT™ and CAAT™ are equivalent and the scores are interchangeable.

Alternative Text: Figure I-1. Screenshot of the COPD Airways Assessment Test (CAAT) questionnaire. The form includes eight labeled questions with a 0-5 scale for responses, an example marked answer at the top of the questionnaire, and a section for total score at the bottom of the questionnaire. The questions address cough, phlegm, chest tightness, breathlessness, activity limitations, confidence with leaving home, sleep, and energy.

Appendix C: Inhaler Techniques

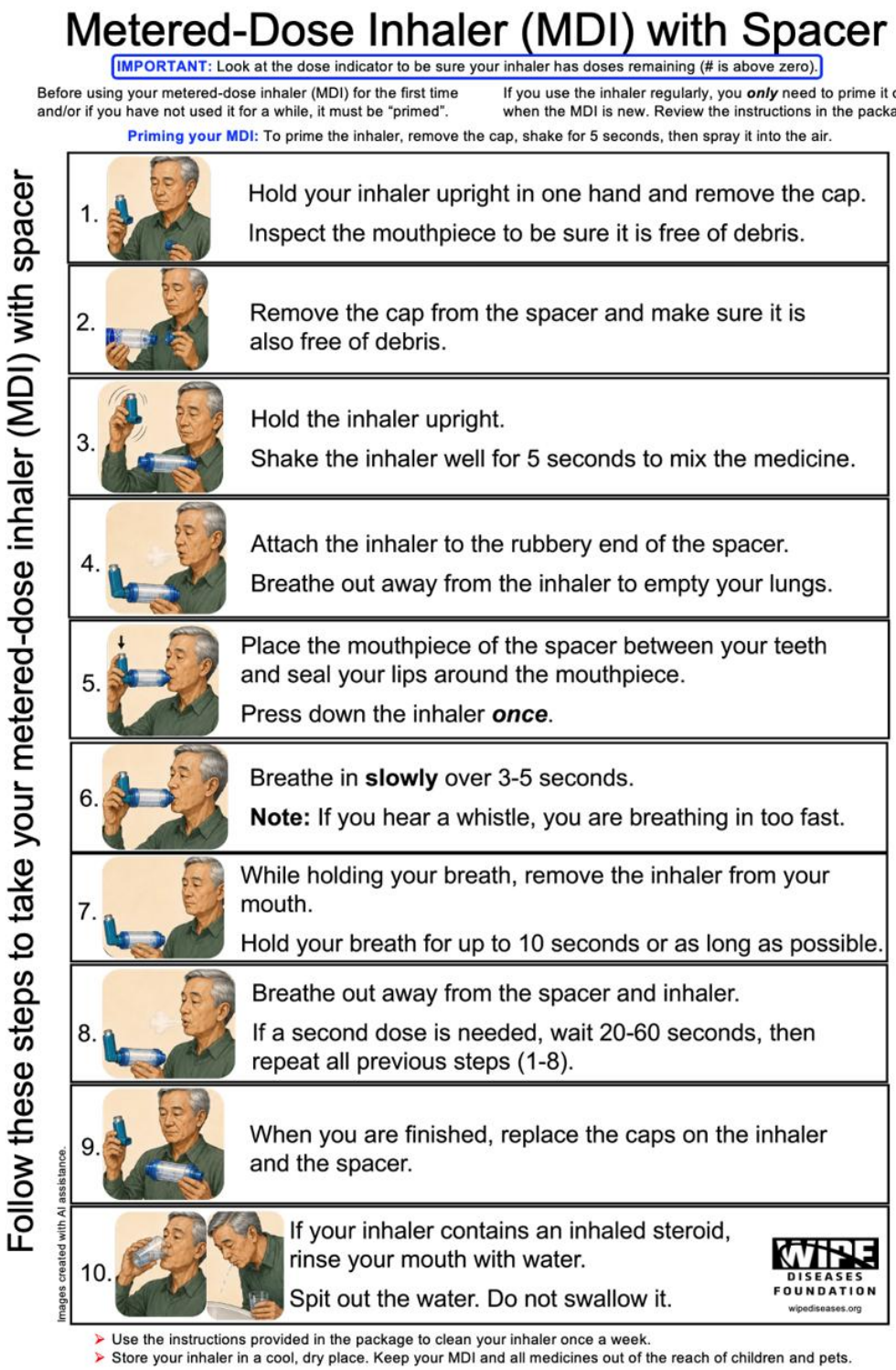
A. Metered-Dose Inhaler

Figure J-1. How to correctly use a metered-dose inhaler (MDI)(9)



Alternative Text: Figure J-1. Instructional graphic illustrating nine sequential steps for proper use of a metered-dose inhaler (MDI), featuring labeled boxes with photos of a person demonstrating each step. Key steps include priming instructions, slow-inhalation timing, breath-holding guidance, and cleanup after use.

