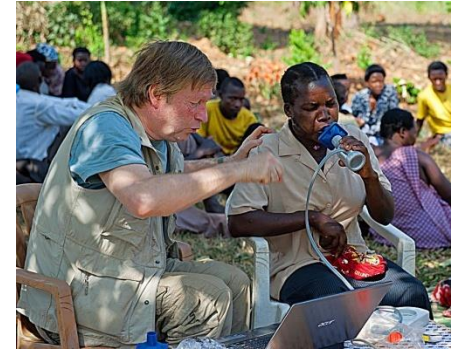




Jaime Correia de Sousa, MD, PhD

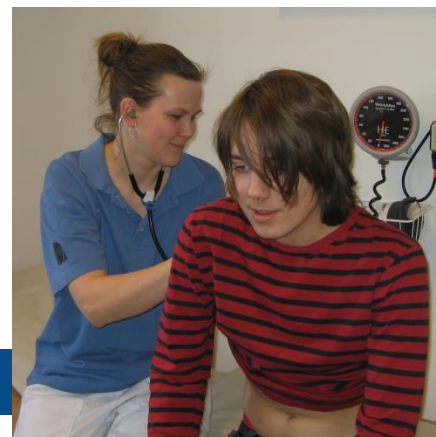
President-Elect of the IPCRG

Associate Professor, School of Health
Sciences, University of Minho, Portugal



International Primary Care Respiratory Group

Promoting good clinical respiratory practice
through research and education.



What is the IPCRG?

- An organisation of organisations
- Established in 2000 and incorporated as a charity in Scotland
- Currently 31 member countries with over an estimated 150,000 primary care doctors



GRAP Spain annual meeting



Athens on Air interviews with conference speakers broadcast live and by web



Tobacco dependence education in the context of lung health - the Global Bridges programme in Uganda



Some of the members of the IPCRG Senate (representatives of each country member)



The launch of the E-Quality programme in São Paulo, virtual respiratory consultations in primary care



Public respiratory and allergy education, Pakistan



Development of the IPCRG's Education Strategy for low, middle and high income countries.



IPCRG Bangladesh, Indonesia and Education for Health asthma learning 1st cohort



FRESH AIR Kyrgyzstan mobile spirometry in the highlands



Athens World Conference prize-winners



www.theipcr.org

- IPCRG
- IPCRG2015
- IPCRG2016

npj Primary Care Respiratory Medicine
www.nature.com/npjpcrm

- FRESH AIR
- Difficult to manage asthma
- E-Quality
- E-Faculty
- UNLOCK
- Conferences



Working locally, collaborating globally to improve respiratory health

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Patients' rep
Kristine Whorlow



Co-optee, Chair,
Singapore 2015, Tan
Tze Lee, Singapore



Co-optee, Ioanna
Tsiligianni, Crete



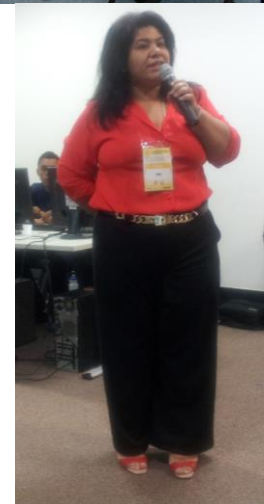
Co-optee, Karin
Lisspers,
Sweden,



Co-optee, Beraki
Ghezai, Norway

Our beliefs

1. The value of primary care in respiratory disease and tobacco dependence
2. Practical peer-led training and education
3. Integrated care involving patients, multi-disciplinary health and social care
4. Production of real life evidence that feeds into guidelines
5. Solutions that reduce exposure to indoor smoke
6. Right incentives for primary care to support patients to stop smoking
7. Universal access to good quality inhaled medicines and training in how to use them
8. IPCRG can leverage major clinician-led change working locally, collaborating globally





