Introduction to IPCRG and Asthma Right Care: for Africa cluster colleagues

26 May 2020

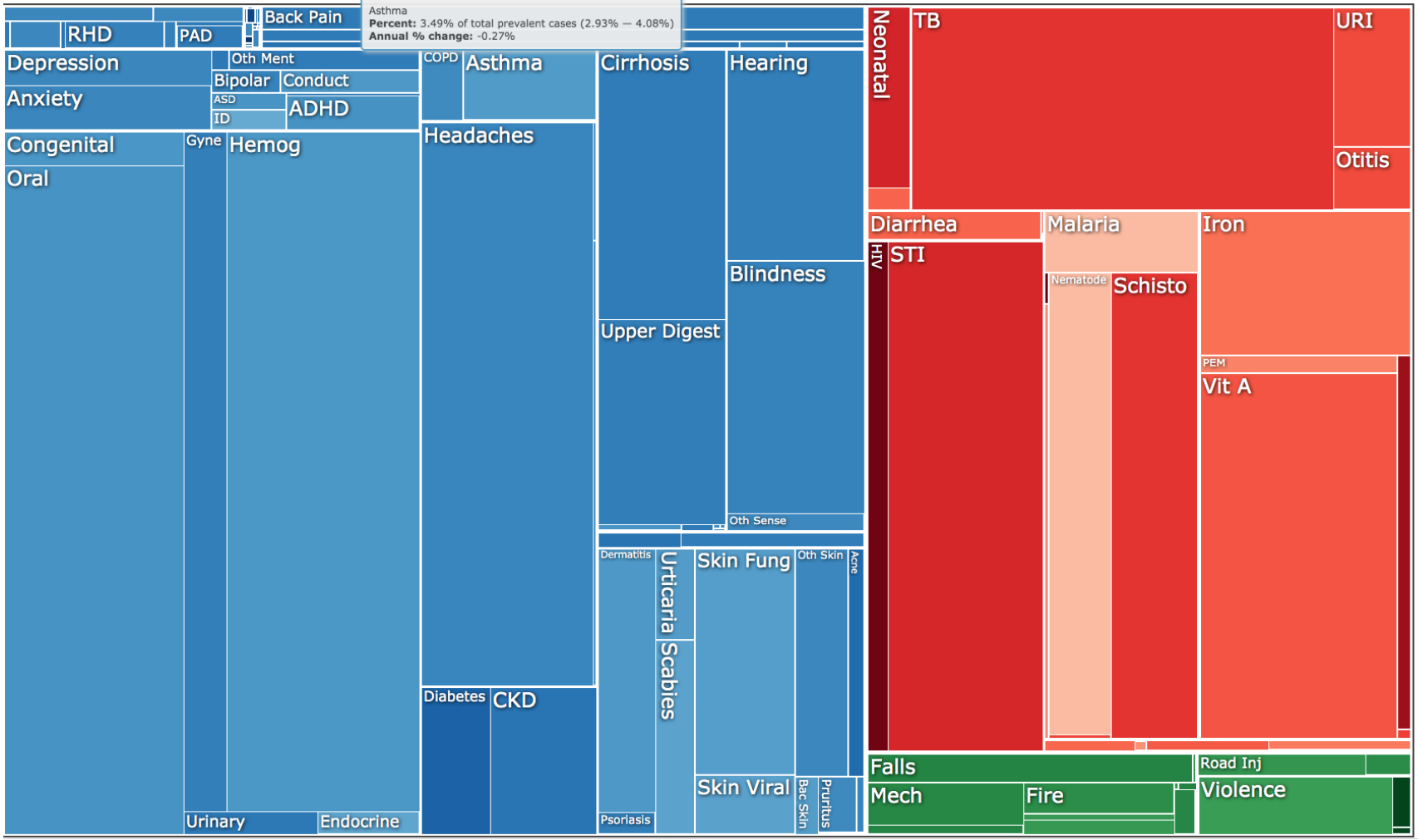



Breathing and feeling well through universal access to right care

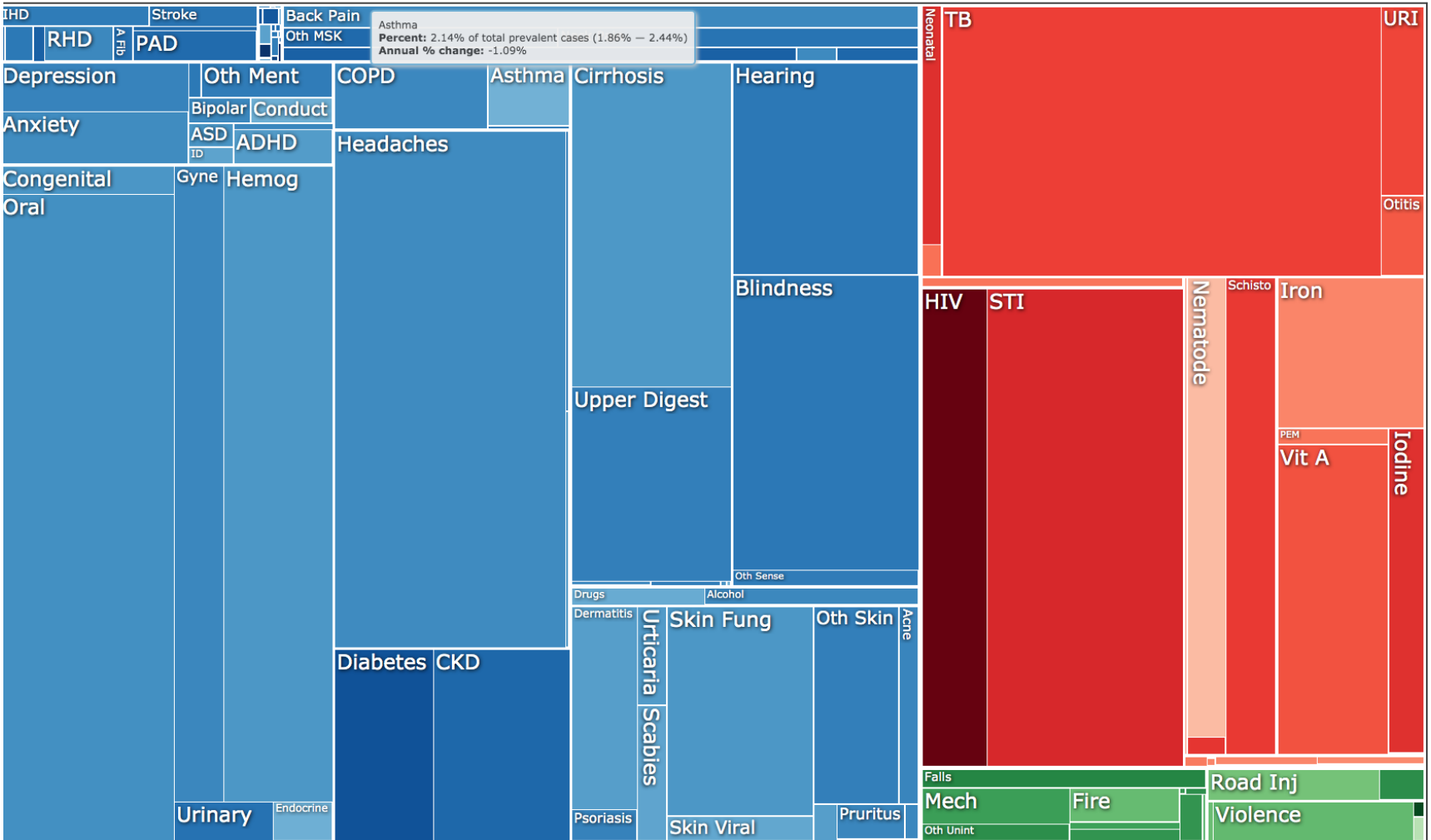
Agenda

Time	Activity	Leader
1700-1710	Welcome Introductions to those on the call Poll questions 1-7	Darush Attar-Zadeh
1710-1725	Introduction to IPCRG and Asthma Right Care and hopes for long term relationship with African countries [short presentation]	Noel Baxter
1725-1730	Introduction to the faculty: How they connected through Asthma Right Care, and where they work now	Darush Attar-Zadeh
1730 – 1800 Guided conversation between the faculty and the participants about what generally happens, and since announcement of pandemic of COVID-19, sharing experiences and stories		Facilitated by Darush Attar-Zadeh
1800-1825	COVID-19 and Asthma	Faculty
1825-1840	Good Lung Health in Preparation for Fighting COVID-19	Faculty
1840-1850	Identifying and Treating Tobacco Dependence	Noel Baxter & Darush Attar-Zadeh
1850-1855	Commitment to action: Sharing Resources Poll Questions	
1855-1900	Closing words	Darush Attar-Zadeh & Noel Baxter