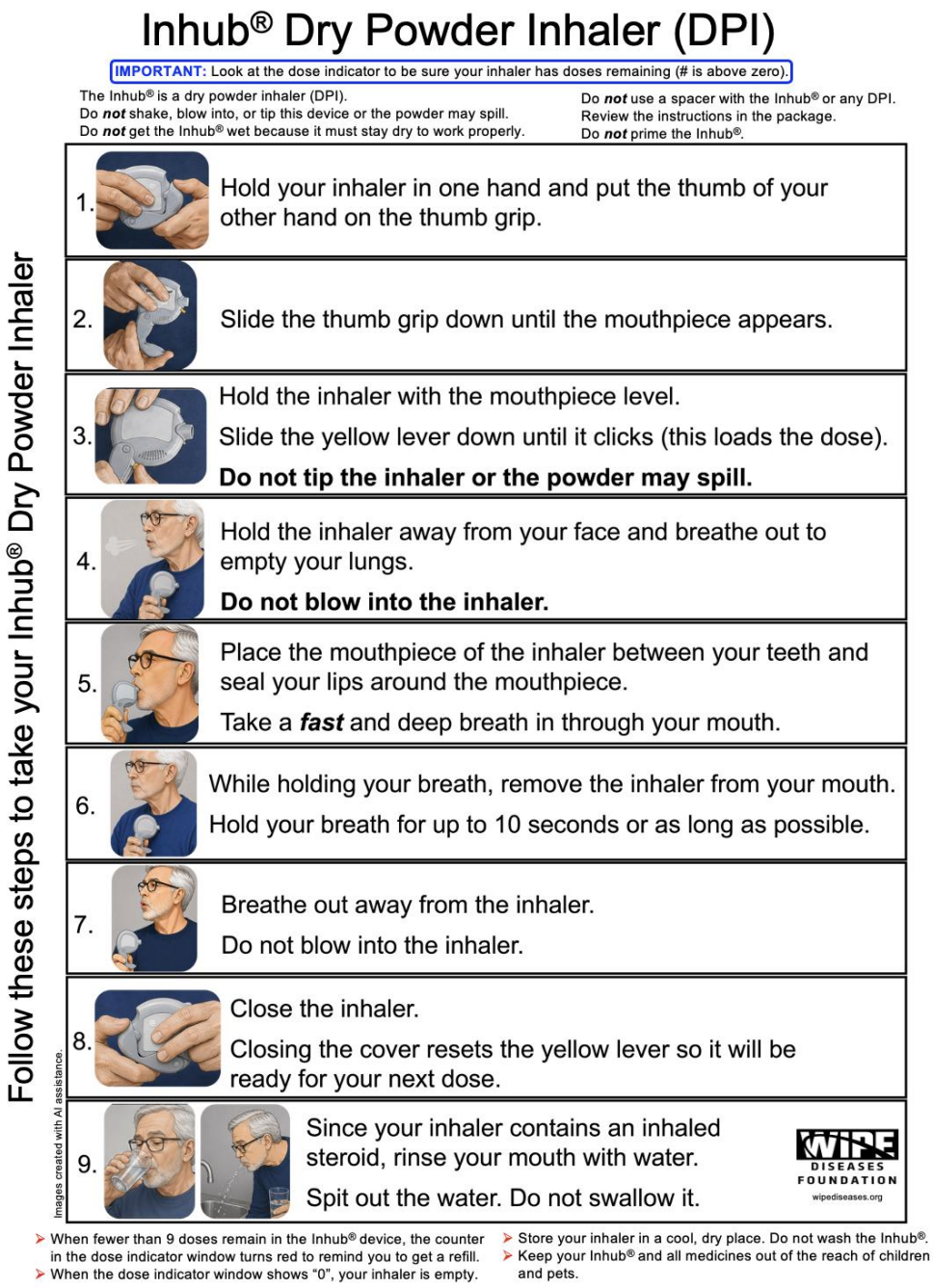
Figure J-2. How to correctly use an MDI with a spacer (9)



Alternative Text: Figure J-2. Instructional graphic illustrating 10 sequential steps for proper use of a metered-dose inhaler (MDI) with spacer, featuring labeled boxes with photos of a person demonstrating each step. Key steps include priming instructions, slow-inhalation timing, breath-holding guidance, and cleanup after use.

