An expert-supported monitoring system for patients with chronic obstructive pulmonary disease in general practice: results of a cluster randomised controlled trial


Rapid changes in general practice have increased possibilities to diagnose and manage chronic diseases such as chronic obstructive pulmonary disease (COPD). Several national and international guidelines for COPD are available\(^1^-^4\) to help general practitioners with this.

"Monitoring", or regular surveillance of patients' health status, is a cornerstone of COPD management.\(^5\) Input of specialist knowledge into monitoring enables comparison of the process and outcome of care with evidence-based guidelines. It can also alert GPs to areas in which individual patient care falls short, and introduce explicit recommendations for management. Our group has demonstrated the effectiveness of expert-supported monitoring on the outcome of diabetes care in general practice.\(^6\)

COPD management places a substantial demand on medical resources,\(^7,8\) and patient adherence is important to the success of treatment.\(^9\) Any expert-supported respiratory monitoring system depends on the cooperation of various groups (ie, GPs, specialists and patients), contains interacting components, and is, therefore, a complex intervention.\(^10\)

We aimed to investigate the long-term effectiveness of a primary care monitoring system with respiratory expert recommendations for general practitioners' management of patients with chronic obstructive pulmonary disease (COPD), compared with usual care.

Objective: To investigate the long-term effectiveness of a general practice monitoring system with respiratory expert recommendations for general practitioners’ management of patients with chronic obstructive pulmonary disease (COPD), compared with usual care.

Design, settings and participants: A multicentre randomised controlled trial of patients with COPD, clustered by general practices; 200 participants were recruited to maintain at least 75 participants per group for analysis. The trial took place from July 2005 to February 2008 in the south-western region of the Netherlands.

Intervention: Ongoing half-yearly monitoring of COPD patients with respiratory expert recommendations for the GP was compared with usual care.

Main outcome measures: Primary outcome — Chronic Respiratory Questionnaire (CRQ) score; secondary outcomes — CRQ domain scores, generic health-related quality of life (Short-Form 12 and EuroQol-5D), breathlessness (Modified Medical Research Council score), exacerbations, and decline in forced expiratory volume in 1 second. A detailed process evaluation was performed along with the trial.

Results: Data from 170 participants were analysed. Based on repeated measurement analyses, the additional gain in CRQ score during follow-up was 0.004 points for monitoring compared with usual care (95% CI, –0.172 to 0.180). Also, no important differences between monitoring and the usual care group were found for secondary outcomes. Half the monitoring visits resulted in disease management recommendations by a respiratory expert, and 46% of these recommendations were implemented by the GPs. Patient adherence to lifestyle recommendations was low.

Conclusion: An expert-supported monitoring system for patients with COPD was not clinically effective. As patients had a pre-existing entry in the monitoring system, the population may be well regulated, with reduced room for improvement.

Trial registration: www.clinicaltrials.gov NCT00542061.

METHODS

Study design

We conducted a multicentre parallel group study with a 24-month patient follow-up (www.clinicaltrials.gov NCT00542061). The trial took place from July 2005 to February 2008. We allocated general practices to intervention (ie, respiratory expert-supported COPD monitoring system) or usual care. All participants at each general practice were allocated to the same treatment group (cluster randomised design).

Participants and sample size calculation

We selected and invited study participants based on patient records already available at a regional diagnostic centre (RDC) in the south-western region of the Netherlands.

Inclusion criteria were:

- patient diagnosed with COPD or asthma with persistent airflow obstruction, as confirmed with the patient’s most recent spirometry (forced expiratory volume in 1 second [FEV\(_1\)]/forced vital capacity [FVC] <70%, or postbronchodilator FEV\(_1\) <80% predicted and ≥9% reversibility), 11,12
- the patient’s lung function data from the previous year were available at the general practice diagnostic centre; and
- patient aged at least 25 years.

Exclusion criteria were:

- patient treated by a chest physician;
- patient participating in another respiratory intervention study;
- GP considered it detrimental to the patient to participate in the study;
- patient had any serious other non-pulmonary diseases (or disease stages) or pulmonary diseases (eg, sarcoidosis, lung cancer, lung fibrosis); or
- patient could not read.
GPs at practices who had referred more than six patients to the RDC were contacted and asked to participate. We used computerised minimisation to allocate practices to the monitoring and usual care groups\textsuperscript{11,12} while stratifying for:

- group versus solo practice;
- practice nurse employed versus no practice nurse employed, and
- \( \leq 10 \) versus \( > 10 \) patients fulfilling the study inclusion criteria.