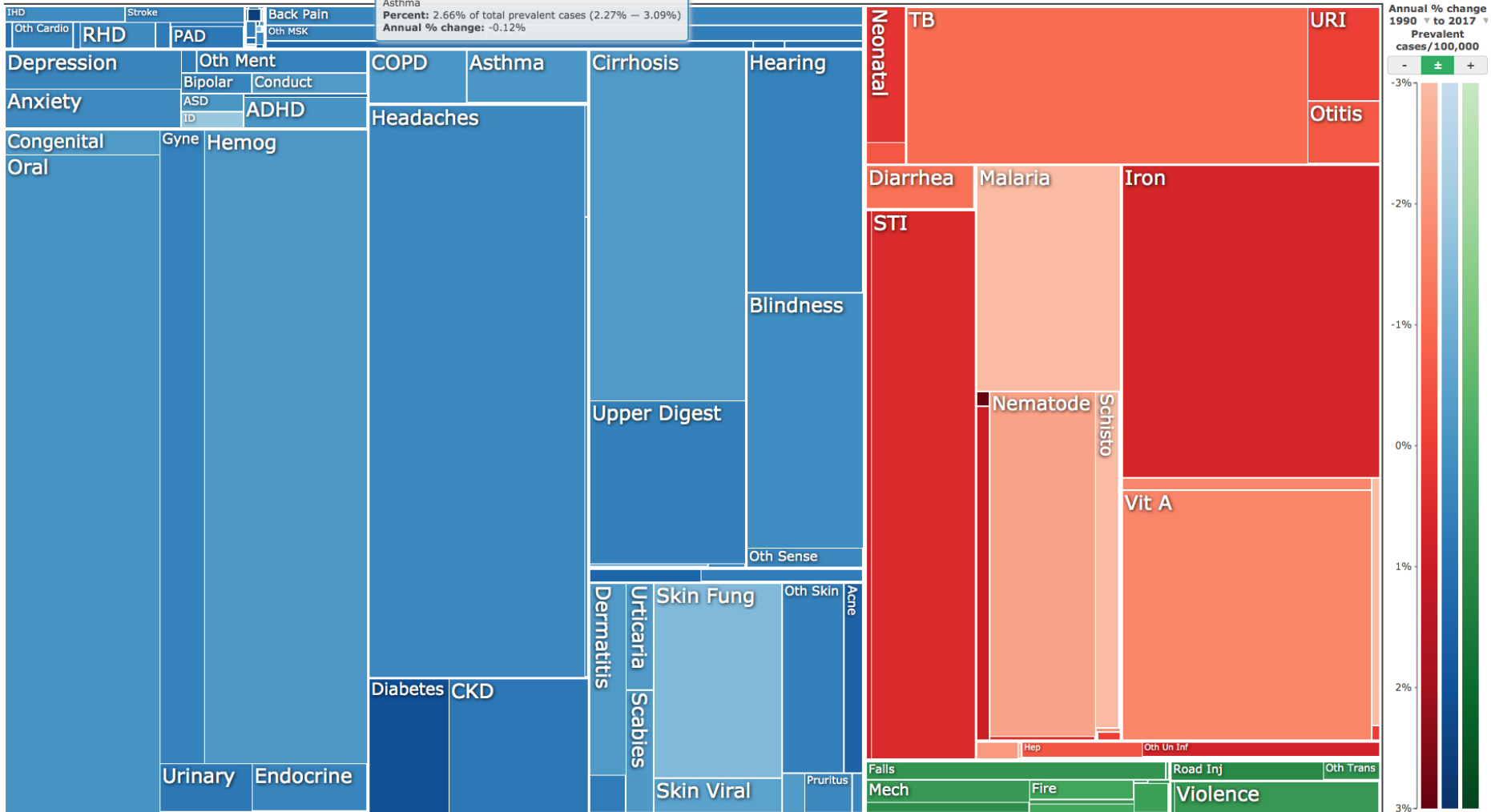
Kenya
Both sexes, All ages, 2017, Prevalent cases



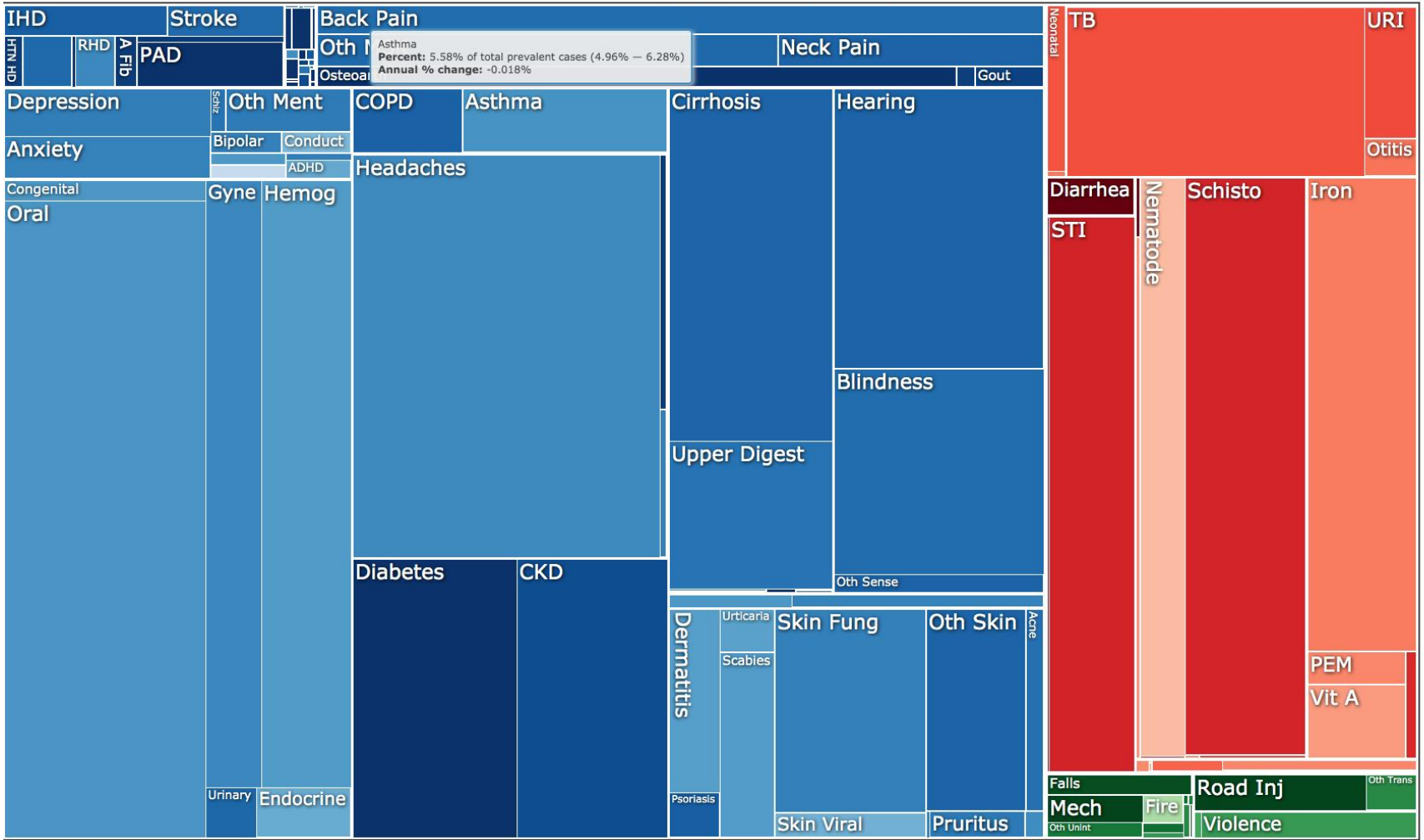
South Africa
Both sexes, All ages, 2017, Prevalent cases