B. Dry Powder Inhalers

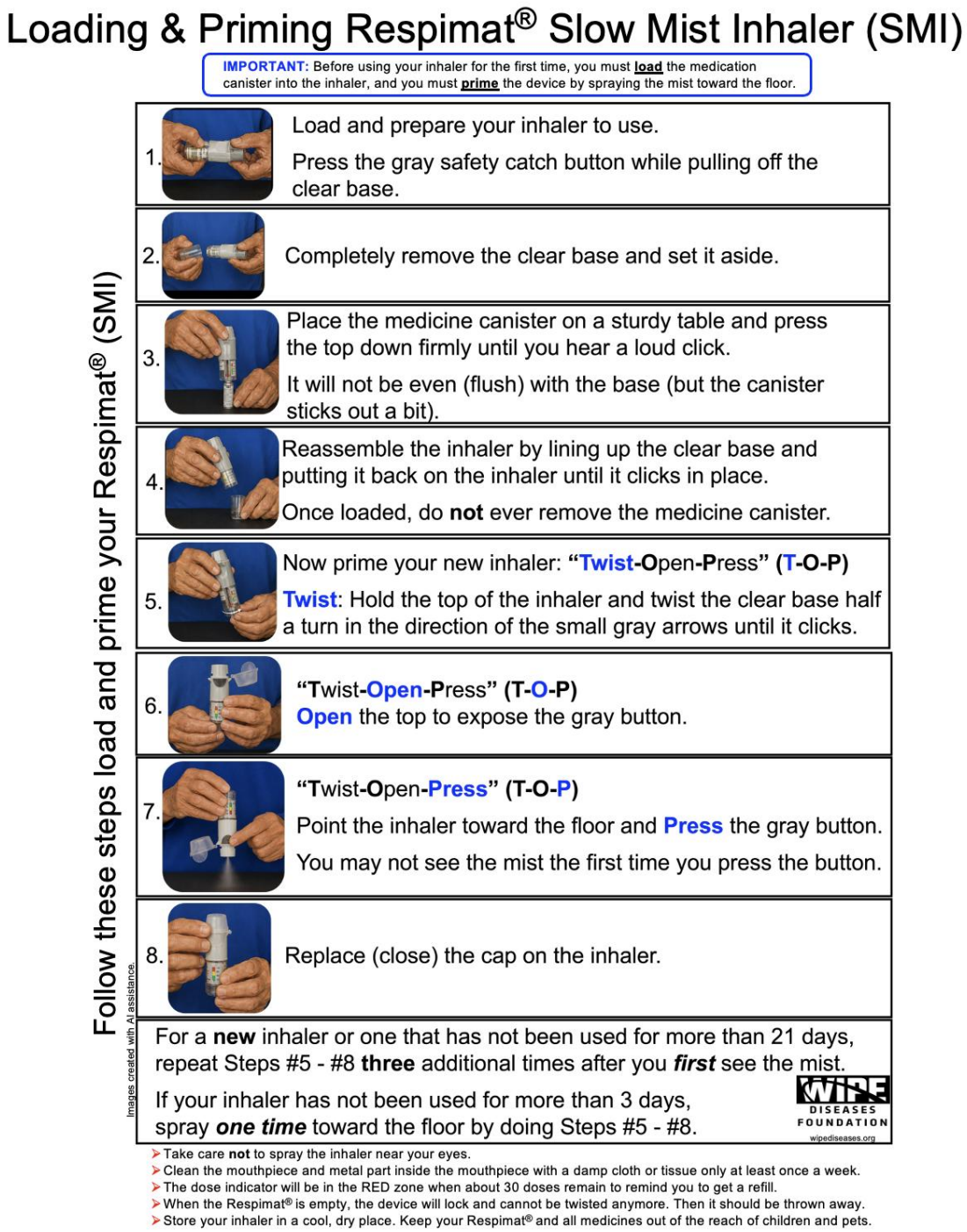
Figure J-3. How to correctly use an Inhub dry powder inhaler (DPI)(9)



Alternative Text: Figure J-3. Instructional graphic illustrating 9 sequential steps for proper use of an inhub dry powder inhaler (DPI), featuring labeled boxes with photos of a person demonstrating each step. Key steps include griping instructions, fast-inhalation timing, breath-holding guidance, and cleanup after use.