A multilevel power calculation (ie, correction for clustering of subjects within general practices) was based on the mean difference in Chronic Respiratory Questionnaire (CRQ) score between monitoring and usual care. A difference of 0.5 points is generally accepted as a minimum important clinical difference for the CRQ score.\textsuperscript{15} We initially aimed to recruit 100 participants per group based on the following assumptions: an intracluster correlation coefficient of 0.04, \( \alpha = 0.05 \), \( 1 - \beta = 0.80 \), and a drop-out rate of 25%.

**Blinding**

In their study information letters, GPs and patients were informed that patients were invited for an unspecified number of visits to the RDC. GPs were informed that participation could imply that the outcome of their patients’ visits would not be forwarded to them during the study as it had been previously. After minimisation, GPs received specific research information for their practice. The respiratory experts involved and the lung function technicians who performed the spirometric tests and collected medical information were not aware of patients’ participation and allocation.

**Intervention**

The expert-supported COPD monitoring system had been in use in the RDC since 1995, and comprised several steps.

**Step A.** Patients with COPD were invited to the RDC for monitoring visits every 6 months. Pre- and post- (after inhaling 400 \( \mu \)g salbutamol) bronchodilator FEV\(_1\) and FVC were measured at each visit with a SpiroPerfect spirometer (WelchAllyn, Delft, The Netherlands) by certified lung function technicians. Body mass index was assessed, and information on respiratory symptoms, exacerbations, smoking and medication use in the previous 6 months was collected in a standardised way.

**Step B.** Information from the monitoring visit and previous visits was sent to a respiratory expert (chest physician or GP with special respiratory interest). The respiratory experts gave recommendations regarding treatment, additional diagnostic tests and referrals to other disciplines, based on national clinical practice guidelines for COPD and asthma.\textsuperscript{11,12} Experts’ interpretation based on spirometry results and written information has been shown to be valid.\textsuperscript{16}

**Step C.** Written feedback was sent to the patient’s GP. The patient was instructed to visit the GP 2 weeks after the monitoring visit to discuss the outcome. During these visits, the expert recommendations could be implemented by the GP (eg, checking inhalation technique) or recommended to the patient. Half-yearly visits from a nurse consultant to the practice to support GPs in implementing the recommendations were an integral part of the expert-supported monitoring system.

**Step D.** Ultimately, the patient should implement the recommendations made (eg, quit smoking, increase exercise).

**Usual care**

We invited participants from the usual care group for spirometry at the beginning and at the end of the trial. No recommendations or feedback were given, and no nurse consultant practice visits were scheduled during the study period.

**Outcomes and process evaluation**

Participants completed questionnaires at baseline, at 1 year, and at the end of the
study. The primary study outcome was the CRQ score. Secondary outcomes were: CRQ domain scores; generic health-related quality of life (physical and mental domains of the Short-Form 12 [SF-12] and the EuroQol-5D [EQ-5D]; breathlessness according to the Short-Form 12 [SF-12] and the EuroQol-5D [EQ-5D]; and occurrence rate of self-reported exacerbations. CRQ domain scores, SF-12 scores, EuroQol-5D scores, FEV₁ decline, and dichotomised MMRC scores. We used a PROC MIXED procedure in SAS statistical software (SAS Institute, Cary, NC, USA), with general practice as the random coefficient and compound symmetry correlation structure. Multilevel logistic regression analysis was used to analyse effects on exacerbations. All models were corrected for sex, age, socioeconomic status, baseline cigarette smoking status, reversibility, exacerbations at baseline, use of inhaled corticosteroids, use of long-acting bronchodilators, and postbronchodilator FEV₁ % of the predicted value. Participants were included in the analysis if they participated in the study (intention-to-treat analysis).

RESULTS

Study population
Box 1 shows the process of practice and patient recruitment and follow-up. Thirty-four general practices participated. From these, 261 of 286 eligible patients (91%) responded to the invitation, and 213 (74%) were willing to participate. No significant differences between participants and non-participants with regard to sociodemographic characteristics, medication use, and spirometric indices were found. Twenty-four patients did not enter the study, and 19 patients were excluded from analyses. Data from 170 participants were used for the analyses. Box 2 shows the baseline characteristics of both groups.