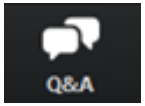
Ghana
Both sexes | All ages, 2017, Prevalent cases



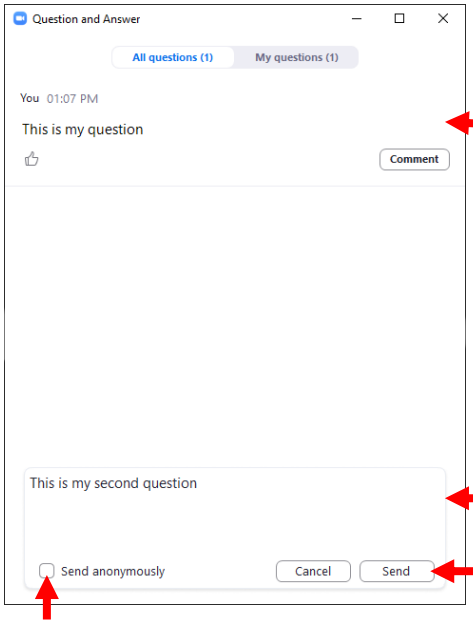
Mauritius
Both sexes, All ages, 2017, Prevalent cases



How to ask a question



Select the Q&A option from the webinar menu found at the bottom of your zoom window



Your submitted questions will appear here

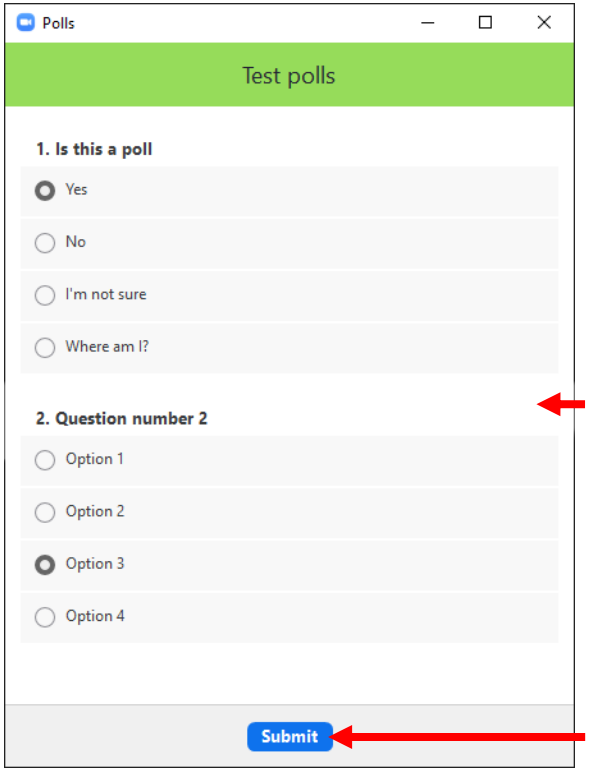
Type your question here

Press send to submit your question

Use this check box to ask a question anonymously

- Your questions will be answered live by the panellists during the Q&A sections of each presentation
- You can comment on other questions by selecting the comment button Comment
- You can upvote questions using the thumbs up icon

But first, we'd like you to complete a few questions..



Select your responses

Press the submit button to complete the survey

Today's Faculty

Darush Attar-Zadeh (UK)
Prescribing respiratory pharmacist, behaviour change specialist who works in the community and GP practices in North Central London.

Noel Baxter (UK)
GP in Edinburgh, Policy Lead of the Primary Care Respiratory Society in the UK, Board Director IPCRG.

Garry McDonald (UK)
Respiratory pharmacist, currently working at University Hospital Crosshouse, Kilmarnock, Scotland "The home of Johnnie Walker Whisky." PCRS Clinical Leadership Faculty Pharmacist. Worked UK wide in Primary and Secondary healthcare.

Ema Paulino (Portugal)
From October 2017 until June 2018, Interim CEO, International Pharmaceutical Federation. From 2011 until November 2018, Director, Projects and Services Department, *Farmácias Holon*. Since 2002, Pharmacist-in-charge and owner, *Nuno Álvares* Pharmacy in Almada, Portugal. Currently, she is General Manager and Scientific Coordinator at Ezfy.

Cláudia Vicente (Portugal)
Cláudia Almeida Vicente is a Family Physician at USF Araceti - ACES Baixo Mondego and has a special interest in the respiratory area, being part of the GRESP Group - Respiratory Group of APMGF (Association of General and Family Medicine) since 2013. Claudia develops activities in continuing medical education, being a training supervisor and collaborating as a tutor for the Faculty of Medicine of Coimbra for national students and exchange projects.

Siân Williams (UK)
Chief Executive Officer, IPCRG

We are the only

- Global primary care respiratory group
- Representative of primary care on WHO-Global Alliance against chronic Respiratory Diseases (GARD)
- Respiratory Group in collaborative relations with WONCA World
- Respiratory Special Interest Group of WONCA Europe
- And we have top 3 primary care journal (open access) npjPCRM published by Springer Nature

International Primary Care Respiratory Group
IPCRG work locally collaborate globally

Our vision

Breathing and feeling well through universal access to right care

through primary care

Lancet definition

UNIVERSAL ACCESS: We believe primary care must include essential quality respiratory services because they all add value:

"Primary care is associated with a more equitable distribution of health in populations." (Starfield)

- Tobacco dependence treatment
- Vaccination: flu, pneumococcal, TB
- Maternal healthcare and information about smoke and dust exposure
- Diagnosis of respiratory symptoms
- Treatment and/or referral of acute problems:
  - Pneumonia, respiratory failure
- Management and treatment of:
  - TB
  - Asthma
  - COPD
  - Allergic rhinitis
- Diagnosis and management of multi-morbidity
- Palliative care
- End of life care

