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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Addressing Gaps in COPD Management: Insights for Pulmonary and Primary Care

Announcer:
You're listening to *Deep Breaths: Updates from CHEST* on ReachMD. This program is produced in partnership with the American College of Chest Physicians. This activity is supported by Regeneron Pharmaceuticals, Inc. and Sanofi. Now, here's your host, Dr. Nate Falk.

Dr. Falk:
This is *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Nate Falk, and I'm a board-certified family physician as well as a Professor and Founding Residency Director for Family Medicine at Florida State University in partnership with BayCare Health System. Joining me to discuss Bridging Specialties in COPD care is Dr. Megan Conroy. She's a Chair and Assistant Professor in the Division of Pulmonary, Critical Care, and Sleep Medicine at The Ohio State University. Dr. Conroy, thanks for being here today.

Dr. Conroy:
Thanks for having me. I'm excited to discuss our work.

Dr. Falk:
I'd like to start off by sharing some background on Bridging Specialties. CHEST launched the Bridging Specialties initiative in 2022 to address systemic gaps in diagnosing serious respiratory conditions such as interstitial lung disease, and CHEST broadened that out into COPD—which we're talking about today—and bronchiectasis and NTM.

The program was developed in direct response to longstanding delays in diagnosis, often caused by fragmented care between primary care providers and pulmonary specialists, resulting in worse patient outcomes and quality of life. CHEST recognized that patients frequently experience significant delays—sometimes years—in receiving accurate diagnoses due to symptoms that mimic common respiratory conditions, highlighting the urgent need to better interdisciplinary coordination.

To address the gaps, CHEST partnered initially with the Three Lakes Foundation to create practical diagnostic tools, clinician education, and structured opportunities for collaboration, aiming to significantly shorten the time to diagnosis, streamline referrals, and improve patient care pathways across multiple respiratory conditions. So we've brought together a group of pulmonologists with expertise in different areas of pulmonary medicine along with partnership with the American Academy of Family Physicians and PCPs like myself to create a series of educational opportunities to help improve and decrease that rate of diagnosis and try to cut that time down until we can get a proper diagnosis and start treatment.

So with that background in mind, let's turn it over to you now, Dr. Conroy. Can you tell us about the recent survey that was conducted and how it led to the development of the CHEST COPD Toolkit?

Dr. Conroy:
Yeah, and thanks for that background on Bridging Specialties. This survey undertaken by CHEST was really to try and help inform some of the educational products that we collaborated on with an eye towards improving diagnostics and reducing delays in care for COPD. So CHEST coordinated a survey of both primary care physicians and pulmonologists—our key audiences here—to both examine medical knowledge as well as inquire about practice patterns and perspectives. We surveyed 400 community-based physicians. Respondents were 100 family medicine-trained primary care doctors, 100 internal medicine-trained primary care doctors, and 200 general pulmonary and critical care physicians. We got a really strong mix of geography across the country of primary care and pulmonologists responding, and a really strong mix in varied tenure since finishing training, with some less than 10 years and many over

30 years out of practice. So we really got a good wide swath both in geographic variation and in time and practice.

We then presented, both to the primary care physicians and to the pulmonologists, different patient cases tailored to the patients that are most likely to walk into their clinics. We asked them then what diagnostics they might consider next, really trying to get an accurate diagnosis of COPD based both on history as well as on findings of obstruction and spirometry. And then we provided them more diagnostic data and asked what therapies they might recommend, really getting at the GOLD recommendations for first-line inhaler therapy—that being the Global Initiative for Obstructive Lung Disease.

We asked then at what point each physician would consider pulmonary referral most appropriate. And for the pulmonologists, we asked them, at what point would they expect referral to a pulmonologist to occur? What kind of testing would they expect to see, or do they see, before a patient is referred? And the case presented to the pulmonologist was a patient with more aggressive COPD and more progressive symptoms and exacerbations with really notable air trapping and hyperinflation on PFTs. And as we give more information, that patient continues to worsen. So we asked questions of what their next steps in diagnostics and management would be.

There is a CHEST Clinical Perspectives white paper forthcoming on these findings to really dig into more of what we saw from the respondents, but these help inform the opportunity that we have to better educate on COPD diagnostics, first-line therapies, and opportunities to find more inhaler technique assessments in clinic, to troubleshoot when patients aren't able to use their inhalers well, and to find some of the nuance in patient selection for advanced treatments for COPD.

We also found that there's significant opportunity to improve the consideration of concurrent palliative care approaches in patients with end-stage COPD. And putting all of this together, to address these opportunities we found, the CHEST Bridging Specialties Toolkit offers a suite of resources for primary care doctors, pulmonologists, and importantly, for patients. To advance some of the medical knowledge and help with some of these practice points, we've developed interactive online modules, separately targeting the primary care physician and the pulmonologist. And we take a case-based approach to walk physicians and clinicians through diagnosis and advanced treatments, ways to consider comprehensive preventive care, when to consider referrals for advanced treatments, and also when to consider some palliative approaches concurrent with disease-directed approaches for end-stage disease.

We've also created a checklist for physicians and clinicians to consider next steps in diagnosis and management, and this applies both to primary care and pulmonary to bridge some of those practice gaps that we found in that needs assessment. We have practical tools available—both in English and translated into Spanish—to be able to reach more patients. This includes a patient questionnaire that may help you more efficiently gather a focused pulmonary history and inhaler technique and step by step visual and written handouts for each of the various delivery systems of the most commonly prescribed inhaled therapies for COPD. You can refer back to these in clinic. Patients can take it home, have it in their hand, and refer to it while they're using their inhalers.

Dr. Falk:
For those just tuning in, you're listening to *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Nate Falk, and I'm speaking with Dr. Megan Conroy about Bridging Specialties and its potential impacts on COPD management.

So now that we know more about Bridging Specialties and the recent survey, I'll turn it over to you, Dr. Conroy.

Dr. Conroy:
Thanks, Dr. Falk. As we zero in on these findings, I'm curious—what were some of the key takeaways that you saw in the data from the primary care group?

Dr. Falk:
Yeah, that's a great question, because we did find some key takeaways and a few surprising items along the way as well. To start with some of those key takeaways, you mentioned previously the GOLD guidelines, and that's one thing that we saw that was a little bit of a struggle out there for PCPs. So they were presented with initial case that was a 61-year-old male who had a 43-pack-year history of smoking, who'd had worsening shortness of breath with exertion for the past several months and an intermittent, productive cough. And PCPs were asked to identify the proper GOLD staging, and only about 58 percent got that initial GOLD B categorization correct.

And then in follow-up to that, they were asked, based off of that, what is the recommended initial treatment for this patient? And based off of this particular case—him being GOLD B—the correct response should have been a LAMA plus a LABA. And unfortunately, only 24 percent of PCPs properly identified that as the option. There were about 24 percent of them that chose an ICS with either a LAMA or a LABA. And unfortunately, this is something that I've seen a lot in practice—the first thing that people jump to is either an ICS combo inhaler, which really doesn't have any particular place in the GOLD guidelines, or they jump right to triple therapy. And that's what about 27 percent of folks jumped to—triple therapy—with, again, only 24 percent getting the correct initial management with the LAMA/LABA.

The other surprising thing about this was that 37 percent of people, when it comes to GOLD guidelines from a PCP standpoint, say that

they only occasionally or never use GOLD with their patients, and only 23 percent said that they use it on every patient. And this was quite different than what we saw with the pulmonologists, who are much more likely to use GOLD on most of their patients, although in the data, interestingly, when asked for the pulmonologist to properly categorize it, they were only marginally better at getting the right category assigned out of GOLD. But they're much more likely to actually use it on most of their patients.

Dr. Conroy:
Yeah, thank you for that. I agree. It really stood out to me, seeing similar endorsement of being able to identify the GOLD category, but that fall-off of really not only identifying that category, but then taking that into the first step of therapy, was a pretty significant drop. And again, that's for most patients who have symptoms from their COPD, and our clear diagnosis of COPD is going to be a combination LAMA and LABA inhaler and adding the inhaled steroid in recent GOLD updates, predominantly for those patients who have evidence of eosinophilia along with their COPD.

Dr. Falk:
Yeah. And you mentioned recent GOLD updates, and that's one thing that both groups struggled with a little bit—the PCPs more so than the pulmonologists—being aware of what the most recent guidelines were. And understandably, both of us right now are in the academic world, so it's part of our job and a little bit easier for us to stay up on guidelines, but having been in private practice before, it is understandably difficult to stay up on every guideline update that comes along when you're very busy seeing 20 to 30 plus patients in any given clinic day. So I'm completely sympathetic with that, but that is something that both groups seem to struggle with—staying up to date on what the most recent version of those guidelines was.

Dr. Conroy:
Absolutely. And it speaks to the opportunities for some of these learning products that we were able to produce here.

And so, Dr. Falk, as a follow-up, were there any other findings that really stood out to you as surprising among the primary care group?

Dr. Falk:
Yeah, I think one of the things that was a nice surprise was the initial workup. 80 plus percent of the PCPs who responded said they'd start with getting a pulse oximetry, chest x-ray, CBC with diff to look at that eosinophilia, and some kind of standard questionnaire. About 70 percent of them said that they would order spirometry, but then when they were asked to interpret spirometry, they struggled a little bit to identify COPD when they were presented with those results.

And a little bit, well, not surprising, but concerning, potentially, is that 29 percent of the PCPs noted that they make the diagnosis of COPD and treat it as such in over 50 percent of their patients without using spirometry. And we know that this is part of the diagnostic workup—it should be done for all of our patients when we're considering COPD. And about a third of PCPs don't do this for more than half of their patients. So that was a little bit concerning to me.

The other concerning thing is, as we mentioned, the case presented to them was a 61-year-old with a 43-pack-year history of smoking who is still an active smoker, and only 46 percent of the PCPs, when asked, said that they would definitely order a lung cancer screening CT, so again, that was a little bit concerning on that end, because clearly this person qualifies for it and should be part of their workup and their screening process.

Dr. Conroy:
Yeah, Absolutely. And I think that really falls out with what we see in statewide pragmatic databases on the use of low-dose CTs in lung cancer screening. It's vastly underutilized for patients in whom this would qualify, and we know that this is a lifesaving cancer screening test. We saw that when we asked pulmonologists, what kind of things do you expect the primary care docs to do before referral? Over half expected that the PCP would coordinate that low-dose lung cancer screening. So we hope with multiple points of contact, we can increase screening for our patients, but it's certainly important for both a primary care and subspecialty pulmonologist to be keeping an eye out for that preventive care.

Dr. Falk:
Yeah. And that's a great point as to why we're trying to do all these Bridging Specialty things—that coordination of care between the pulmonologist and the PCPs as to who's going to order the lung cancer screening, who's going to ensure that they're getting their immunizations, nutrition information, counseling on inhalers and proper techniques, and those kind of things, because you could see it go either direction. But when one group is assuming the other group is doing it, then likely no one is.

So those are the findings from the PCP group. But if we switch gears a little bit and focus on the pulmonologists, Dr. Conroy, can you tell us about those findings?

Dr. Conroy:

Yeah. So you referenced some, and we asked similar questions to the pulmonologists as we did the primary care physicians, but gave them a more complex, end-stage COPD case. Here we found some more concordance in the diagnostic steps recommended for this patient with uncontrolled symptoms of COPD in comparison to some of the initial diagnostic tests offered to the primary care physicians, which fits how we've got a narrower view in some of the differential. But concerningly, only about 30 percent of pulmonologists reported assessing inhaler technique at every visit, and 8 percent reported rarely assessing. This is sort of a simple intervention that is vastly underutilized to help improve medication delivery for our patients.

We also asked the pulmonologists and gave a scenario where the patient was unable to use their pressurized metered dose inhaler due to symptoms of osteoarthritis. And while most pulmonologists took action to address that, 44 percent of them moved directly to nebulized therapies when they really could've appropriately assessed for a dry powder inhaler. And so some more educational and practice improvement opportunity for the navigation of inhaler technique teaching, assessment, and troubleshooting.

With regards to partnership for ongoing care for COPD patients, the pulmonologists told us that they would help a primary care doctor to continue supporting a patient in tobacco cessation, in assessing and treating depression and anxiety, which are very often comorbid in these patient populations, and also to understand the patient's living conditions. The pulmonologists felt that they would assume primary responsibility for the treatment of COPD symptoms and exacerbations, as well as pulmonary-targeted therapies.

When we talked to pulmonologists about some of the more advanced and surgical therapies for end-stage COPD, we found almost 90 percent of pulmonologists would consider endobronchial valves for lung volume reduction in a patient presented to them with hyperinflation and air trapping, though less than 40 percent considered surgical therapies like surgical lung volume reduction or lung transplant, and only 24 percent considered palliative approaches concurrent with disease-directed care.

There is an emerging space right now for the use of biologic therapies in COPD with eosinophilia. And at the time we sent this survey out, this was an indication that was just gaining FDA approval, so it was not really a focus on our survey, but we did find that less than 10 percent of pulmonologists responding had a consideration for biologics in the case presented, which really points to, with evolving and more advanced therapies available for COPD, both medical and procedurally, how there's ongoing opportunity for educating physicians to ensure appropriate consideration and patient selection for these advanced therapies.

Dr. Falk:
Thank you very much. And finally, Dr. Conroy, to wrap us up here for this session, what are some of the notable takeaways you can share with us?

Dr. Conroy:
The thing that really stands out to me here is the underutilization of spirometry in the diagnosis of COPD. 87 percent of primary care docs felt that they could diagnose COPD without it. And when prompted, they did order spirometry, but it's really important to note that it is necessary to order spirometry in the evaluation of dyspnea to establish a diagnosis of COPD.

When we asked pulmonologists, we saw for less than 25 percent of patients that they see, they reported had spirometry before they were sent for referral. So we're seeing this, not only in the primary care self-reported behavior, but what the pulmonologists are saying that they see. So significant opportunity to improve diagnostics there.

We've got an opportunity to improve first-line inhaler therapy. As you noted, those GOLD recommendations would recommend a LAMA and LABA as first-line therapy and reserve the use of inhaled steroids for those who have eosinophilia, very poorly controlled symptoms, or frequent exacerbations as a follow-up.

We also found very low prevalence of the use of symptom assessments for COPD, and that held for both primary care doctors and pulmonologists. This is an important component of following this disease in the long term to be able to titrate and address these appropriate next-line therapies. We saw pretty low frequency of inhaler and technique assessment in pulmonary practice, and even lower in primary care, where they certainly are managing so many different things with very short visit times. And as we've already said, it really stood out that only about 30 percent of primary care docs suggested that they would order a lung cancer screening CT for a patient who clearly qualified.

So we find several opportunities for education and to bridge some of these practice patterns. We're hopeful that both from advancing medical knowledge through some of these modules and providing some of the practice materials, like the inhaler technique handouts and the history questionnaires, that the Bridging Specialties suite of resources can help to bridge this gap in COPD care, both for primary care physicians as well as for pulmonologists.

Dr. Falk:
Well, those are some great insights, and brings us to the end of today's program. I want to thank Dr. Megan Conroy for joining me to

discuss how Bridging Specialties can impact the care of patients with COPD. Dr. Conroy, it was great having you on the program.

Dr. Conroy:
Thanks for having me.

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