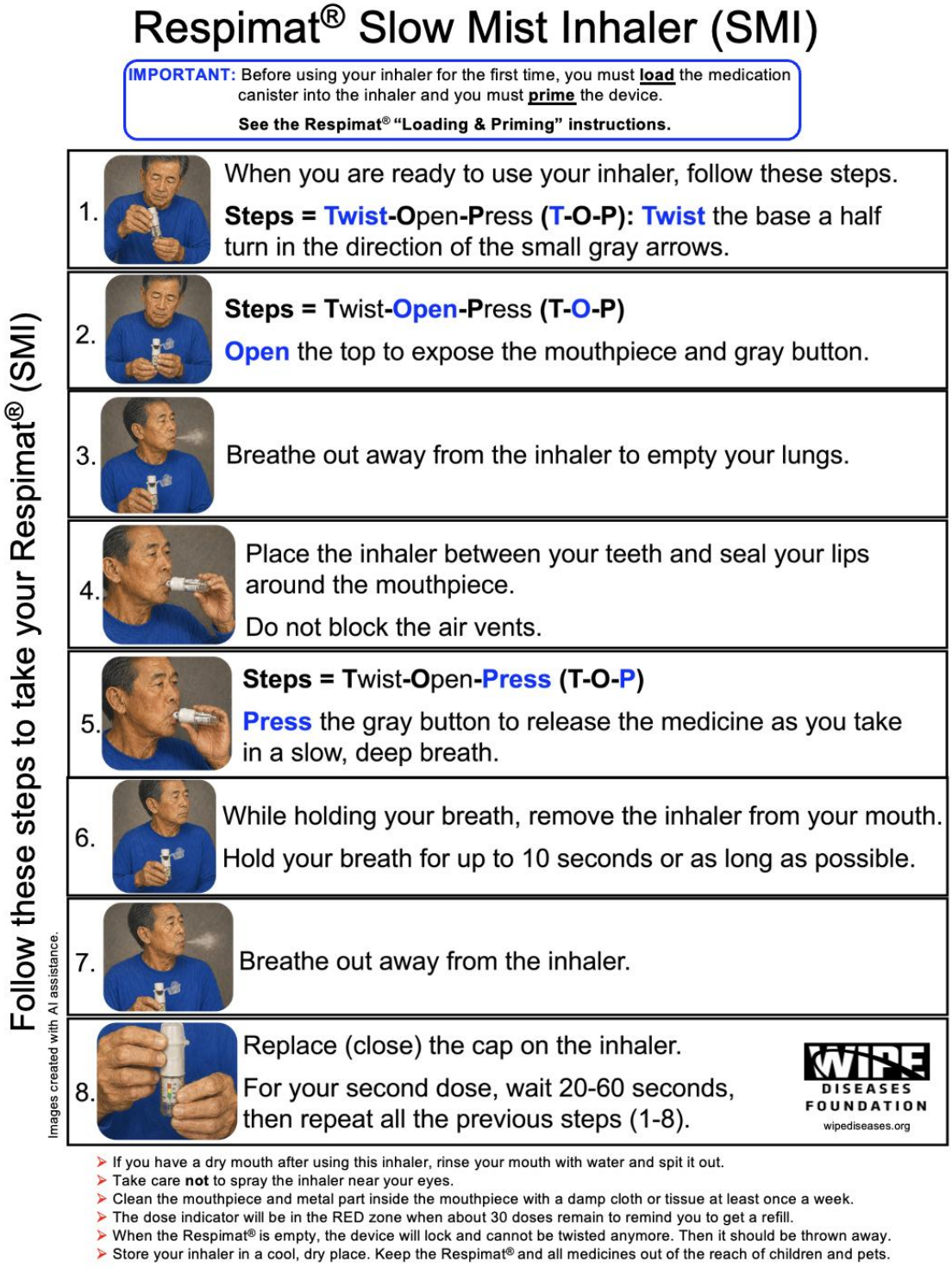
C. Respimat Inhalers

Figure J-4. How to correctly load and prime a Respimat Slow Mist Inhaler (SMI)(9)