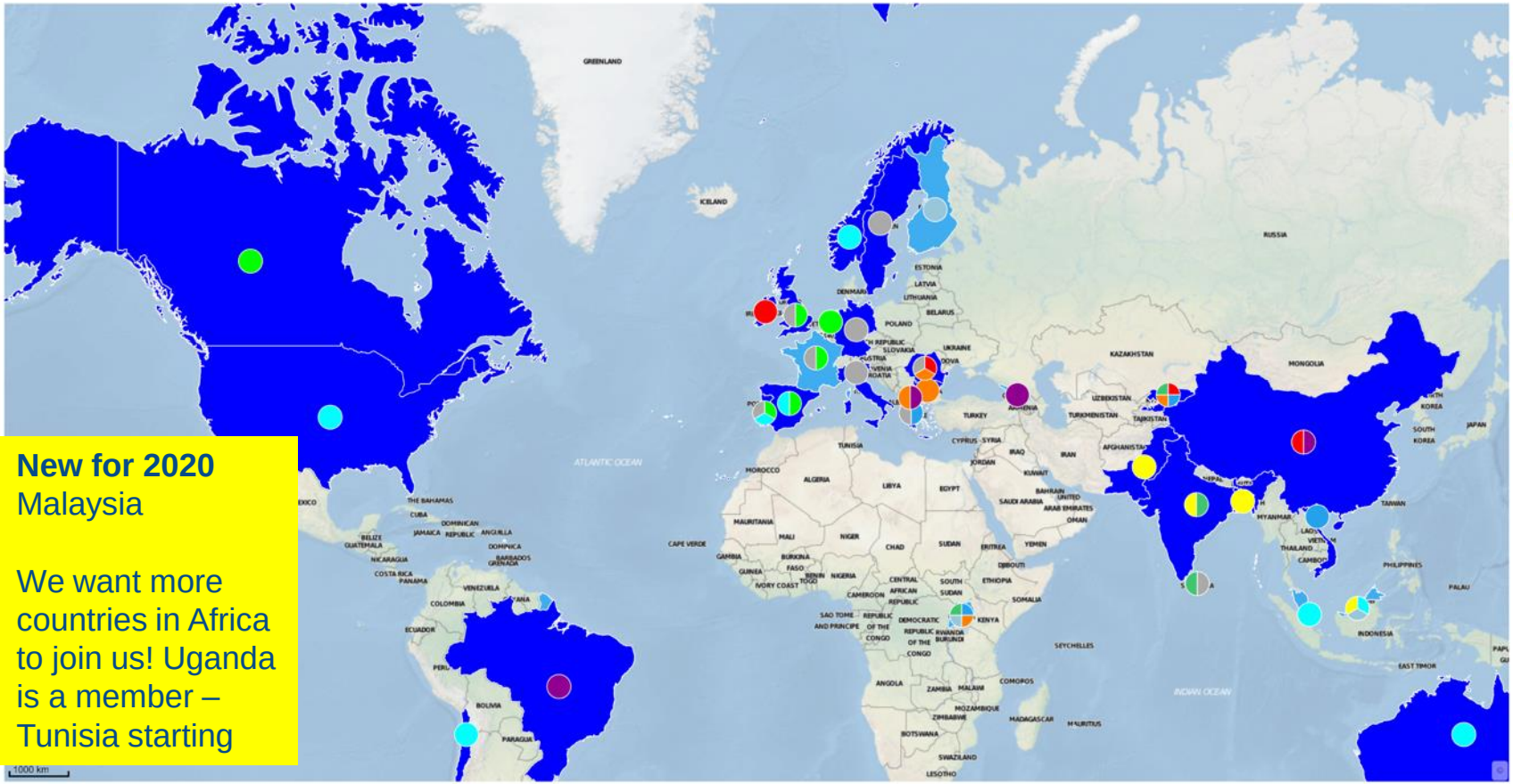
Right Care. (Lancet Series 2017)

"With the focus firmly on universal health coverage as a central part to the UN Sustainable Development Goals, there is an opportunity to examine how to achieve optimum access to, and delivery of, healthcare and services.

Underuse and overuse of medical and health services exist side-by-side with poor outcomes for health and wellbeing.

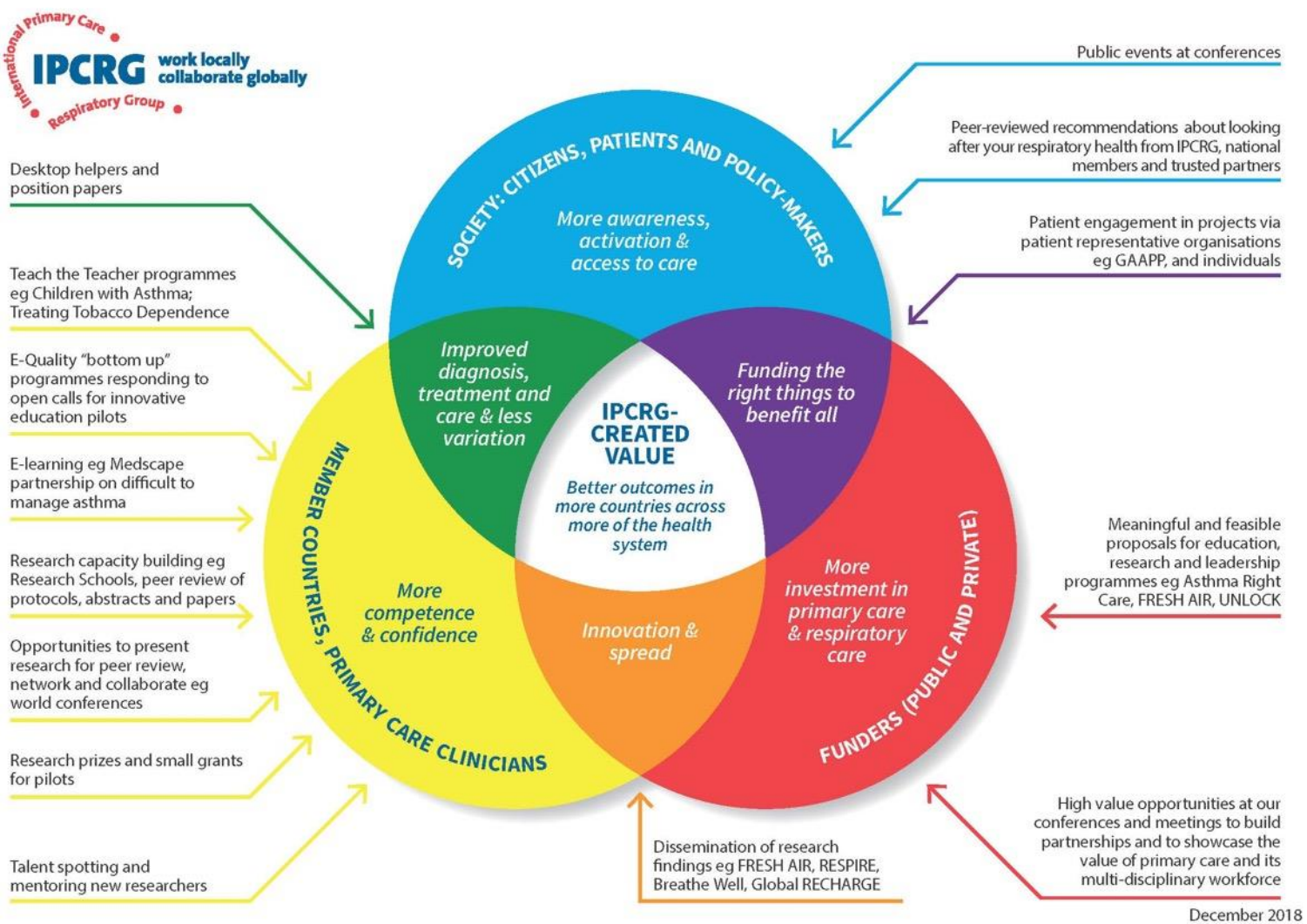
This Series ….provides a framework to begin to address overuse and underuse together to achieve the right care for health and wellbeing… achieving the right care is both an urgent task and an enormous opportunity."

We reach 150,000 primary care colleagues through our 34 country members



New for 2020
Malaysia

We want more countries in Africa to join us! Uganda is a member – Tunisia starting



