ATS International Conference 2003, May 16-21, Seattle, Washington, USA

Behavioral Needs Assessment of Canadian Physicians in the Care of COPD Patients

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1 ABSTRACT

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Purpose: To identify the critical gaps facing Canadian physicians in the screening, diagnosis, treatment and management of patients with Chronic Obstructive Pulmonary Disease (COPD).

Introduction: Needs assessments must tease out fine discrepancies in the knowledge and competencies of highly educated and experienced physicians. To achieve this goal, educational and behavioural research methodologies that employ both qualitative and quantitative strategies provide a rich opportunity to best understand the clinical practice of physicians in the care of COPD. Utilizing this methodology, a national needs assessment on the diagnosis, treatment, and management of COPD among family physicians and specialists was conducted.

Methods: Panel meetings with family physicians (N=17) and specialists (N=64) from across the country were conducted. Quantitative (surveys) and qualitative (structured discussion and clinical decision-mapping) data was collected during the panels, and analyzed (Tashakkorri and Teddlie, 1998). To enhance the reliability and validity of the results, triangulation [Patton, 1990] was incorporated. Triangulation is a research design method that combines various methodologies and sources to assure a high degree of reliability and validity.

Results: The results indicated the following issues as critical gaps and primary themes of essential importance to the practice of physicians in this therapeutic area: (a) poor perception and use of guidelines; (b) inconsistency in the use and perceived value of assessment tools; (c) a breakdown in the referral network between specialists and family physicians; (d) physicians' struggle in recognizing COPD as a progressive disease wherein there are valuable and meaningful interventions available along a continuum of care.

Conclusions: The study revealed important barriers that extend beyond clinical knowledge or empirically driven practice. The study highlights the opportunity and need for: (a) development of COPD guidelines that reflect the needs of physicians; (b) educational strategies to enhance the perception and value of COPD assessment methods (e.g. spirometry) and treatments (e.g. combination treatments), (c) strategies to enhance multidisciplinary communication and networking; (d) tools and aids targeted toward physicians to support communication and management with patients who have a chronic disorder; and (e) interventions to address attitudinal and practice barriers that prevent the desired health outcomes in the care of a chronic disorder.

Funding: An unrestricted education and research grant from Boehringer Ingelheim (Canada) Ltd. and Pfizer Canada Inc.

2 OBJECTIVES

- **Identify needs and challenges of Family Physicians and Specialists in screening, diagnosing, treatment and management of COPD patients**
- **Assess the knowledge and clinical practice behavior "gaps" among these Canadian physicians**
- **Identify learning and practice needs of physicians, and identify formats for learning**
- **Collect data to guide the design of an effective and accredited educational program**

Made possible by an unrestricted education and research grant from Boehringer Ingelheim (Canada) Ltd. and Pfizer Canada Inc.

3 METHODOLOGY

MULTIPLE ANALYSES AND PERSPECTIVES

Categorizing, axial, and multidisciplinary coding

Gap analysis

Frequencies, rankings, and means

Marketing, Educational, Medical and Psychological

MULTIPLE DATA COLLECTION

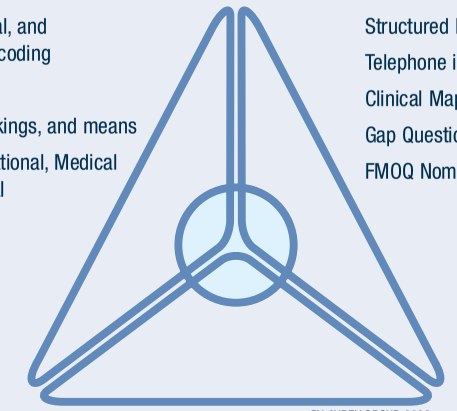
Structured Democratic Panels

Telephone interviews

Clinical Mapping

Gap Questionnaire

FMOQ Nominal Group



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MULTIPLE SOURCES

Literature review and monographs

Representative sample of FP's (N=17)

Representative sample of Specialists (N=64)

4 CONCLUSIONS

Study highlights the opportunity and need for:

1. Development of COPD guidelines that reflect the needs of physicians
2. Educational strategies to enhance the perception and value of COPD assessment methods (e.g. spirometry) and treatments (e.g. combination treatments)
3. Strategies to enhance multidisciplinary communication and networking
4. Tools and aids targeted toward physicians to support communication and management with patients who have a chronic disorder
5. Interventions to address attitudinal and practice barriers that prevent the desired health outcomes in the care of a chronic disorder