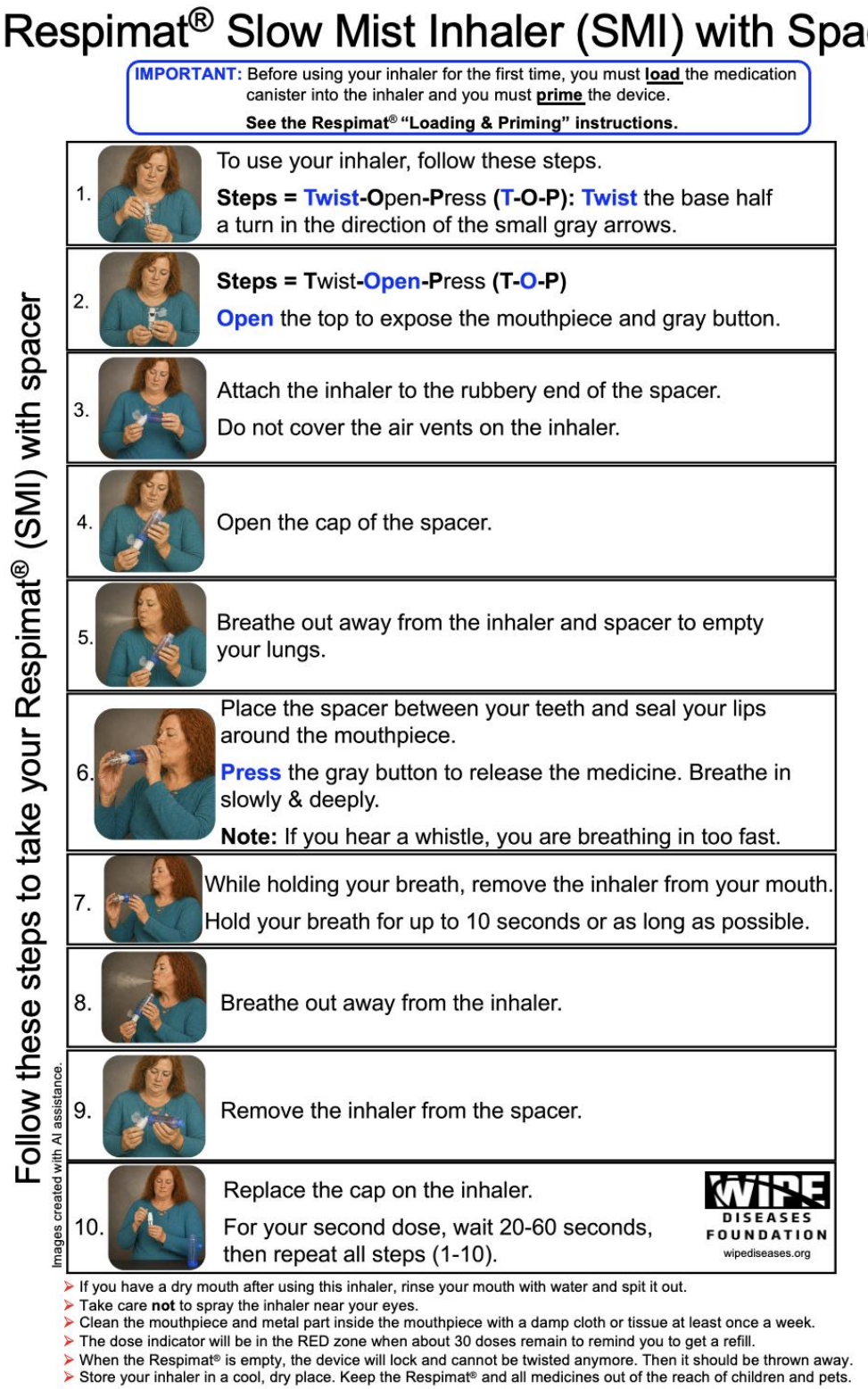
Alternative Text: Figure J-4. Instructional graphic illustrating 8 sequential steps for proper loading and priming of a Respimat slow mist inhaler (SMI), featuring labeled boxes with photos of a person demonstrating each step. Key steps include base removal, medication insertion, and twisting instructions to prime the inhaler.

