COPD DIAGNOSIS AND MANAGEMENT: PRIMARY CARE NEEDS ASSESSMENT SURVEY

Case # 1: Tim Pierce is a 61-year-old male who sees you at least three or four times a year for management of diabetes, hypertension, and hyperlipidemia. He reports that his sugars are in his usual 110-130 range, and says he is feeling good and enjoying retirement. During your review of systems, he states he coughs up phlegm most mornings, but denies noticing dyspnea. He has not mentioned this previously. Mr. Pierce continues to smoke 1 ppd and hasn't thought further about your previous advice to quit. Examination of the heart and lungs, pulses, and extremities is unremarkable.

1. **Considering your usual practice patterns, would you order spirometry on this patient?** (select only one)

- ❑ Yes
- ❑ No

Case # 1 continued: You discuss the risks of smoking and order a spirometry study hoping that it will motivate the patient to stop smoking. Spirometry shows an FEV1 that is 3.20 L (81% of predicted for gender, height, and age). The FVC is 4.85 L (93% of predicted) and the FEV1/FVC ratio is 0.66. After using a short-acting beta-agonist, FEV1 is 3.30 L (84% of predicted); FEV1/FVC is 0.68.

2. **What is this patient's diagnosis?** (select only one)

- ❑ Normal pulmonary function
- ❑ Mild persistent asthma
- ❑ Mild COPD
- ❑ Moderate persistent asthma
- ❑ Moderate COPD
- ❑ Mixed COPD and asthma

3. **In addition to offering continued advice to quit smoking, which of the following would you do?** (select only one)

- ❑ Would not do anything further at this time
- ❑ Recommend an inhaled short-acting bronchodilator
- ❑ Recommend an inhaled long-acting bronchodilator
- ❑ Recommend an inhaled corticosteroid

Case #2: Anna Fletcher is a 58-year-old white female with no previous medical diagnoses. She presents with an acute illness characterized by cough productive of purulent sputum and dyspnea. Her symptoms began gradually over two days progressing to where she was unable to work. She has smoked 2 packs/day for 40 years. She has a usual morning cough, often productive of sputum that is smaller in amount and clearer than the sputum associated with the acute illness. She denies chronic dyspnea, but has a sedentary lifestyle and does not exercise regularly. She has not had a similar episode. Physical examination reveals a mildly obese (BMI=30) white female who is mildly dyspneic. Vital signs: P 90, RR 20, BP 130/75 and T = 37.5 C. There are prominent rhonchi without rales. Except for mild nasal flaring, the remainder of the examination is unremarkable. Percutaneous oximetry is 94% saturated while the patient is breathing room air.

4. **How would you rate the likelihood that this patient has COPD? (**Select only one**)**

- ❑ Very Likely
- ❑ Likely
- ❑ Possible
- ❑ Unlikely

❑ Very Unlikely

5. Which *ONE OR MORE* of the following therapies would you recommend for this patient? (select *ALL* that apply)

- ❑ Empiric antibiotics
- ❑ Short-acting bronchodilator inhaler
- ❑ Long-acting bronchodilator inhaler
- ❑ Inhaled corticosteroid
- ❑ Oral leukotriene modifier

Case #2 continued: After two weeks, Mrs. Fletcher returns for follow-up. She is back at work and feels she is back to her baseline. It is much easier to climb a flight of stairs, but she still notes some shortness of breath. She has tried to cut down on smoking since her previous visit, but can't seem to go more than a few hours without a cigarette. Pt is now breathing comfortably, but still has rhonchi on exam. Chest x-ray and EKG are unremarkable.