Current projects

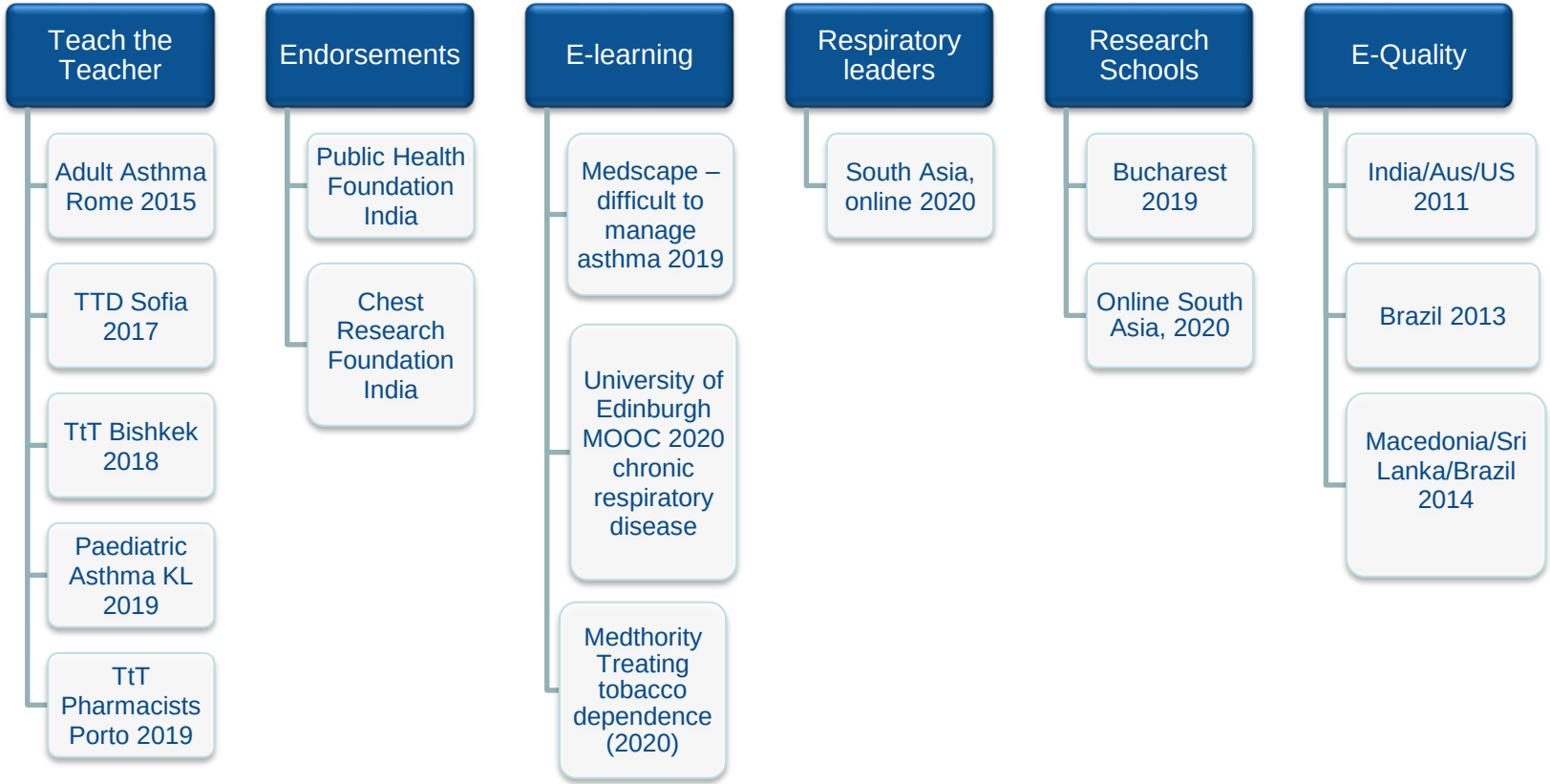
- Asthma Right Care Teach the Teacher for Pharmacists
- Children with Asthma Teach the Teacher (4 countries)
- 3 global health research programmes in 12 LMICs
- 2 e-learning programmes
- Research needs prioritization
- Supporting new groups in Tunisia,
- Webinars to replace 10th world Conference in Dublin and 1st China conference

IPCRG Education Strategy

- Stimulating debate on the most effective educational methods and evaluation
- Building capacity and capability—nationally or regionally—by testing locally acceptable programmes
- Sharing best practice in primary care and practical experience of respiratory programmes
- Evaluating the results of our efforts using improvement science methods

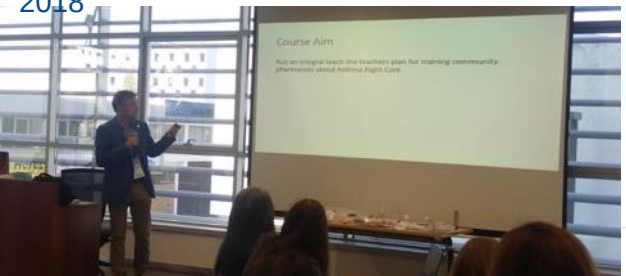
Building capacity to improve respiratory care: the education strategy of the International Primary Care Respiratory Group 2014–2020
npj Primary Care Respiratory Medicine **volume 24**, Article number: 14072 (2014).

Track Record



Tier 1 Children with Asthma KL 2019

Tier 2 Treat tobacco dependence, Bulgaria 2018



Tier 1 Pharmacist Asthma Right Care Porto 2019

A 'cascade approach'

International Primary Care Respiratory Group IPCRG TEACH THE TEACHER ©

International masterclass brings together IPCRG international master faculty and national master teachers to develop master curriculum and 4 adapted to country need; pre-work essential to review existing materials

Children with asthma content

- **Tier 1**
- 4-5 master teachers per country

National Primary Care teaching network of national teachers developed through national teach the teacher workshop

- **Tier 2**
- Network of 15 – 20 teachers per country

Regional meetings for Primary care clinicians

- **Tier 3**
- 250+ primary care clinicians per country [numbers depend on number of roll-out interventions]

IPCRG Teach the Teacher Master Faculty

Reaching patient population

Ave. no. of children (ages to be defined) per GP/FP
Estimate of children with asthma
Potential no. of children benefitting per year
eg In UK 0-12s are about 12% of GP list
12%* registered list of 1500 = 180
180 children * 250 HCPs = potential reach of 45,000 children aged 0-12
Assume asthma prevalence of 10% = 4,500 children with asthma reached by one iteration of the programme

Asthma Right Care

The problem we're trying to solve

Every system is perfectly designed to get the results it gets

(*Earl Conway and Paul Batalden)*

That is, both intended and unintended consequences are designed into our systems

Asthma ticks the boxes of things that are ***wrong*** with healthcare systems globally: (and so does COPD)

1. Unwarranted variation (not due to disease difference)
2. Harm
3. Failure to prevent disease and disability
4. Waste of human and physical resources through low value activity
5. Inequity

(5 global problems: Prof Muir Gray)

O'Byrne PM, Jenkins C, Bateman ED. The paradoxes of asthma management: time for a new approach? Eur Respir J 2017; 50: 1701103

Our case for change

It is time to refocus attention on asthma because the total burden of disease in terms of quality of life is high yet avoidable and there is significant unwarranted variation and waste.

Only ≅ 40% of people take their prescribed treatment

Of whom only ≅ 30% then use it right

So only ≅12% are taking the right treatment right

Therefore the value of investment is severely compromised.

BTS/SIGN Asthma 2016
Chrystyn, H., et al. (2017). "Device errors in asthma and COPD: systematic literature review and meta-analysis." NPJ Prim Care Respir Med 27(1): 22

Inhaler errors are outrageously common

Patients

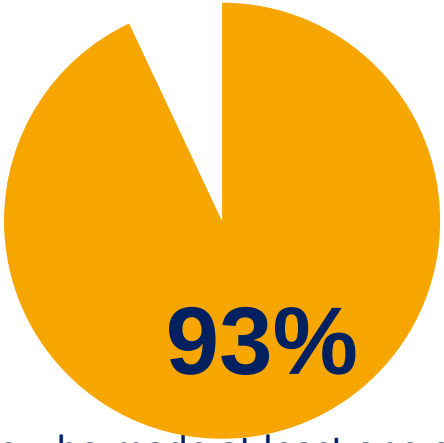
pMDI:
86.8%

DPI:
60.9%

pMDI + spacer:
52.0%

Overall percentage of patients with at least one error, according to systematic review[1]

Healthcare professionals (HCPs)



HCPs who made at least one error in the seven steps of using a pMDI[2]

pMDI: pressurised metred-dose inhaler; DPI: dry powder inhaler.