Figure J-5. How to correctly use a Respimat Slow Mist Inhaler (SMI)(9)



Alternative Text: Figure J-5. Instructional graphic illustrating 8 sequential steps for proper use of Respimat slow mist inhaler (SMI), featuring labeled boxes with photos of a person demonstrating each step. Key steps include opening of the SMI and inhalation instructions, breath-holding guidance, and second-dose use instructions.

Figure J-6. How to correctly use a Respimat Slow Mist Inhaler (SMI) with spacer (9)

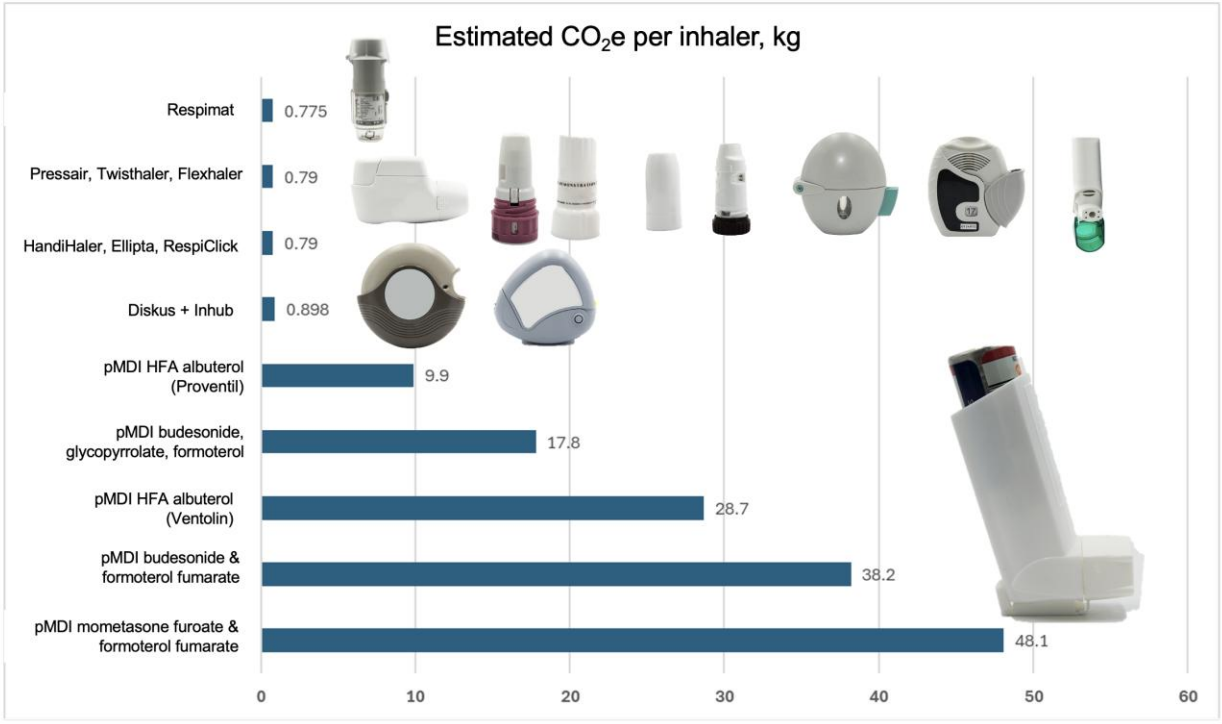


Alternative Text: Figure J-6. Instructional graphic illustrating 10 sequential steps for proper use of Respimat slow mist inhaler (SMI) with spacer, featuring labeled boxes with photos of a person demonstrating each step. Key steps include opening of the SMI and spacer attachment instructions, breath-holding guidance, and second-dose use instructions.