6. Which *ONE OR MORE* of the following would you order to evaluate her respiratory complaints? (select *ALL* that apply)

- ❑ Peak flow measurement
- ❑ Spirometry without bronchodilator administration
- ❑ Spirometry post-bronchodilator administration
- ❑ Lung volume measurement
- ❑ Would not order additional studies at this time

7. Assuming that the patient is on a short-acting beta-agonist, what therapeutic change would you recommend? (select only one)

- ❑ Change to a short-acting anti-cholinergic
- ❑ Change to combination short-acting ß-agonist/anti-cholinergic
- ❑ Add a Long-acting anti-cholinergic
- ❑ Add an Inhaled steroid
- ❑ Add oral theophylline

8. What further steps would you most likely take to help her quit smoking? (select only one)

- ❑ Encourage a continued quit effort and suggest an OTC nicotine replacement product
- ❑ Recommend a follow-up visit to discuss smoking cessation in depth
- ❑ Discuss available cessation strategies, review medication options and help establish a quit date.
- ❑ Discuss available cessation strategies, review medication options and help establish a quit date. Arrange follow-up by your office staff.

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9. How optimistic are you that COPD can be effectively prevented and treated with current interventions?

1	2	3	4	5	6	7	8	9	10
Not At All Optimistic				Somewhat Optimistic					Very Optimisti

10. Does your practice have a spirometer? (select only one)

- ❑ No
- ❑ No, but a spirometer is immediately available in a nearby location
- ❑ Yes, but the spirometer is not used routinely
- ❑ Yes, spirometer is on-site and used routinely

11. Please rank the following patient factors from 1 to 4 in terms of their impact on your on optimal diagnosis and management of COPD in your practice. (1 = Biggest obstacle; 4 = Smallest obstacle. Use each number only once.)

____ Tendency of smokers to avoid medical care
____ Patient non-adherence to recommended therapy
____ Presence of competing co-morbid conditions (CAD, DM, depression)
____ Low patient awareness of COPD symptoms and their affect on daily living

12. Please rank the following practice factors in terms of their impact on your on optimal diagnosis and management of COPD in your practice. (1 = Biggest obstacle; 4 = Smallest obstacle. Use each number only once.)

____ Complexity and inconvenience of spirometry testing
____ Low reimbursement for patients requiring frequent medical care
____ Low suspicion of COPD in patients with minimal respiratory complaints
____ Insufficient resources for patient education and self-management skill training

13. How confident are you that you can detect patients with early COPD?

1 2 3 4 5 6 7 8 9 10

Not At All Confident — Somewhat Confident — Very Confident

14. How confident are you that you can accurately diagnose and stage COPD?

1 2 3 4 5 6 7 8 9 10

Not At All Confident — Somewhat Confident — Very Confident

15. How confident are you that you can optimally manage COPD?

1 2 3 4 5 6 7 8 9 10

Not At All Confident — Somewhat Confident — Very Confident

16. Approximately how many patients do you see each day? _____/per day

17. Approximately what percentage of your patients has COPD? _____%

18. How many years have you been in practice? _____

19. How many physicians are in your practice (including yourself)?_____

20. Are you aware of the GOLD or ATS/ERS clinical practice guidelines for the diagnosis and management of COPD? (select only one)

- ❑ No – not aware of these guidelines
- ❑ Yes – but not familiar with specific recommendations
- ❑ Yes – but have not found them to be a useful resource
- ❑ Yes – use them to guide my clinical decision making

21. How would you rate your exposure to CME focused on COPD detection, diagnosis, and management during the past year?

1 2 3 4 5 6 7 8 9 10

Far Too Little — Just Right — Far Too Much

22. During the past year, which of the following CME formats did you use most often? (select only one**)**

- ❑ Live activity (i.e. lecture, workshop)
- ❑ On-line activity

- ❑ Handheld activity
- ❑ Podcast activity
- ❑ Audio CD activity
- ❑ Print activity

23. Which of the following would you like to see more of in future CME? (select only one**)**

- ❑ Realistic case scenarios
- ❑ Recent clinical trial data
- ❑ Cost-effectiveness information
- ❑ Evidence underlying important points
- ❑ Strategies for daily practice

24. Physician Specialty

- ❑ General Practice
- ❑ Family Practice
- ❑ Internal Medicine
- ❑ Pulmonary Medicine
- ❑ Other_____

25. Practice Type

- ❑ Private
- ❑ Hospital
- ❑ Academic
- ❑ Non-practicing
- ❑ Other_____

26. Practice Location

- ❑ Urban
- ❑ Suburban
- ❑ Rural