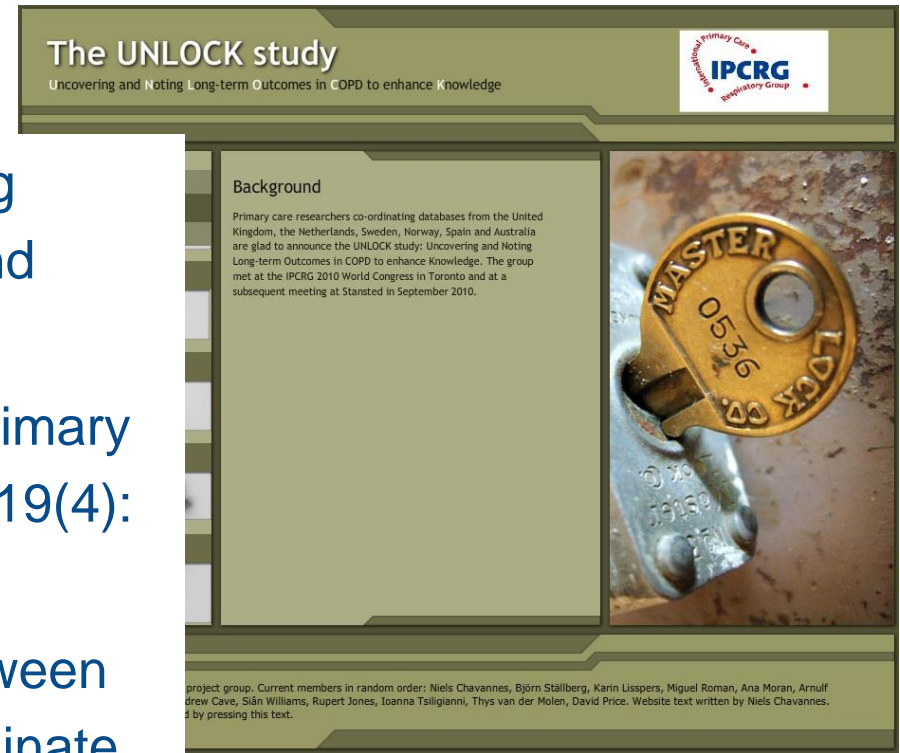
What we do?

- Provide primary care voice in major EU projects: UBIOPRED
- UNLOCK COPD and asthma
- FRESH AIR Vietnam, Uganda, Kyrgyzstan, Greece
- Build capacity
 - E-Faculty in Vietnam, Romania, Chile
 - E-Quality in Bangladesh, Sri-Lanka, India, Brazil, FYR Macedonia



UNLOCK: using real life primary care population data

- UNLOCK - **U**ncovering and **N**oting **L**ong-term **O**utcomes in **C**OPD and asthma to enhance **K**nowledge
- Protocol summary published in Primary Care Respiratory Journal (2010); 19(4): 408
- An international collaboration between primary care researchers to coordinate and share datasets of relevant diagnostic and follow-up variables for COPD and asthma management in primary care



Increasing capability + capacity

- **FRESH AIR**
 - Vietnam
 - Uganda
 - Kyrgyzstan
 - Greece

Fresh Air project

- Identifying COPD
- Smoking
- Biomass fuels

- Supported by WHO GARD and EU

- In line with Airways ICP strategy



Increasing capability + capacity in research

- E-Faculty
 - Vietnam
 - Romania
 - Chile

E-Faculty Equip one primary care research-aspiring country with the skills to conduct high quality original research[in the field of] chronic respiratory disease and appropriate respiratory management



Understanding what actually happens

- July 2013 published
- First ever
- international
- mapping of primary
- care use of national
- respiratory
- guidelines