5 FINDINGS

1 ISSUES INFLUENCING COPD CARE

FAMILY PHYSICIANS

1. Smoking
2. Comorbidity/Time constraints
3. Differentiation from Asthma
4. Resources and facilities / COPD Clinics
5. Patient education and compliance
6. Symptomatic Treatment / Consensus re: New Treatments (ie."struggle with short/long term implication of steroid use")

SPECIALISTS

1. Patient education and compliance
2. Smoking
3. Management and follow up
4. Screening and Diagnosis
5. Resources and facilities, COPD clinics
6. Achieving treatment goals
7. COPD drugs and treaments

2 PERCEPTION AND USE OF GUIDELINES

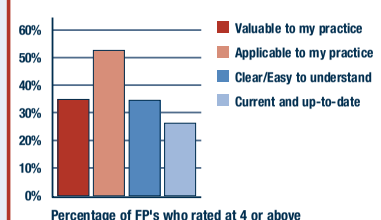
FAMILY PHYSICIANS

COPD Clinical Guidelines

64% of FP's rated their knowledge average or below average, and desired a much greater level of knowledge of COPD guidelines

Perception of COPD Guidelines

Question: "On a scale of 1 to 5, the COPD Guidelines are..."



Percentage of FP's who rated at 4 or above

Guideline Comments

Family Physicians receive about 1 guideline per month, and read guidelines about once every 4 to 5 months.

3 ASSESSMENT & DIAGNOSIS

Triggers to Screening

Family Physicians report they screen:

- All smokers > 10 years
- If patient has recurrent (>3) bronchial difficulties (e.g. sputum, wheezing)
- If patient complains of recurrent cough
- If patient complains of decreased activity tolerance

However, physicians acknowledge they are 'not organized' in this process.

Specialists have said:

"We see them too late."
"Understanding of the disease can be reached by studying patients in the early stages."
"Only then can worthwhile and mechanistic treatments be found and change the course of the disease."

Spirometric Testing

"Cheap, good and not being used"

"FP's are not testing systematically because they don't know how or they don't feel the results are useful (because the patient won't stop smoking or will die anyway)"

Why is Spirometry not ordered?

1. Low reimbursement ($8.00)
2. Lack of screening facilities/availability
3. Poor training for the testing
4. Poor interpretation of results
5. Machine calibration
6. Initial investment in machine
7. Time and space for test
8. FPs don't "feel" results useful

4 REASONS FOR REFERRALS

FAMILY PHYSICIANS

FP's do refer to a respirologist when:

1. Disease not controlled/Exacerbations
2. Atypical/complex cases
3. Diagnostic clarification
4. Moderate to severe COPD
5. Need O_2 at home
6. Other (patient education, comorbid issues, complete testing)

SPECIALISTS

Referrals from FP's

"FPs sometimes refer reluctantly Do they feel nothing can be done for patients?"

"Patients tolerate their symptoms for many years before we see them"

"Overall there is an absence of early recognition by FP's and thus, they do not refer to us until the patient is severe"

Reasons for Referrals by FPs to a Respirologist

1. Atypical/complex cases
2. Moderate to severe COPD
3. Confirm diagnosis and adjust treatment
4. Disease not controlled/not responding
5. Exacerbations/assessment of home O_2
6. Comorbid issues or further testing
7. Patients with grave asthma, hospitalization, hyperventilation, frequent bronchitis

5 MANAGEMENT

Acute Exacerbation Plan

- Physicians recognize the value of a plan for their patients but stated that they are not consistent in discussing one with all of their patients
- Obstacles to acute exacerbation planning includes, (a) limited time with patients and (b) a lack of confidence and knowledge in preparing an established plan

"I do this for some of my patients, but I should do it more"

"Because in asthma, it's become a disease that the patient manages and comes to us when they have a problem. In COPD, it's still a process that we're managing and they haven't taken ownership of it like they have taken on asthma."

End-of-Life Discussion

"No, we didn't discuss it. We just kind of hoped it didn't happen… In general, I can manage pretty well. But I wasn't so good ten years ago. I just developed the ability because I sort of had to do it!"

"People don't even realize that they can die. Unfortunately, it ends up with me to have these decisions that have to be made with the family."

End-of-Life Discussion: Why does it not happen?

- Involves family
- MDs are afraid to have end of life discussions
- No continuity of care for end for end of life issues in Alberta (vs. Saskatchewan's long term care facilities require end of care discussions prior to admission)