The study was originally designed to evaluate monitoring of patients with COPD and asthma with a chronic airflow obstruction. However, after the recruitment phase we found that almost all of the patients fulfilled the criteria for COPD (ie, FEV₁/FVC < 70% postbronchodilator); therefore, we decided to focus on COPD.

Clinical effectiveness of the expert-supported monitoring system
Box 3 shows the mean overall CRQ scores in the monitoring and usual care groups. Based on repeated measurement analyses, the additional gain in CRQ score during follow-up was 0.004 points for monitoring compared with usual care (95% CI, –0.172 to 0.180). Box 4 summarises the results for the secondary outcomes. No significant differences between the monitoring and usual care groups were observed other than CRQ domain mastery.

Process evaluation
A total of 292 visits took place among the monitoring groups. Fifty-eight participants attended all four planned monitoring visits at the RDC (71%). Fifteen patients (18%) attended three, six patients attended two, and three patients attended one planned visit.

In total, respiratory experts gave 290 recommendations (Box 5). Smoking cessation was the most frequent recommendation (28% of all recommendations), and inhaler technique training and assessment of compliance with medical treatment were also recommended regularly. In 146 monitoring visits (50%), the respiratory experts did not consider any modification in disease management necessary. For 73 patients (89%), the GPs received at least one recommendation to change disease management.

Information about 274 of the 290 recommendations could be collected (Box 5). According to GPs, they attempted to implement 125 (46%) of the 274 recommenda-
4. Effects of expert-supported chronic obstructive pulmonary disease monitoring compared with usual care on outcomes of respiratory health and quality of life

A. Mean (95% CI) at baseline, change (95% CI) at follow-up, and difference between groups (95% CI) for continuous variables

<table>
<thead>
<tr>
<th>Monitoring group</th>
<th>Usual care group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (n = 82)</td>
</tr>
<tr>
<td>Overall CRQ score</td>
<td>5.1 (4.9 to 5.3)</td>
</tr>
<tr>
<td>CRQ domain dyspnoea</td>
<td>4.9 (4.6 to 5.3)</td>
</tr>
<tr>
<td>CRQ domain fatigue</td>
<td>4.9 (4.7 to 5.2)</td>
</tr>
<tr>
<td>CRQ domain emotions</td>
<td>5.4 (5.2 to 5.6)</td>
</tr>
<tr>
<td>CRQ domain mastery</td>
<td>4.8 (4.7 to 5.0)</td>
</tr>
<tr>
<td>SF-12 physical scale</td>
<td>44.5 (43.0 to 46.1)</td>
</tr>
<tr>
<td>SF-12 mental scale</td>
<td>52.2 (50.2 to 54.1)</td>
</tr>
<tr>
<td>EuroQol-5D score</td>
<td>0.89 (0.86 to 0.92)</td>
</tr>
</tbody>
</table>

**Difference between monitoring and usual care is significant; Monitoring versus usual care based on multilevel repeated measurement analysis corrected for sex, age, socioeconomic status, smoking status at baseline, reversibility, CRQ = Chronic Respiratory Questionnaire. SF-12 = Short-Form 12. MICD = minimum important clinical difference. MMRC = Modified Medical Research Council.**

B. Frequency (no. [%]) of categorical variables at baseline and follow-up, and odds ratios

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Monitoring group</th>
<th>Usual care group</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (n = 82)</td>
<td>Baseline (n = 88)</td>
<td></td>
</tr>
<tr>
<td>≥1 exacerbations in previous year</td>
<td>16 (20.0%)†</td>
<td>12 (15.8%)</td>
<td>1.05 (0.34–3.24)</td>
</tr>
</tbody>
</table>

**CRQ = Chronic Respiratory Questionnaire. SF-12 = Short-Form 12. MICD = minimum important clinical difference. MMRC = Modified Medical Research Council.**

5. Number of times a respiratory expert recommended each disease management change, and general practitioner adherence to recommendations overall and in practices with and without a practice nurse

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Expert recommendations</th>
<th>Recommendations evaluated*</th>
<th>Overall</th>
<th>Practices with nurse†</th>
<th>Practices without nurse‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cease smoking</td>
<td>82</td>
<td>78</td>
<td>44</td>
<td>25/47</td>
<td>19/31</td>
</tr>
<tr>
<td>Optimise physical condition</td>
<td>21</td>
<td>20</td>
<td>6</td>
<td>2/5</td>
<td>4/15</td>
</tr>
<tr>
<td>Avoid allergens and triggers</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1/1</td>
<td>2/3</td>
</tr>
<tr>
<td>Check inhaler technique</td>
<td>47</td>
<td>45</td>
<td>21</td>
<td>15/23</td>
<td>6/22</td>
</tr>
<tr>
<td>Check treatment compliance</td>
<td>49</td>
<td>46</td>
<td>29</td>
<td>18/25</td>
<td>11/21</td>
</tr>
<tr>
<td>Reduce bodyweight</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1/2</td>
<td>0/1</td>
</tr>
<tr>
<td>Introduce ICS</td>
<td>15</td>
<td>14</td>
<td>5</td>
<td>2/7</td>
<td>3/7</td>
</tr>
<tr>
<td>Increase ICS dosage</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>1/2</td>
<td>2/4</td>
</tr>
<tr>
<td>Reduce dosage or cease ICS</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>6/10</td>
<td>0/0</td>
</tr>
<tr>
<td>Introduce short-acting BD</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1/1</td>
<td>0/0</td>
</tr>
<tr>
<td>Introduce long-acting BD</td>
<td>10</td>
<td>8</td>
<td>0</td>
<td>0/4</td>
<td>0/4</td>
</tr>
<tr>
<td>Additional diagnostic procedures</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0/2</td>
<td>0/1</td>
</tr>
<tr>
<td>Chest x-ray</td>
<td>14</td>
<td>13</td>
<td>3</td>
<td>1/8</td>
<td>2/5</td>
</tr>
<tr>
<td>Refer to chest physician</td>
<td>24</td>
<td>23</td>
<td>3</td>
<td>1/9</td>
<td>2/14</td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>274</td>
<td>125</td>
<td>74/146‡</td>
<td>51/128†</td>
</tr>
</tbody>
</table>

**Adherence = GP attempted to implement recommendation. BD = bronchodilator. ICS = inhaled corticosteroids. * Eleven recommendations were not discussed by GPs and three GPs` responses were missing. † No. of GPs adhering to recommendation/no. of recommendations evaluated in each type of practice. ‡ Difference between practices with and without practice nurses is significant; P < 0.05 (χ² test). **Monitoring versus usual care based on multilevel logistic regression analysis, corrected for covariates.◆**

DISCUSSION

We did not find a clinical benefit for patients who received ongoing care according to a well structured respiratory expert-supported COPD monitoring system compared with usual care by GPs. The adherence of patients to the monitoring visits was good. In half the cases, the respiratory experts felt that disease management could be improved, and almost half the recommenda-
Monitoring group (n = 82) | Usual care group (n = 86)
---|---
**Recommendations** | **Implementation**
---|---
Cease smoking | 14 | 3 | 13 | 0
Increase bodyweight | 1 | 1 | 0 | —
Reduce bodyweight | 16 | 0 | 12 | 0
Increase physical exercise | 13 | na | 7 | na
Check treatment compliance | — | 22 | — | 20
Check inhaler technique | — | 14 | — | 18
Introduce/increase ICS dosage | — | 4 | — | 5
Reduce dosage or cease ICS | — | 4 | — | 3
Introduce short-acting BD | — | 7 | — | 5
Introduce long-acting BD | — | 11 | — | 8
Chest x-ray | — | 6 | — | 5
Refer to chest physician | 9 | 9 | 6 | 6

BD = bronchodilator; ICS = inhaled corticosteroids. na = not applicable. Recommendations = by GPs.

In monitoring group, these were based on expert recommendation or own initiative.

* According to the patient. † Implementation of recommendations by the patient. ‡ Patient stopped smoking according to the last questionnaire and medical information of the last visit to the regional diagnostic centre. §±3kg bodyweight change according to measurement during lung function visits. ¶ Information on exercise tolerance was not collected. ** According to GPs’ electronically recorded information (nine missing values in monitoring group; 10 missing values in usual care group).

In conclusion, an ongoing respiratory expert-supported monitoring system for patients with COPD was not effective in terms of clinical outcomes. The lack of effectiveness may have been the result of a combination of limited options to intervene, the diluting effect on the intervention caused by the many steps in this complex process, and the low adherence of patients to crucial recommendations such as smoking cessation.

ACKNOWLEDGEMENTS

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COMPETING INTERESTS

None identified.
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