1. Chrystyn H, et al. *npj Prim Care Respir Med.* 2017;27:22; 2. Baverstock M, et al. *Thorax.* 2010;65:117–118

Change for improvement starts with ‘hunches’

SABA USE IN ASTHMA NEEDS MAJOR IMPROVEMENT

- Over-reliance needs defining
- Not “use” but “reliance” = type of *dependency*

ASTHMA IS LOW PRIORITY FOR CHANGE

This is despite:

- Unwarranted variation in outcomes
- Avoidable mortality, morbidity and HCU
- Substantial investment in education over time

FIRST SABA CONVERSATIONS AFFECT FUTURE USE

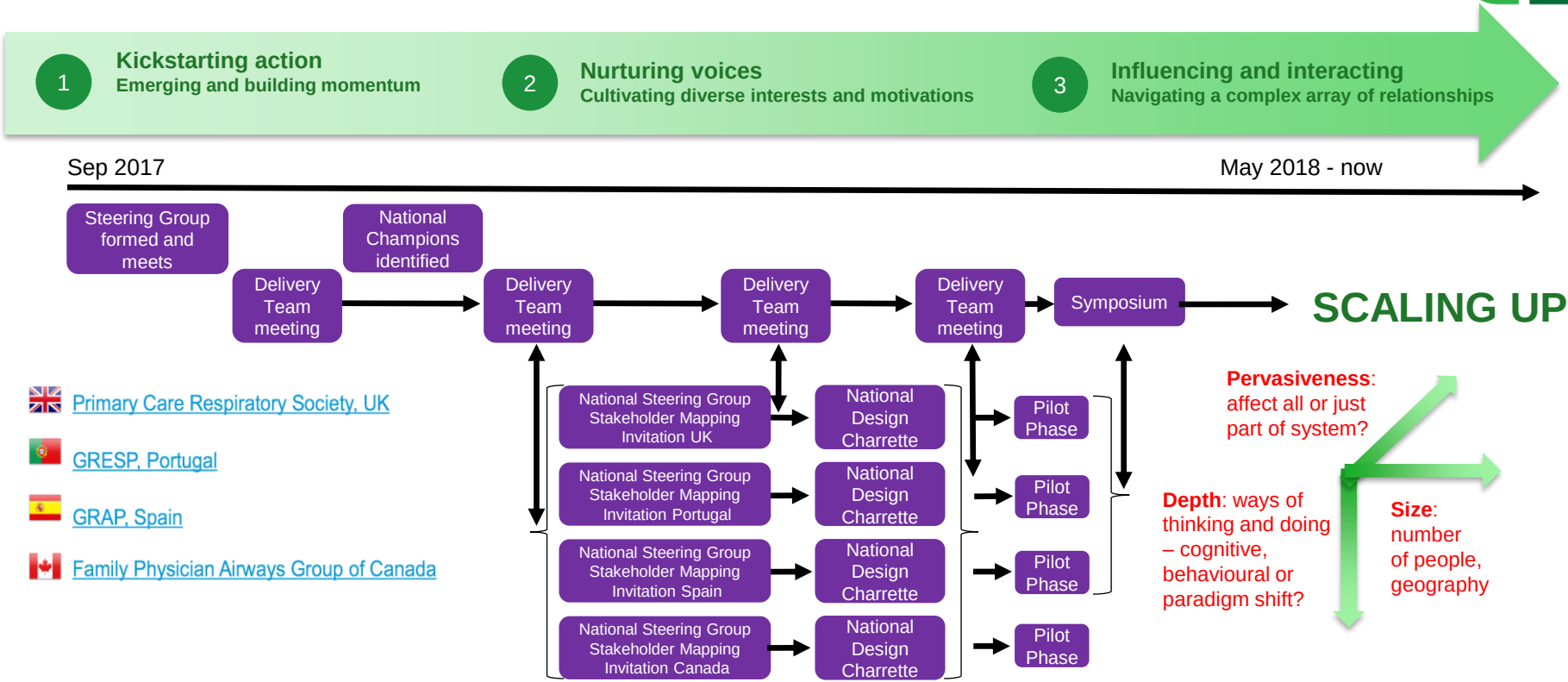
- Occur in many settings (pharmacies, EDs, GP/FP)
- Need to understand these conversations

HCPS NEED TO WANT CHANGE

- Messages about asthma improvement will only be received and adopted once HCPs desire change

- ☐ **Apply the evidence about achieving change at scale**
- ☐ **Disrupt comfort with the current state!**
- ☐ **Gain acceptance of room for improvement**
- ☐ **Move on to addressing underuse of ICS**

Getting our social movement going



Nesta 2017. : https://media.nesta.org.uk/documents/we_change_the_world_report.pdf (accessed August 2019)

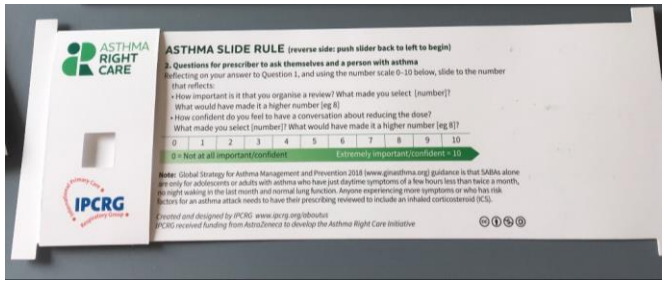
What is the best single measure for our aim of Asthma Right Care? Ultimately….

- A shift in the primary care office/practice average ratio of reliever:inhaled corticosteroid inhalers prescribed in a year for asthma
  - We believe the ideal ratio should be 1:6
  - Currently, the ratio is thought to be 2:1

- What do you think?

Prototype conversation pieces for discussion and co-creation in design charrettes

SABA Slide Rule: what happens now – raise discomfort



SABA Slide Rule – inspired by the Readiness Ruler

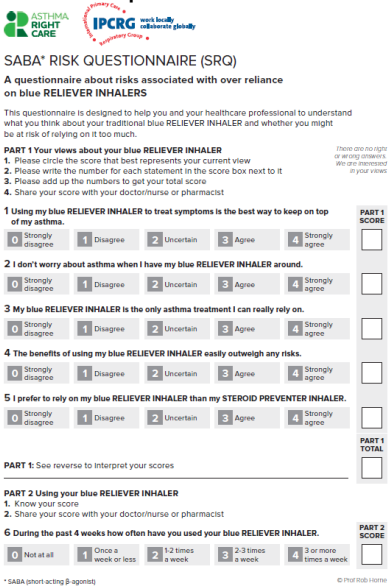
Ambition: embrace more people, more methods, bring joy to lives: let's have fun, while being challenging

Moyers TB, et al. J Consult Clin Psychol 2009;77:1113–1124

Reliever Reliance Test (RRT)

- Complements Asthma Slide Rule:
  - Slide Rule – identify **what** patient does with SABA
  - RRT – identifies **why**
- RRT helps patients and HCPs identify the (often hidden) beliefs driving over-reliance on SABA
- This can then form the basis for discussions to change the way that patients think about SABA relative to ICS and reduce over-reliance on SABA
- RRT is derived from the Beliefs about Medicines Questionnaire, extensively validated and applied in asthma[1-3]

Patient self-completes RRT



ASTHMA RIGHT CARE

IPCRG work locally collaborate globally

SABA* RISK QUESTIONNAIRE (SRQ)

A questionnaire about risks associated with over reliance on blue RELIEVER INHALERS

This questionnaire is designed to help you and your healthcare professional to understand what you think about your traditional blue RELIEVER INHALER and whether you might be at risk of relying on it too much.

PART 1 Your views about your blue RELIEVER INHALER

there are no right or wrong answers. We are interested in your views

1. Please circle the score that best represents your current view
2. Please write the number for each statement in the score box next to it
3. Please add up the numbers to get your total score
4. Share your score with your doctor/nurse or pharmacist

1 Using my blue RELIEVER INHALER to treat symptoms is the best way to keep on top of my asthma.	0 Strongly disagree	1 Disagree	2 Uncertain	3 Agree	4 Strongly agree
2 I don't worry about asthma when I have my blue RELIEVER INHALER around.	0 Strongly disagree	1 Disagree	2 Uncertain	3 Agree	4 Strongly agree
3 My blue RELIEVER INHALER is the only asthma treatment I can really rely on.	0 Strongly disagree	1 Disagree	2 Uncertain	3 Agree	4 Strongly agree
4 The benefits of using my blue RELIEVER INHALER easily outweigh any risks.	0 Strongly disagree	1 Disagree	2 Uncertain	3 Agree	4 Strongly agree
5 I prefer to rely on my blue RELIEVER INHALER than my STEROID PREVENTER INHALER.	0 Strongly disagree	1 Disagree	2 Uncertain	3 Agree	4 Strongly agree

PART 1 SCORE

PART 1 TOTAL

PART 1: See reverse to interpret your scores

PART 2 Using your blue RELIEVER INHALER

1. Know your score
2. Share your score with your doctor/nurse or pharmacist

6 During the past 4 weeks how often have you used your blue RELIEVER INHALER.	0 Not at all	1 Once a week or less	2 1-2 times a week	3 2-3 times a week	4 3 or more times a week

PART 2 SCORE

* SABA (short-acting β-agonist)

© Prof Rob Horne

Feedback information for patients on reverse of RRT

PART 2: If you score 3 or more you may be using too much of your blue RELIEVER INHALER.[1,2] The higher the score the greater the risk of experiencing preventable asthma symptoms and attacks. Talk to your doctor as there may be better ways of managing your asthma.