D. Inhaler Emissions

DPIs: Diskus, Ellipta, Flexhaler, HandiHaler, Inhub, Pressair, RespiClick and SMI: Respimat each produce less than 1 kg of carbon dioxide equivalents (CO_2e) per inhaler (ranging from 0.775 to 0.898 kg). In contrast, the pressurized metered dose inhalers (pMDIs) produce 10 to 48 times more emissions (ranging from 9.9 kg CO_2e for one of the albuterol formulations (Proventil) to 28.7 kg CO_2e for Ventolin and up to 48.1 kg CO_2e for mometasone/formoterol).(10,11)
For reference, 10 kg of CO_2e equals 25.6 miles driven in an average gasoline-powered passenger vehicle.(12)

Figure J-7. Estimated CO_2e per Inhaler (12)

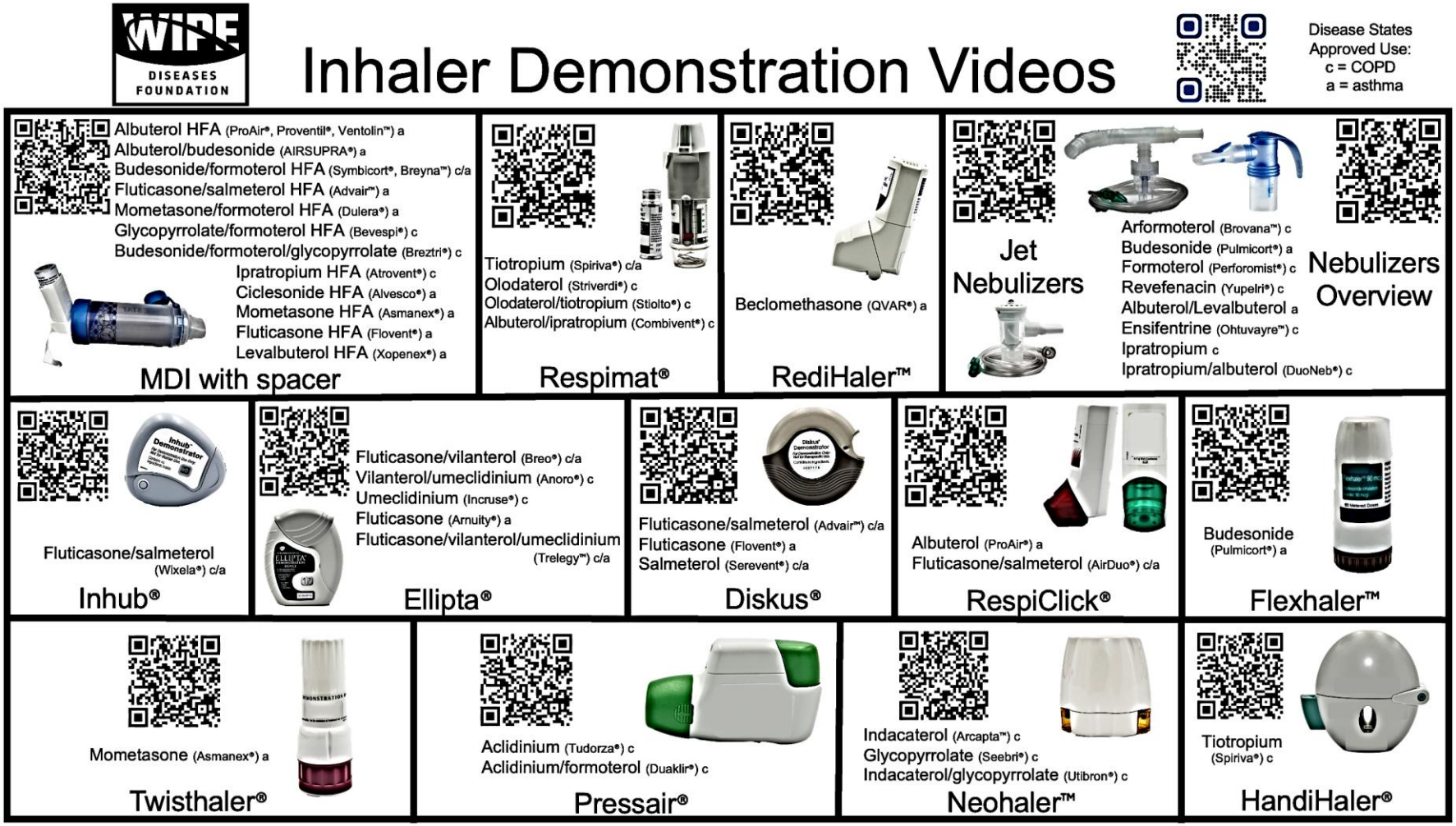


Data sourced from: Tirumalasetty J, Miller SA, Prescott HC, et al. Greenhouse Gas Emissions and Costs of Inhaler Devices in the US. *JAMA*. 2024;332(12):1017–1019. doi:10.1001/jama.2024.1533