National respiratory guidelines used by primary care

Introduction

In May and June 2013 the IPCRG mapped the clinical guidelines used by primary care in its member countries for the chronic lung conditions commonly found in primary care: chronic obstructive pulmonary disease (COPD), asthma, allergic rhinitis, community-acquired pneumonia (CAP), obstructive sleep apnoea (OSA) and tobacco dependence. The mapping collected information on clinical respiratory guidelines at the national level (referred to as national guidelines) that are used by primary care for these conditions and which of these guidelines had involved primary care in their development. The overall aim of the mapping is to provide a resource on the IPCRG web platform that enables country members easily and quickly to share information and learning about national guidelines. The IPCRG anticipates that it will also be useful for health care planners developing national action plans for chronic lung conditions as it brings together for the first time information on guidelines currently in use across a wide range of countries. To ensure this resource remains relevant and useful, it will be updated as new information becomes available and additional countries will be added. This position paper provides a snapshot of the key features of the guidelines included in the mapping in June 2013. Further details of all the national guidelines identified by members can be found at: <https://www.theipcr.org/display/ResMapping/Mapping+of+national+guidelines+used+by+primary+care>. The methodology used for the mapping is described at: <https://www.theipcr.org/display/ResMapping/How+the+mapping+was+developed>.

The importance of primary care and national guidelines

Primary care's importance in the health system and its health economic value have been fully described in the research

literature.^{1,2} The IPCRG has summarised the extensive evidence that primary care has a pivotal role to play in managing the growing global burden of chronic lung disease through prevention, education and disease management.³ We have also stressed that clinical guidelines, defined by the Institute of Medicine as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances", are an essential tool to enable primary care to fulfil its role effectively.⁴ Clinical guidelines seek to improve the quality of healthcare, to reduce inappropriate variations in clinical practice and to support the education of health professionals. They are also used by patients to increase understanding of a condition, to improve self-management and to inform decision-making.

Clinical guidelines developed at a national level are able to take account of contextual factors such as epidemiological, demographic, political and economic factors that international guidelines cannot. Importantly, national guidelines can be designed to reflect the specific configuration of health services in a country including the distribution and resourcing of primary care. They can also address the particular health needs of population groups such as ethnic minorities and take account of cultural issues. In addition, they can include clinical factors that are specific to the country.

Countries included in the mapping

This mapping included the following 21 countries:

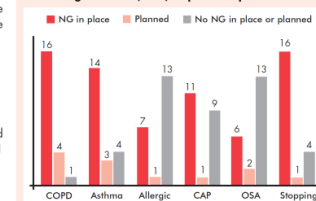
- Australia
- Bangladesh
- Canada
- Chile
- Cyprus
- Greece
- India
- Ireland
- Italy
- Netherlands
- New Zealand
- Norway
- Pakistan
- Poland
- Portugal
- Singapore
- Spain
- Sri Lanka
- Sweden
- UK
- Vietnam

How many national guidelines did we find?

Across these 21 countries we identified a total of 70 national guidelines that were used by primary care for COPD, asthma, allergic rhinitis, CAP, OSA and support for stop smoking. In addition, a further 12 national guidelines were either planned or currently being developed. Figure 1 presents the number of participating countries with national guidelines in place or planned for each condition and the number with no national guidelines in place or planned.

National guidelines were in place for all six of the conditions in three participating countries (14%) and three had no national guidelines for any of these topics (14%). Figure 2 below shows how many national guidelines for the six conditions were in place. The mean number of national guidelines per country was 3.3.

Figure 1. Number of participating countries with national guidelines (NGs) in place or planned



Delivering value for respiratory research

- Undertaken within primary care
- Recruiting populations representative of primary care patients
- Evaluating interventions realistically delivered within primary care
- Drawing conclusions meaningful to professionals working within primary care

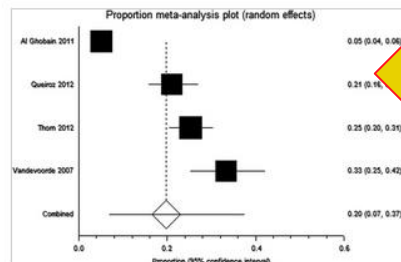
npj | Primary Care
Respiratory Medicine

Formerly *Primary Care Respiratory Journal*



Impact Factor of **2.504**

Featured Article



Chronic obstructive pulmonary disease: Finding

Diagnostic challenges

Shamail Haroon and colleagues from the University of Birmingham, UK, summarise and compare the effectiveness of different case finding approaches for undiagnosed COPD in primary care. Read the paper in full.

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Job FM van Boven, Jaap CA Trappenburg [...] Niels H Chavannes

“How to” eg improving adherence

dealing key opportunities
Amanda Landers, Rachel Wiseman [...] Lutz Beekert

Submit manuscript

Announcements

PCRS-UK Annual Conference: Registration open
Registration is now open for the PCRS-UK Annual Meeting 16th-17th October 2015. The theme of the meeting is 'Expanding our horizons: delivering high value patient centred care'.

Featured Content



Abstracts from the 4th International Primary Care Respiratory Group (IPCRG) Scientific Meeting - available
The abstracts from the 4th International Primary Care Respiratory Group (IPCRG) Scientific Meeting are now available online, spanning global primary care research on chronic and infectious respiratory disease and tobacco dependence. IPCRG is devoted to the improvement of chronic and infectious respiratory care in primary and community settings in low, middle and high income countries.

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Exposure for IPCRG conference abstracts

What changes clinical behaviour: E-Quality



Prim Care Respir J 2012; 21(4): 431-436

Primary Care
 RESPIRATORY JOURNAL
www.thepcrj.org

DISCUSSION PAPER

Effecting change in primary care management of respiratory conditions: a global scoping exercise and literature review of educational interventions to inform the IPCRG's E-Quality initiative

Juliet McDonnell¹, Sian Williams², Niels H Chavannes³, Jaime Correia de Sousa⁴,
 H John Fardy⁵, Monica Fletcher⁶, James Stout⁷, Ron Tomlins⁸, Osman M Yusuf⁹, *Hilary Pinnock¹⁰

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⁶ Chief Executive, Education for Health, Warwick, UK

⁷ Professor, Department of Paediatrics, University of Washington, Seattle, Washington, USA

⁸ Adjunct Associate Professor, Discipline of General Practice, Western Clinical School, University of Sydney, Sydney, Australia

⁹ Chief Primary Care/GP Trainer and Consultant Allergy and Asthma Specialist, The Allergy and Asthma Institute, Islamabad, Pakistan

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Received 26th April 2012; accepted 3rd June 2012; online 8th August 2012

Abstract

This discussion paper describes a scoping exercise and literature review commissioned by the International Primary Care Respiratory Group (IPCRG) to inform their E-Quality programme which seeks to support small-scale educational projects to improve respiratory management in primary care. Our narrative review synthesises information from three sources: publications concerning the global context and health systems development; a literature search of Medline, CINAHL and Cochrane databases; and a series of eight interviews conducted with members of the IPCRG faculty. Educational interventions sit within complex healthcare, economic, and policy contexts. It is essential that any development project considers the local circumstances in terms of economic resources, political circumstances, organisation and administrative capacities, as well as the specific quality issue to be addressed. There is limited evidence (in terms of changed clinician behaviour and/or improved health outcomes) regarding the merits of different educational and quality improvement approaches. Features of educational interventions that were most likely to show some evidence of effectiveness included being carefully designed, multifaceted, engaged health professionals in their learning, provided ongoing support, were sensitive to local circumstances, and delivered in combination with other quality improvement strategies. To be effective, educational interventions must consider the complex healthcare systems within which they operate. The criteria for the IPCRG E-Quality awards thus require applicants not only to describe their proposed educational initiative but also to consider the practical and local barriers to successful implementation, and to propose a robust evaluation in terms of changed clinician behaviour or improved health outcomes.

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J McDonnell et al. *Prim Care Respir J* 2012; 21(4): 431-436

<http://dx.doi.org/10.4104/pcrj.2012.00071>

Keywords educational interventions, global health, IPCRG, primary care, quality improvement, respiratory care

Bids for small scale educational interventions to improve respiratory diagnosis treatment and care

Bangladesh, Sri-Lanka, India, Brazil, FYR Macedonia

* Corresponding author: Dr Hilary Pinnock, Allergy and Respiratory Research Group, Centre for Population Health Sciences, The University of Edinburgh, Doonway 3, Medical School, Teviot Place, Edinburgh EH8 9AG, UK. Tel: +44 (0)131 650 8102. Fax: +44 (0)131 650 9119. E-mail: hilary.pinnock@ed.ac.uk

FYR Macedonia, Ohrid, 1-2 May 2015



Symposium Antibiotics in Primary Health Care: field for improvement. Results from the E-Quality program 2014/2015



São Bernardo do Campo, São Paulo, Brazil, 29-30 June 2015



Matrix Project



OPINION

IPCRG OPINION 3

Helping patients quit smoking: brief interventions for healthcare professionals

How to help smokers quit: flowchart

Ask about tobacco use (smoking and e-cigarettes) for all patients and reassess once at every clinic visit or at least once a year. This alone doubles the rate of success. Document smoking status/stage of motivation/tobacco burden.

ASK

How you use tobacco in the last 12 months?

- Yes - never:** Congratulations. Reinforce non-use. Patients who have smoked in the past should be asked about smoking for some years after quitting. Relapse is unlikely after 2 years abstinence.
- Yes - Quit in the last 12 months:** Congratulations. Ask if they need help to remain smoke free. Advise them to contact you or to seek other counselling if they have any difficulty quit line, smoking cessation clinic, other...
- Yes - Current smoker:** Take brief smoking history including number of cigarettes smoked a day, year started smoking, presence of smoking-related disease, previous quit attempts and what happened!

Use non-judgmental questions such as "How do you feel about your smoking at the moment? Express concern/interest and not criticism."

ASSESS

Reduction in step: 1-2 steps for every 10 cigarettes you're trying to quit.

1 2 3 4 5 6 7 8 9 10

Are you planning to QUIT in the next 6 months?

Not planning to QUIT: YES, but not yet: YES, READY TO QUIT

Planning to QUIT within a month

NO NOT READY (PRECONTINGPLATION)

ADVISE

Focus on their ambivalence, help them explore their ambivalence.

Offer help by making their quit time as low as possible and don't let them off the hook.

Ask if you can help them to quit.

What are your goals when you quit?

What would you like to happen when you quit?

How many cigarettes do you smoke a day?

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DESKTOP HELPER

No. 2 April 2012

Improving the care of adults with difficult to manage a practical guide for primary healthcare professional

INTRODUCTION

This guide provides a systematic, practical approach to support primary care and other community healthcare professionals to improve the care of people over the age of 18 years with difficult to manage asthma.

Difficult to manage asthma is asthma that either the patient or the clinician finds difficult to manage.

A patient with difficult to manage asthma has daily symptoms and regular exacerbations despite apparently best treatment.

People whose asthma has been controlled in the past but who now have lost control.

People whose asthma has never been controlled.

Investigation and management should aim to:

Identify what asthma control is best / has ever been achieved by patient and effective monitoring.

Classify, control and then maintain control of asthma with effective, well-tolerated treatment.

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IPCRG TEACH THE TEACHER Difficult to manage asthma

IPCRG 'Teach the Teacher' Workshop - Rome - January 2015

Aim

To build a trusted faculty with the knowledge, influence, communication and teaching skills to deliver effective workshops that are relevant to the local situation, and can be embedded in local primary care practice and pathways including hospital care.

Target Audience

The course is aimed at educators in primary care who are involved in teaching at the university or practice level. We expect experienced teachers and also those on the beginning of their educational careers.

An invitation-only audience of primary care teachers, and where available, secondary care leaders sympathetic to primary care and expert patients proposed by our partner, European Federation of Allergy and Airways Diseases Patients' Associations (EFA). They need to be willing to attend a faculty meeting and to run a local difficult to manage asthma meeting, with our support.

Curriculum:

- Assessing learning needs
- Setting learning objectives
- Designing a programme
- Teaching methods including working with small groups, and distance learning
- Assessing learning and monitoring
- Project planning and evaluation

Objectives of the workshop

At the end of the workshop the participants will be able to:

- Assess learning needs and define learning objectives adapted to different learning environments
- Design a teaching programme
- Develop teaching materials
- Know how to choose between different teaching methods
- Value the use of appropriate teaching methods in medical education
- Put together a proposal for a local event including evaluation

List of speakers

- Breda Flood (BF)
- Dermot Ryan (DR)
- Hilary Finnock (HF)
- Jaime Correia de Sousa (JCS)
- Juliet McDonnell (JMC)



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The service should not be considered as a recommendation for treatment. The abstracts printed here contain only a general description of the main ideas embedded in the original publication. Comments are welcome. Please send any comments to the Project Manager, Linda Kennison at Administration@ipcrgrg.org

Telehealth program leads to fewer hospital admissions for COPD

Am J Med. 2015;128(3):323-31. doi: 10.1016/j.amjmed.2015.01.002.

Researchers in Seattle investigated health outcomes for 616 Medicare COPD patients who used the Health Buddy Program, a content-driven telehealth system together with care management for 3 years compared to 616 matched controls. The telehealth system aims to improve patient health education, self care and encourage timely healthcare access. Compared to baseline, quarterly all cause hospital admission rates were 23% lower and quarterly admissions linked to lung disease were 40% lower in the Health Buddy patients versus controls. There was no change in quarterly ED use. The authors concluded that this program could be useful for improving health outcomes in COPD patients.

Am J Med. 2015;128(3):323-31. doi: 10.1016/j.amjmed.2015.01.002.

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National educational workshops



- Primary care led
- Address real life questions: infant wheeze, case-finding in COPD, stop smoking in 3 minutes...
- Adapted for local situation and resources
- Springboard for local group

Research meetings + World conferences



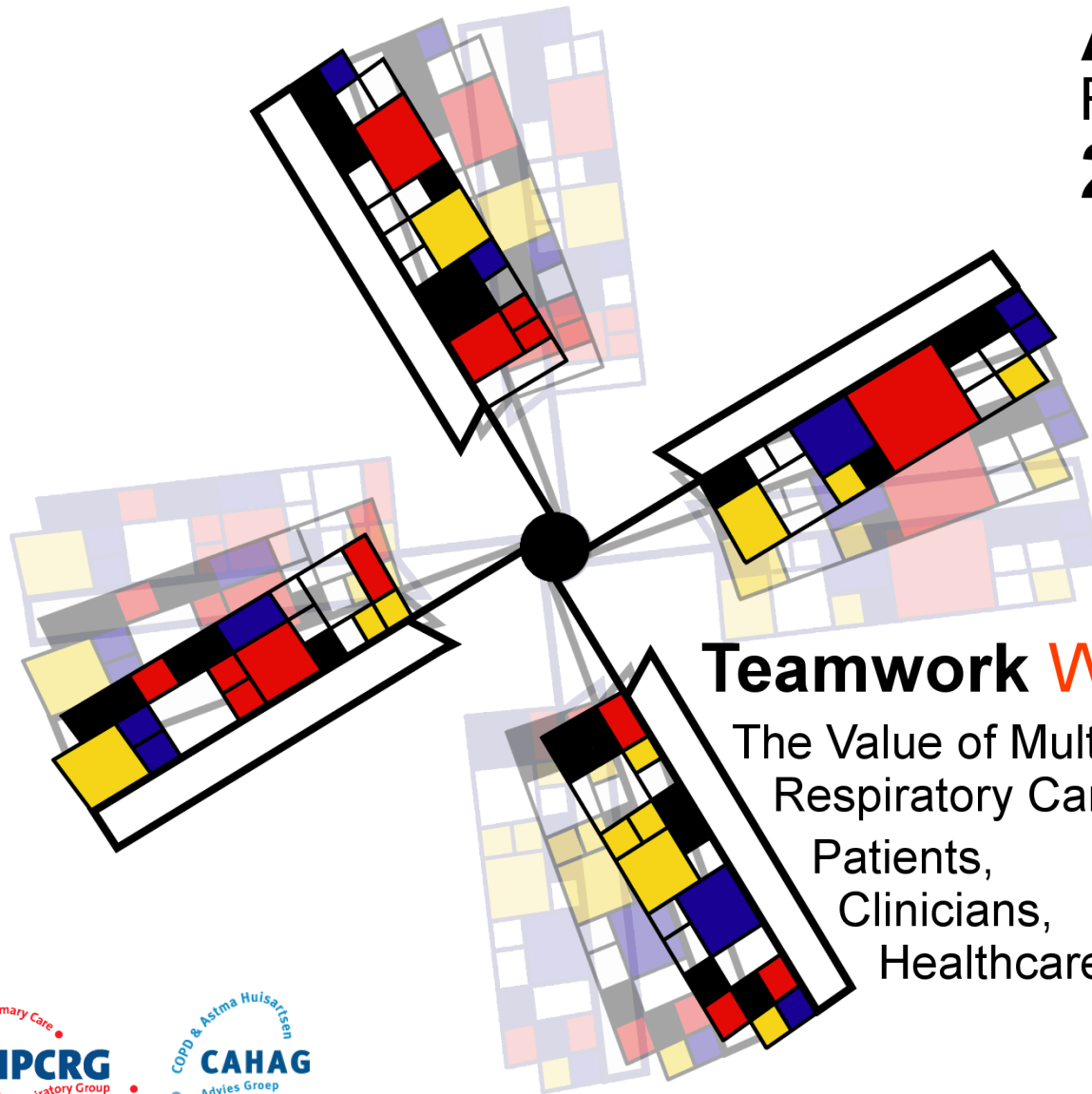
8th **IPCRG**
World Conference
Amsterdam
RAI Theatre
25-28 May 2016

TEAMWORK: WHO CARES?
The Value of Multidisciplinary Respiratory Care for:
Patients, Clinicians and Healthcare Systems

An abstract graphic consisting of four stylized buildings or structures arranged in a cross pattern. Each building is composed of a grid of colored squares (red, yellow, blue, black, white) and is tilted at an angle. The buildings are connected by a central black dot.

Building on the success of Athens 2014....

8th **IPCRG** World Conference Amsterdam Rai Auditorium Centre **25-28 May 2016**



Teamwork Who Cares?

The Value of Multidisciplinary
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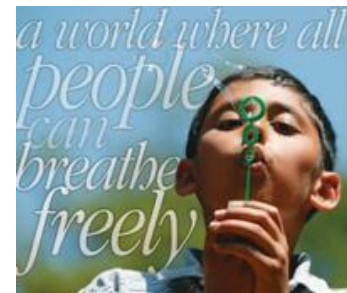
IPCRG

9th World Conference
of the International Primary Care
Respiratory Group

Portugal, 2018

WHO-GARD

- Primary care reps on Planning Executive
- Demonstration projects in Vietnam, Bangladesh, Uganda and Kyrgyzstan
- All national action plans should involve primary care



And what's new?

- First scientific meeting in Asia Pacific
- First respiratory research school
- First school prize winner
- Three IPCRG directors on rejuvenated WHO-GARD
- President Elect attending WHO CRD Technical Meeting 5/6 October 2015
- **2017** meetings in **Europe** and **Sri Lanka**
- **2018** 9th World Conference in **Portugal**
- European Commission Horizon 2020: FRESH AIR **3m euro** Implementation Science project combatting chronic respiratory

FRESH AIR



To conclude, IPCRG is

- Independent
- Work in low, middle and high income countries (aligned to NCD Alliance, Union)
- Aligned to primary care (WONCA Europe and global)
- Aligned to respiratory care (ERS, GARD, EAACI, ARIA, WAO, Airways ICP)
- Supported by patients (ELF, EFA, GAAPP, COPD Coalition)
- Communities of practice: research, education, care delivery
- Because primary care, can tackle multiple morbidities

Our challenges

- Scaling up in Asia Pacific, in South America, in parts of Europe where family practice less developed
- Primary care is more than general practice
 - Scaling up from GP-oriented to primary care oriented
- Getting respiratory interventions on the WHO best buy list

Thank you for your attention!