How can this questionnaire help me?

Many people tend to rely too much on their blue RELIEVER INHALER.[3,4] It's easy to see why, as it usually makes you feel better, often as soon as you take it. People often see it as the most important part of their treatment. This over-reliance may be a problem as the blue RELIEVER INHALER can have both 'good' and 'not-so-good' effects.

The 'good' effects are that it can feel as if the asthma symptoms are improving quickly.

The 'not-so-good' effects are that by relying on the blue RELIEVER INHALER too much, some people don't use their PREVENTER INHALER (which usually contains a medical steroid) as prescribed. This means they might be dealing with the symptoms but not helping to manage the root cause of their asthma attacks.

What does my score mean?

18 - 25	**High risk of over-reliance on your blue RELIEVER INHALER.** You seem to be using your blue RELIEVER INHALER a lot. This could be putting you at risk of preventable asthma symptoms and attacks. Talk to your doctor/nurse about how to get the best from your asthma treatments.
11 - 17	**Medium risk of over-reliance on your blue RELIEVER INHALER.** Your blue RELIEVER INHALER is important to you, but you could be relying on it a bit too much and not getting the best from your asthma treatments. Talk to your doctor/nurse to check that you are getting the best from your asthma treatments.
Less than 10	**Low risk of over-reliance on your blue RELIEVER INHALER.** This is reassuring.

What should I do now?

Talking to your doctor/nurse about your score may help you to get the best from your asthma treatments and to better manage your asthma in the long-term.

NOTE: Guidelines apply a pragmatic threshold to define uncontrolled (NICE 2017)[1] or partially controlled/ uncontrolled (GINA 2019)[2] asthma as using the reliever for symptomatic relief three or more days/times a week. **The SRQ questionnaire is adapted from the validated and globally used Beliefs about Medicines Questionnaire[5] (BMQ), created and designed by leading behavioural medicine expert Professor Rob Horne.** IPCRG received funding from AstraZeneca to develop the Asthma Right Care Initiative. The production and distribution of the SRQ questionnaire has been supported by AstraZeneca UK Limited.

[1]NICE. Guideline [NG80]. Asthma: diagnosis, monitoring and chronic asthma management. November 2017. [2]Global Initiative for Asthma (GINA). Pocket Guide for asthma management and prevention (for adults and children older than 5 years). 2019. Available from: www.ginasthma.org (last accessed 08.05.19). [3]Price D, Fletcher M, van der Molen T. Asthma control and management in 8,000 European patients: the REcognise Asthma and LInk to Symptoms and Experience (REALISE) survey. *NPJ Prim Care Respir Med* 2014; 24:14009. [4]Partridge MR, van der Molen T, Myrseth SE, *et al*. Attitudes and actions of asthma patients on regular maintenance therapy: the INSPIRE study. *BMC Pulm Med* 2006; 6:13. [5]Horne R, Weinman J, Hankins M. The beliefs about Medicines Questionnaire: The development and evaluation of a new method for assessing the cognitive representation of medication. *Psychology & Health*. 1999; 14(1):1-24.

PromoMats ID 24.13.894
Date of preparation: May 2019
Expiration date: May 2021

© Prof Rob Horne

Horne R, et al. Psychol Health 1999;14:1–24; 2. Horne R, Weinman J. Psychol Health 2002;17:17–32; 3. Horne R, et al. PloS One 2013;8:e80633

Challenge cards

What does good asthma control look like?
What does bad asthma control look like?

Is there a general level of knowledge of what a SABA (rescue inhaler) for asthma actually does?

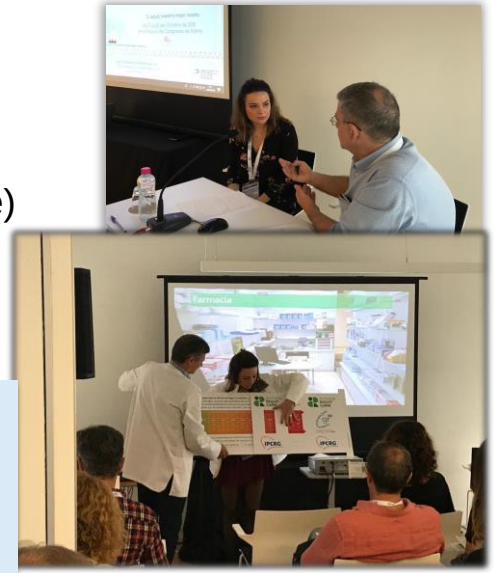
Does it help to explain that these work on the bronchoconstriction on the “outside” of the airway but not the inflammation and mucous on the “inside”?
(It helps to have 3D models for this).

What conversation do you have about asthma and SABA use?

Does that influence future thinking about SABAs?

Summary of the Asthma Right Care movement

- 10,000 frontline HCPs and global primary care leaders reached so far
- Now launching in Netherlands, Greece, France, Tunisia, Australia and Latin America
- 4 international and multiple national conferences attended
- Materials produced:
  - Asthma Right Care Slide Rule (English, Spanish and Portuguese)
  - Question Cards in different formats (English, Spanish and Portuguese)
  - Reliever Reliance Test (led by Rob Horne; IPCRG endorsed)
  - 5 teaching case studies
    (primary care, ED, etc)



- Mild asthma
- “Chest infection”
- Transition from child to adult
- Seen in ED, but not admitted
- Difficult to manage (moderate or severe?)

ED, emergency department; HCP, healthcare professional; SABA, short-acting beta$_2$-agonist

Key message

- The “rate limiting step” in most asthma pathways is the quality of the interaction with the pharmacist

THINKPHARMACY

PHARMACY
the Heart of our Community

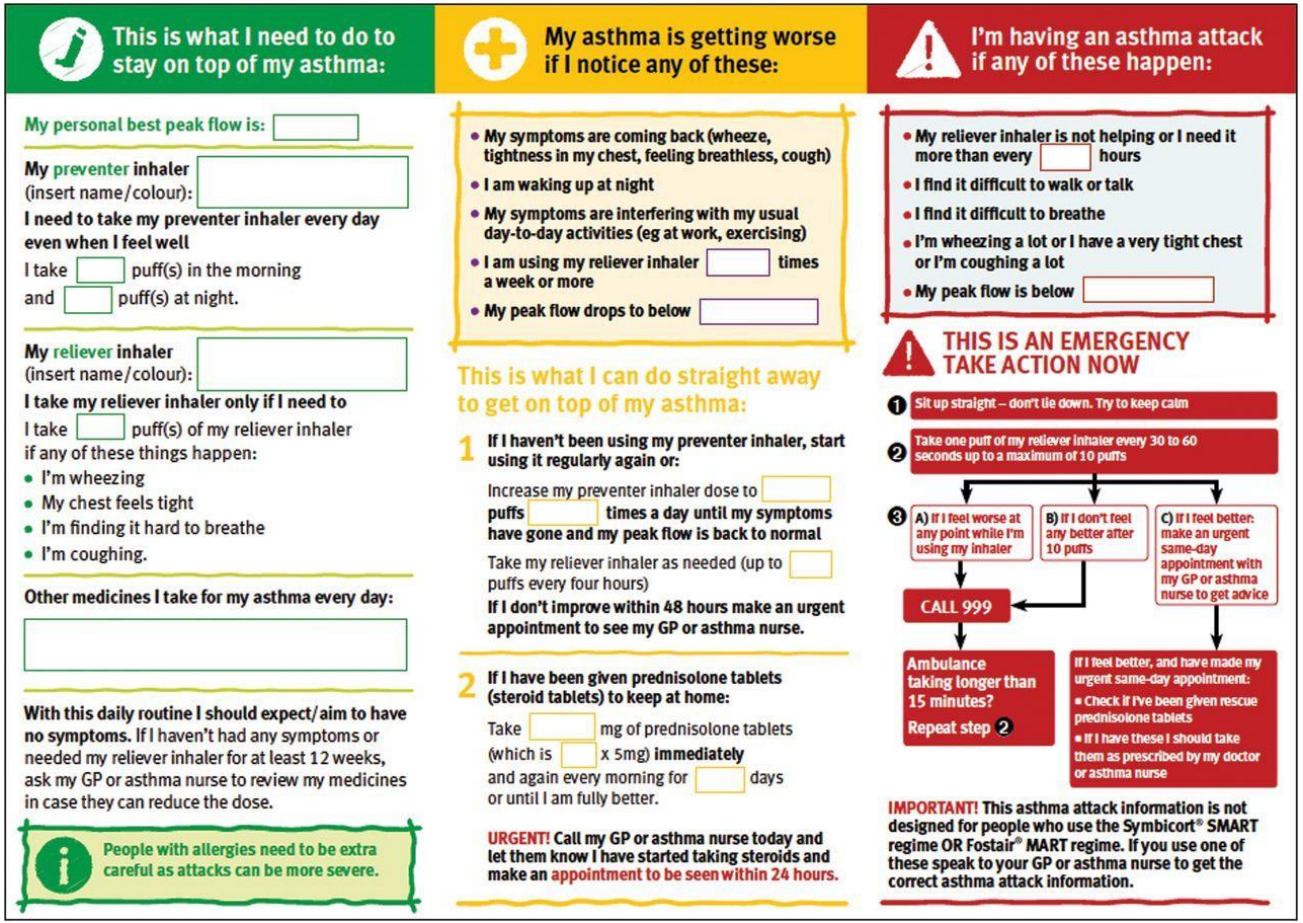
ASTHMA RIGHT CARE

INHALER TECHNIQUE SERVICE

Your health challenge

- Up to a third of people with asthma aren't using their inhaler in the right way[1]
- Using the wrong technique can mean patients are more likely to get side effects, such as oral thrush or a sore throat[1]
- People with asthma who are unable to use their inhaler correctly are at increased risk of poor asthma control, potentially resulting in an attack which may lead to the patient being hospitalised[2]

Education



This is what I need to do to stay on top of my asthma:

My personal best peak flow is: ____

My **preventer** inhaler (insert name/colour): ____

I need to take my preventer inhaler every day even when I feel well

I take ____ puff(s) in the morning and ____ puff(s) at night.

My **reliever** inhaler (insert name/colour): ____

I take my reliever inhaler only if I need to

I take ____ puff(s) of my reliever inhaler if any of these things happen:

- I'm wheezing
- My chest feels tight
- I'm finding it hard to breathe
- I'm coughing.

Other medicines I take for my asthma every day:

With this daily routine I should expect/aim to have no symptoms. If I haven't had any symptoms or needed my reliever inhaler for at least 12 weeks, ask my GP or asthma nurse to review my medicines in case they can reduce the dose.

People with allergies need to be extra careful as attacks can be more severe.

My asthma is getting worse if I notice any of these:

- **My symptoms are coming back (wheeze, tightness in my chest, feeling breathless, cough)**
- **I am waking up at night**
- **My symptoms are interfering with my usual day-to-day activities (eg at work, exercising)**
- **I am using my reliever inhaler ____ times a week or more**
- **My peak flow drops to below ____**

This is what I can do straight away to get on top of my asthma:

1 If I haven't been using my preventer inhaler, start using it regularly again or:

Increase my preventer inhaler dose to ____ **puffs** ____ **times a day until my symptoms have gone and my peak flow is back to normal**

Take my reliever inhaler as needed (up to ____ puffs every four hours)

If I don't improve within 48 hours make an urgent appointment to see my GP or asthma nurse.

2 If I have been given prednisolone tablets (steroid tablets) to keep at home:

Take ____ mg of prednisolone tablets (which is ____ x 5mg) **immediately** and again every morning for ____ days or until I am fully better.

URGENT! Call my GP or asthma nurse today and let them know I have started taking steroids and make an appointment to be seen within 24 hours.

I'm having an asthma attack if any of these happen:

- **My reliever inhaler is not helping or I need it more than every ____ hours**
- **I find it difficult to walk or talk**
- **I find it difficult to breathe**
- **I'm wheezing a lot or I have a very tight chest or I'm coughing a lot**
- **My peak flow is below ____**

THIS IS AN EMERGENCY TAKE ACTION NOW

1. Sit up straight – don't lie down. Try to keep calm
2. Take one puff of my reliever inhaler every 30 to 60 seconds up to a maximum of 10 puffs
3. A) If I feel worse at any point while I'm using my inhaler → CALL 999
   B) If I don't feel any better after 10 puffs → CALL 999
   C) If I feel better: make an urgent same-day appointment with my GP or asthma nurse to get advice

Ambulance taking longer than 15 minutes? Repeat step 2

If I feel better, and have made my urgent same-day appointment:

- Check if I've been given rescue prednisolone tablets
- If I have these I should take them as prescribed by my doctor or asthma nurse

IMPORTANT! This asthma attack information is not designed for people who use the Symbicort® SMART regime OR Fostair® MART regime. If you use one of these speak to your GP or asthma nurse to get the correct asthma attack information.

Hilary Pinnock. Supported self-management for asthma. Breathe (Sheff). 2015 Jun; 11(2): 98–109.
doi: 10.1183/20734735.015614 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4487370/pdf/EDU-0156-2014.pdf

Introduction to the Faculty

Darush Attar-Zadeh is a prescribing respiratory pharmacist, behaviour change specialist who works in the community and GP practices in North Central London. He got to know some of the Asthma Right Care team through his international work around treating tobacco dependence.

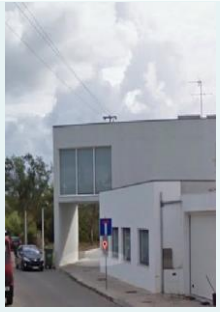
Noel Baxter was an early “first follower” of Asthma Right Care. Sian had already started questioning why we weren’t getting change in asthma despite so much education! Noel joined a group that included a pharmacist and respiratory physician colleague and started to talk about doing things differently. Sian showed them the first prototype of the slide rule. It's all taken off from there really quickly.

Garry McDonald
Garry first met Darush at a CPD evening meeting in London in 2012, and was impressed with his inhaler technique session. He was introduced to The Primary Care Respiratory Society by Noel at a Primary Care Respiratory Academy Roadshow in Glasgow and joined that year. As PCRS chair at the time, Noel introduced Garry to Sian, IPCRG and the Asthma Right Care family for the launch of ARC in Portugal 2018.

Introduction to the Faculty

Ema Paulino is a community pharmacist who practices in her own pharmacy, located in a town on the other side of the river from Lisbon, Portugal. She got connected to Asthma Right Care through an invitation based on the work she is doing to engage community pharmacists in her country in services that promote treatment effectiveness and safety.

Cláudia Vicente a GRESP member who is an IPCRG member. Prof Jaime, a portuguese GP and a GRESP founder introduced ARC to the group. She immediately was interested in the program because of the burden of Asthma and the multidisciplinary approach. She became one of the project responsables in her country; a big challenge in the last 3 years. Connecting with other health care professionals, with patients and families and with the international group always with the focus of improving asthma control and people´s health are our major concerns.



Siân Williams is CEO of the IPCRG and came up with the social movement approach following a conversation with an AstraZeneca colleague who said "education doesn't work"! She therefore reviewed the evidence about social movements, and the Right Care concept and proposed Asthma Right Care to IPCRG colleagues who have then built on it in amazing imaginative ways, bring joy to work and to a really important public health problem.