Improving Inpatient and Outpatient Treatment of COPD: What Local Coalitions Can Do?

Sidney S. Braman MD FCCP
New York, NY
Questions to be Addressed

- Does COPD Care Need Improvement?
- If so, what are the causes of inadequate treatment for COPD patients?
- What is the evidence that treatments are effective?
- What can local COPD coalitions do to help?
Many patients with COPD do not have a proper diagnosis
Approximately 24 million adults with impaired lung function

Most patients with COPD are cared for by primary care physicians that have a limited experience with the disease.
Physician Specialty Seen Most Often by COPD Patient

- General/Family: 52%
- Internal Medicine: 15%
- Respiratory Specialist: 22%
- Cardiologist: 3%
- Allergist: 1%
- Other: 2%
- Not Sure: 5%

Physician Specialty Seen Most Often by COPD Patient

General/Family 52%
Internal Medicine 15%
Respiratory Specialist 22%
Other 2%
Not Sure 5%
Cardiologist 3%
Allergist 1%

Minnesota ALA review of claims data 2004: 64% PCP & 27% chest MDs

National Survey of Primary Care Physicians Concerning the Management of Respiratory Diseases

Conducted by Schulman, Ronca and Bucuvalas, Inc.

June 5, 2006
Q28. How serious a medical condition do you consider COPD? In most cases, would you describe it as extremely serious, moderately serious, mildly serious or not too serious? N=458
Q50a. Are you aware of any professional guidelines for the diagnosis and management of COPD?  N=457
Publisher of Guidelines

- ALA: 23%
- AMA: 14%
- ATS: 12%
- ERS: 4%
- GOLD: 3%
- NIH: 3%
- NHLBI: 1%
- WHO: 3%
- Other medical society: 6%

Base: Aware of guidelines N=332
Communication for COPD Patients

Only:

- 50% discuss smoking cessation
- 31% discuss spirometry results
- 78 discuss inhaler technique when initiated
- 18% discuss matters of quality of life

Undertreatment of COPD

- Management of patients with COPD deviates from guideline recommendations for both routine and acute care.
- Often this is due to clinical inertia, which is broadly defined as “recognition of the problem, but failure to act.”
Often patients with COPD underestimate symptoms and avoid taking helpful medications.
Misperception and Denial of Both Symptoms and Activity Limitations Are Significant Barriers to Diagnosis and Management

- Patients may misunderstand or minimize symptoms such as fatigue, dyspnea, and cough
  - They may neglect to mention these symptoms to their healthcare provider

- Symptoms may be misattributed to “asthma” or “getting older”
  - “I’ve been coughing when I wake up each morning, but it’s just smoker’s cough. This is normal and not harmful to my health”
  - “Carrying these groceries is harder than it used to be. I must be old and out of shape”

Patients who adhere to their prescribed medications are significantly less likely to die or be admitted to the hospital.

“I don’t need meds for my breathing because it’s not a serious problem”

- 52% of patients with COPD received medication treatment for COPD in their last year of life, many use medication sporadically
- 40% of patients discontinued medication within 30 days of death
- 70% discontinued medications within 90 days of death

There is widespread lack of public knowledge about COPD
COPD Awareness and Understanding
“COPD is a Disease of the Lungs”

%  

<table>
<thead>
<tr>
<th>Country</th>
<th>Unprompted</th>
<th>Prompted</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Brazil</td>
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<td>15</td>
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</tr>
<tr>
<td>USA</td>
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<td>25</td>
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GOLD Newsletter March 2003
How effective is COPD therapy?
Multimodal Approach to the Treatment of COPD

Patient Education

Pharmacotherapy

Exercise
Comprehensive Approach for COPD Management

**Treatment Goals**

- Relieve symptoms
- Prevent disease progression
- Improve exercise tolerance
- Improve health status
- Prevent and treat complications
- Prevent and treat exacerbations
- Reduce mortality

**Management Approach**

- Smoking cessation
- Pharmacotherapy and other nonpharmacologic interventions

Benefit of Smoking Cessation: Lung Health Study 11-year Results

FEV$_1$ (Liters)

Year

Sustained Quitters

Intermittent Quitters

Continuous Smokers

Evidence shows that patients who are assigned to a self-management program compared to usual care have better outcomes.

**Elements of Self Management Program**

- Practice and feedback regarding new skills
- Improve decision making ability
- Problem solving education programs
- Group sessions to share knowledge and experiences
- Develop a personal action plan
Benefits of Patient Education in COPD: Self-management after 1 year*


*Weekly visits for 2 months
Monthly telephone calls
The Society - Individual Challenge

How do we create reliable, reproducible standardized, efficient population interventions....

that respond to unique

individual needs?

Standardized
Reproducible

Unique and
Individualized
Listening to the Patient’s Perspective: Goals of Therapy

- Improve my quality of life
- Reduce my shortness of breath
- Consider how you can help reduce my health care costs
- Help me and my family cope with chronic illness
- Provide an honest and frank assessment of my prognosis
- Discuss end of life issues with me and my family when my disease is advanced
- Provide prompt responses to my telephone calls
What Local Coalitions Can Do

Advocacy
Public education
Patient education
Philanthropy

Take advantage of a looming threat!
Physician Education
## US Economic Burden of COPD-Related Emergency Department (ED) Visits or Hospitalizations Is High

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unadjusted Mean Cost ($US, 2001)</th>
<th>Unadjusted Mean Length of Stay</th>
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<tbody>
<tr>
<td>ED visit</td>
<td>$571 (± 507)</td>
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</tr>
<tr>
<td>Standard Admission</td>
<td>$5,997 (± 5752)</td>
<td>5.08 (± 4.45)</td>
</tr>
<tr>
<td>ICU + intubation</td>
<td>$36,743 (± 62,886)</td>
<td>14.82 (± 16.65)</td>
</tr>
</tbody>
</table>

In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion—one of every 10 dollars of total hospital expenditures.

4.4 million hospital stays could possibly have been prevented with better ambulatory care, improved access to effective treatment, or patient adoption of healthy behaviors.
CMS Populations of Focus

- Initial: AMI, CHF, Pneumonia
- Expansion: COPD, CABG, PTCA and other vascular procedures
What will CMS’s solution be?

- Don’t pay for readmissions
- Pay bonuses or penalties based on rate of readmission
- Provider will not charge for readmissions meeting certain criteria
- Global payments for all inpatient and outpatient patient care

Source: Harold Miller Center for Healthcare Quality and Payment reform, Network for Regional Healthcare Improvement
Discussion: