

The COPD Foundation hosted a multi-stakeholder collaborative workshop on improving the quality of Chronic Obstructive Pulmonary Disease (COPD) care on December 7, 2007.

This workshop was made possible by a generous educational grant from Boehringer Ingelheim Pharmaceuticals and Pfizer Pharmaceuticals.

Representatives from patient organizations, public health organizations, professional membership organizations and government organizations attended.

*Participating organizations include:
American Academy of Family Physicians
American Academy of Physician Assistants
American Association of Cardiovascular and Pulmonary Rehabilitation
American College of Chest Physicians
American College of Physicians
American Lung Association
American Thoracic Society
Boston University
COPD Foundation
Columbia University
Outcomes, Inc.
Division of Lung Diseases at NHLBI
The Joint Commission
University of Minnesota*

On behalf of the COPD Foundation, John W. Walsh, welcomed and thanked the participants for taking time to attend the workshop.

To focus the agenda and provide a baseline of information, three speakers presented study findings related to COPD care in primary care practice.

**1. COPD and Co-morbidities -
DR. BYRON THOMASHOW:**

Dr. Thomashow described "COPD and Co-morbidities," drawing on findings from the COPD Foundation study of 2006. The study focused on types of co-morbidities and causes of death in COPD patients.

Dr. Thomashow emphasized that COPD is a preventable and treatable disease.

Dr. Thomashow and other researchers studied co-morbidities in COPD patients including:

- Heart Disease
- Hypertension
- Elevated Cholesterol
- Diabetes
- Joint Pain
- Osteoporosis
- Depression
- Stroke
- GERD
- Ulcer Disease
- Liver Disease
- Bowel Problems
- Sleep Apnea
- Sinus Problems
- Glaucoma
- Cataracts

- Kidney Disease
- Bladder Problems
- Male Impotency
- Cancer

Dr. Thomashow reported that over 50% of COPD patients have at least 6-10 co-morbidities and 20% more have over 11 co-morbidities. These co-morbidities contribute to the complexity, morbidity, cost and mortality of COPD.

Dr. Thomashow suggested that co-morbidities in COPD patients may be associated with a systemic inflammatory response. Further studies are needed to better define the relationship of COPD and its co-morbid illnesses.

2. Adopting COPD guidelines into Primary Care Practice - DR. BARBARA YAWN:

Dr. Yawn discussed the problems physicians face with "Adopting COPD guidelines into Primary Care Practice". Her study found that despite the availability of up-to-date guidelines on COPD care many PCPs were unfamiliar with these guidelines. Interestingly, more than 10% of PCPs were inappropriately using asthma guidelines to guide COPD care. Although most PCPs indicated that they used spirometry to diagnose COPD, few obtain pre-and post-bronchodilator measurements, a problem that could contribute to misdiagnosis

COPD is often misdiagnosed by primary care physicians, and treatment is often discordant with guidelines. Barriers to optimal care

facing primary care physicians include:

- Subtle presenting symptoms
- Failure of patient to recognize symptoms
- Multiple chronic conditions
- Lack of training/knowledge
- Lack of on-site spirometry access
- Perceived lack of effective therapy

Although significant gaps in diagnosis and treatment of COPD by primary care physicians were identified, there also appeared to be increasing interest in COPD among both primary care physicians and patients. Dr. Yawn stressed that patient/public empowerment is essential because questions from patients to physicians about COPD will lead to heightened physician awareness and knowledge of the disease.

3. Current Practice Patterns of Primary Care Physicians in Managing COPD - DR. JILL FOSTER:

Dr. Foster gave a presentation titled: "Current Practice Patterns of Primary Care Physicians in Managing COPD" Using various qualitative and quantitative methods, the authors of the study found significant gaps in patient care and barriers to managing COPD patients.

Echoing Dr. Yawn's findings, a national survey of primary care physicians also showed limited guideline awareness, with only a fourth of PCPs actually utilizing the

resource to guide COPD care. Similarly, while 2 of 3 physicians had an office spirometer available to facilitate COPD diagnosis, a third of physicians rarely used this resource. Based on the data collection, nearly 50% of primary care physicians did not know about COPD treatment guidelines, and of those who did know about the guidelines, less than half follow the recommendations. Only 33% of primary care physicians reported that they have a spirometer in their practice, with 66% not using it to diagnose COPD.

Dr. Foster reported that a majority of primary care physicians surveyed reported insufficient exposure to CME focused on COPD patient care, with family physicians expressing a greater need for education than internists. Additional implications of the needs assessment include results of the survey. In combination, findings from her needs assessment suggest the following targets for future education:

- Guidelines
 - Guideline use favorably impacts COPD care
 - Further guideline dissemination may be useful, but efforts to facilitate actual guideline utilization are also needed
- Early COPD Detection
 - Prompts appear needed to elicit and evaluate subtle signs of COPD
- Spirometry to accurately diagnose COPD

- Perceived as burdensome, but important for COPD diagnosis
- Additional skill appears needed to correctly order and interpret spirometry tests
 - Family physicians may particularly benefit from training

- Improving Patient Self-Management

- Inadequate patient adherence and self-care considered a major barrier to optimal COPD care
- Physicians may need improved skills to help better engage COPD patients
- Perceived limitations of physician time and resources suggest that patient-directed interventions to improve self-care are needed

Supporting Physician Learning - DR. NANCY BENNETT

Effective CME requires understanding the evidence derived from the literature. A short list for discussion includes:

- CME can be effective if planned according to evidence
- No single educational format is superior

- Using a traditional setting with adaptations to the traditional format can be effective
- Most physicians are not effective at self-assessing their own learning needs
- CME can be planned to address a gap in practice, provide

interactivity/feedback, address barriers, be continuous, and support self-directedness for participants

Using the information presented and their extensive expertise, three working groups were formed. Each was charged with a task.

WORKING GROUP SUMMARIES:

Each working group developed action items for discussion in the full group. The action plans were submitted to the full working group for assessment.

WORKING GROUP INSTRUCTIONS:

Working groups were given the following objectives:

Group 1 – Targeting Practice Gaps in COPD Care

Given the discussion this morning and your expertise in COPD, create a list of at least 3-5 practice gaps that limit optimal care. Why do these gaps exist – is it a result of lack of knowledge, poor understanding of research findings, no available information, or lack of acceptance on the part of clinicians? How can practice gaps be identified? List at least 3 barriers to closing those gaps, and at least 3 strategies for ensuring that those who plan and provide learning activities will know about your results.

Group 2 – Targeting Knowledge Gaps in COPD Care

Given the discussion this morning and your expertise in COPD, create a list of at least 5 gaps in knowledge that are necessary to address in order to provide better care. Describe at least 3 barriers for practitioners in gaining that necessary knowledge. Provide at least 3 suggestions for addressing the knowledge gaps through learning activities.

Group 3 – Targeting Performance Gaps in COPD Care

Given the discussion this morning and your expertise in COPD, create a list of at least 3 areas of performance that result in unwanted variation and/or less than optimal care for patients with COPD. List at least 3 barriers to improving performance, and describe at least 3 approaches to improving performance through CME.

ACTION PLAN SUGGESTIONS:

Each working group met for 2 hours and developed a set of action items related to their assignment topic. Summaries of the working group discussions were presented, critiqued by the overall group, and integrated into a master action plan.

MASTER ACTION PLAN SUMMARY:

- 1. Each participant will share the ideas generated by the group within their respective professional organization and utilize them in needs assessment.**
- 2. The COPD Foundation will create an online educational resource and serve as a repository for all physician and patient education materials related to COPD.**
- 3. The COPD Foundation will create a series of brief documents to assist patients and primary care physicians in diagnosis, treatment and management of COPD.**
- 4. Realistic and practical resources about COPD management for primary care physicians should either be created or existing materials could be disseminated more widely.**
- 5. Public and patient awareness of COPD and of its diagnosis and treatment should be enhanced.**
- 6. CME activities with a focus on COPD should be increased and strategies to increase availability of such CME activities for primary care physicians are imperative.**

ACTION PLAN DETAILS:

The workshop participants were asked to rate and prioritize the action items discussed at the meeting. After receiving comments on the action plan, it was clear that each organization has different priorities, and that every action item is a priority. Therefore, the action items listed below are not in priority order.

The COPD Foundation will work with partner organizations on the specific action item(s) that were identified as of interest to them. In addition, as a result of this workshop and review of the workshop summary and action plan, the COPD Foundation will work with workshop attendees to develop a comprehensive list of COPD activities including projects in the planning, development and completed stages. Further, the COPD Foundation will work with workshop attendees to review the list of COPD activities and identify and gaps or duplicative efforts.

Suggestions that will IMPACT PATIENT CARE:

Each of the items listed below was identified as a task likely to have an immediate impact on patient care that should be considered high priority and targeted for development as soon as possible, ideally before December 31, 2008.

- The COPD Foundation should create an online collective educational resource and serve as a repository for all physician and patient education materials related to COPD.
 1. The materials must be categorized for the intended user and the sponsoring organization will be recognized as the source.
 2. Gaps in physician and patient education materials should be identified and appropriate organization(s) should be commissioned to create materials to fill the gaps.
- Each participating organization should notify their members of the availability of educational materials on the COPD Foundation website.
- A need for patient information in a simple and user friendly format was identified. It was suggested that the COPD Foundation create a series of one page check lists for patients similar to those that are currently available for patients with diabetes through the American Diabetes Association. The COPD Foundation should create or coordinate creation of:
 1. A one page list identifying symptoms of COPD and how to identify a person that is at risk for COPD. It was suggested that this could be formatted as a series of questions.
 2. A one page list for patients identifying items that should be covered in the first

physician visit. The list should include, but not be limited to:

- a. List of necessary tests to identify COPD
- b. Description of personalized plan for managing COPD (including nutrition, medications, exercise, smoking cessation, and lifestyle changes)
- c. List of questions that the patient should ask his/her physician

3. A one page list for patients identifying items that should be covered in the future physician visit (including maintenance of COPD). The list should include, but not be limited to:

- a. Discussion of recommended follow up visits to health care providers
- b. Preventive measures (e.g. annual flu shot, smoking cessation)
- c. Signs and symptoms of an exacerbation and when to call a physician
- d. Early treatment of an exacerbation
- e. List of questions that the patient should ask his/her physician

- A need for primary care physician information in a short and user friendly format was identified. It was suggested that the COPD Foundation facilitate the creation of a series of one page check lists for primary care physicians or providers of COPD care.

Algorithms or brief webcasts should also be considered when developing these materials. Physician education should include:

1. A one page list for primary care physicians to assist in diagnosing patients with diagnosed or suspected COPD. This list should include specific questions that could be asked by either a nurse or physician within the office. A brief list of suggested “next steps” should also be included. For example, if a patient answers “yes” to the first 3 questions, a spirometry test is recommended.

2. A one page list for primary care physicians to assist in treating patients with diagnosed COPD. This list should include specific questions that could be asked by either a nurse or physician within the office. This should include specifics on how to handle an exacerbation, smoking habits and how to identify and address co-morbidities.

In addition, these materials should highlight standards of care identified in the COPD guidelines; pulmonary rehabilitation should be included and explained in detail.

- *COPD Digest*, published and distributed by the COPD Foundation reaches over 220,000 people. It was suggested that the COPD Foundation capitalize on the success

of the *COPD Digest* and move forward with the following:

1. Reprint the November 2007 New York Times article about COPD for distribution with *COPD Digest*.
2. Reprint the list of questions for patients to ask physicians in *COPD Digest*.

LONG TERM IMPACT ON PATIENT CARE:

These items were identified as a high priority and the impact on patient care would likely be gradual, but long term. In addition, some of these items may require support and funding from organizations outside of the COPD Foundation and its partners.

- Each professional organization represented at the workshop agreed to approach their Education and CME programming committee, distribute the workshop summary and stress the importance of COPD learning activities. Workshop participants discussed the idea of CME programs including management of COPD. It was suggested that management of COPD could be considered for a symposia topic at a professional meeting.
- Establish patient education groups modeled on the existing structure that the Alpha-1 Foundation has developed for Alpha-1 patients.
- It is essential that there is one collaborative set of guidelines on diagnosis, treatment and management of COPD. The diverse guidelines on COPD published independently by professional organizations are confusing and disadvantageous to patient care. There is an ongoing effort by NIH to facilitate development of coordinated COPD guidelines.
- It was agreed that public awareness of COPD is essential to improving patient education and care. The COPD Foundation will work with its partners to develop public awareness and education programs.
- The COPD Research Registry, established in March 2007, is an important venue for public and patient awareness of COPD. It is critical that the COPD Foundation advertise the registry and capture data from the hundreds of thousands of COPD patients that may currently be underserved.
- The workshop participants discussed the idea that in an ideal situation, each patient would have access to a Chronic Disease Educator who would assist each patient and family in managing their COPD according to their lifestyle. This educator could be a nurse, PA or physician. While it is not possible to have a Chronic Disease Educator in each physician's office, the COPD Foundation should consider the feasibility of an online chronic disease education module.
- The workshop participants discussed novel approaches to COPD education. Suggestions included:

1. Encourage small group case discussions among physicians by offering CME credit for a “lunchtime” case discussion within a small practice (4-6 physicians) and either identify a COPD expert within that practice or

facilitate the availability of an expert consultant via telephone.

2. Develop or partner (as appropriate) to develop asynchronous online or webcast educational programs.

The COPD Foundation extends thanks to the workshop faculty and participants:

Nancy Bennett, PhD-moderator

Jill Foster, MD-speaker

Byron Thomashow, MD-speaker

Barbara Yawn, MD-speaker

American Academy of Family Physicians-

Susan Richart, CPHQ, MBA

American Academy of Physician Assistants-

Marie-Michèle Léger, MPH, PA-C

American Association of Cardiovascular and Pulmonary Rehabilitation-

Gerene S. Bauldoff, RN, PhD, FCCP

American College of Chest Physicians-
Ed Dellert

American College of Physicians-
Steven Weinberger, MD, FACP

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Janine L. Chambers

American Lung Association-
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Gerard M. Turino, MD

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John W. Walsh

Division of Lung Diseases at NHLBI-
James Kiley, Ph.D.

The Joint Commission-
Caroline Isbey

The Joint Commission-
Jean Range

Outcomes, Inc.
Mazi Abdolrasulnia, PhD

COPD Foundation staff:
Ifdy Perez
Elisha Malanga