Alternative Text: Figure J-7. Bar chart comparing estimated CO2 emissions per inhaler in kilograms, with images of each inhaler type displayed above their respective bars. The data indicates that dry powder inhalers (DPIs) and soft mist inhalers have lower emissions, ranging from 0.775 to 0.896 kg, while pressurized metered-dose inhalers (pMDIs) produce much higher emissions, between 9.9 and 48.1 kg.

E. Inhaler Demonstration Videos

Figure J-8. QR codes for WipeDiseases Foundation Demonstration Videos (13)



Alternative Text: Figure J-8. A diagram displaying images of various respiratory inhaler devices, including MDI with spacer, Respimat, RediHaler, Jet Nebulizers, and multiple branded inhalers like Inhub, Ellipta, Diskus, RespiClick, Flexhaler, Twisthaler, Pressair, Neohaler, and HandiHaler. Each inhaler lists its active ingredients and includes QR codes linking directly to instructional videos.

VHA Links to Inhaler Demonstration Videos

English Versions

- HOW TO USE NEBULIZER: https://youtu.be/UKUClmyRC2Q
- HOW TO USE MDI: https://youtu.be/yQiGzELcMg4
- HOW TO USE RESCUE: Proper Inhaler Use - Albuterol - YouTube
- HOW TO USE RESPIMAT: https://youtu.be/In6zmUHVdfE
- HOW TO USE TWISTHALER: https://youtu.be/-VBAvheKvM0
- HOW TO USE HANDIHALER: https://youtu.be/8TYU73CZvi0
- HOW TO USE DISK: How to use your Fluticasone/Salmeterol Inhaler (Wixela Inhub) - YouTube

Spanish Versions

- HOW TO USE NEBULIZER: Cómo Utilizar su Nebulizador - YouTube
- HOW TO USE MDI: https://youtu.be/yQiGzELcMg4
- HOW TO USE RESPIMAT: Cómo Utilizar su Inhalador Respimat - YouTube
- HOW TO USE TWISTHALER: Cómo utilizar su Twisthaler - YouTube
- HOW TO USE HANDIHALER: Cómo Utilizar su Handihaler - YouTube

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Methods

The 2026 COPD CPG is an update to the 2021 VA/DOD COPD CPG. The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA/DOD EBPWG updated in January 2026 that outlines procedures for developing and submitting VA/DOD CPGs.(14) The *Guideline for Guidelines* is available at https://www.healthquality.va.gov/HEALTHQUALITY/charter/index.asp. A full description of this guideline's methodology is available at https://www.healthquality.va.gov/guidelines/CD/copd/index.asp.

Patient-Centered Care

VA and DOD encourage providers to be sensitive to demographic, cultural, and other differences that affect patients' values, needs, and preferences, aimed at treating the condition while also optimizing the individual's overall health and well-being. Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence.(15,16) A whole health approach (https:/www.va.gov/wholehealth/) empowers and equips individuals to meet their personal health and well-being goals. Clear communication is essential and should be supported by evidence-based information tailored to each patient's needs. Guideline recommendations should be applied in a holistic approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities.

Shared Decision-Making

This CPG encourages providers to practice shared decision-making, a process in which providers, patients, and patient care partners (e.g., family, friends, caregivers) consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient's treatment.(17) Shared decision-making is emphasized in "Crossing the Quality Chasm," an Institute of Medicine (now National Academy of Medicine [NAM]) report, in 2001 (18) and is a core component of a patient-centered, whole health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, possible outcomes, and levels and/or settings of care, especially where patient heterogeneity in weighing risks and benefits might exist. The VA and DOD have embraced shared decision-making. Providers are encouraged to use shared decision-making to individualize treatment goals and plans based on patient capabilities, needs, values, and preferences.

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Access to the full guideline and additional resources are available at the following link:
https://www.healthquality.va.gov/guidelines/CD/copd/index.asp