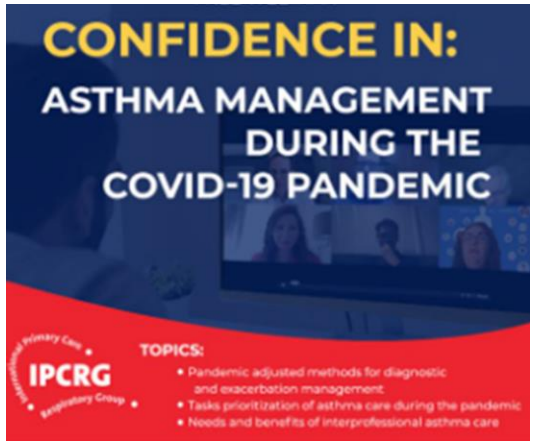
1st IPCRG *Confidence In* Webinar & Abstract Presentations



Presentation 1

Making an Asthma Diagnosis – Anders Østrem, Oslo, Norway

My context:

- GP in Oslo since 1989. Medical centre with 4 GPs, 2 nurses and 3 health secretaries, part of PHT pilot.
- Chronic care not well managed, few pulmonary patients are reviewed annually.
- Public health care system, patient lists average 1050 patients per GP. Fee for service, capitation fee and small patient payment.
- Norway`s Covid-19 figures: Total 31 500 cases, 120 hospital and 305 deaths.
- Minister of health in charge:
  - Directorate of health and Norwegian institute of public health - advisors.
  - “Government Pension Fund Global” = Oil fund =1 trillion $ value.

Covid-19 and asthma diagnosis.

- Normally we see patients in the office.
  - History
  - Physical examination
  - Tests
  - = diagnosis.

- Covid-19 pandemic gives us several challenges:
  - Not possible to have patients in the office.
  - Some of the procedures may increase risk of transmitting the virus.
  - Some of the features of Covid-19 infection can mimic asthma, both language and cultural differences may cause misunderstandings.

What do we known about asthma?

- Asthma is a common and potentially serious chronic disease that can be controlled but not cured

- Asthma causes symptoms such as
  - Wheezing
  - Shortness of breath
  - Chest tightness
  - Cough

Vary over time in their occurrence, frequency and intensity

- Symptoms are associated with variable expiratory airflow,
  - Bronchoconstriction (airway narrowing)
  - Airway wall thickening
  - Increased mucus

- Symptoms may be triggered or worsened by factors such as viral infections, allergens, tobacco smoke, exercise and stress

Definition of asthma

Asthma is a heterogeneous disease, usually characterized by chronic airway inflammation.

It is defined by the history of respiratory symptoms such as wheeze, shortness of breath, chest tightness and cough that vary over time and in intensity, together with variable expiratory airflow limitation.

Diagnosis of asthma

- The diagnosis of asthma should be based on:
  - A history of characteristic symptom patterns
  - Evidence of variable airflow limitation, from bronchodilator reversibility testing or other tests

- Document evidence for the diagnosis in the patient's notes, preferably before starting controller treatment
  - It is often more difficult to confirm the diagnosis after treatment has been started

Diagnosis of asthma – symptoms

- *Increased* probability that symptoms are due to asthma if:
  - More than one type of symptom (wheeze, shortness of breath, cough, chest tightness)
  - Symptoms often worse at night or in the early morning
  - Symptoms vary over time and in intensity
  - Symptoms are triggered by viral infections, exercise, allergen exposure, changes in weather, laughter, irritants such as car exhaust fumes, smoke, or strong smells
  - Personal or family history of asthma.

- *Decreased* probability that symptoms are due to asthma if:
  - Isolated cough with no other respiratory symptoms
  - Chronic production of sputum
  - Shortness of breath associated with dizziness, light-headedness or peripheral tingling
  - Chest pain
  - Exercise-induced dyspnea with noisy inspiration (stridor)

Diagnosis of asthma – physical examination

- Physical examination in people with asthma
  - Often normal
  - The most frequent finding is wheezing on auscultation, especially on forced expiration

- Wheezing is also found in other conditions, for example:
  - Respiratory infections
  - COPD
  - Upper airway dysfunction
  - Endobronchial obstruction
  - Inhaled foreign body

- Wheezing may be absent during severe asthma exacerbations (‘silent chest’)

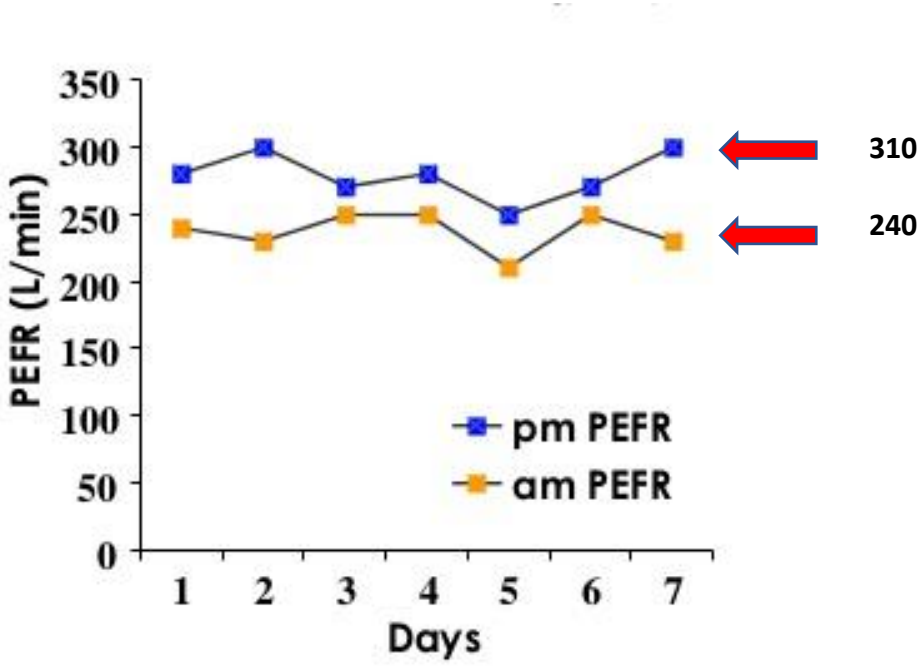
Diagnosis of asthma – variable airflow limitation

- Confirm presence of airflow limitation
  - Document that FEV_1/FVC is reduced
  - FEV_1/ FVC ratio is normally;
    - >0.75 – 0.80 in healthy adults
    - >0.90 in children

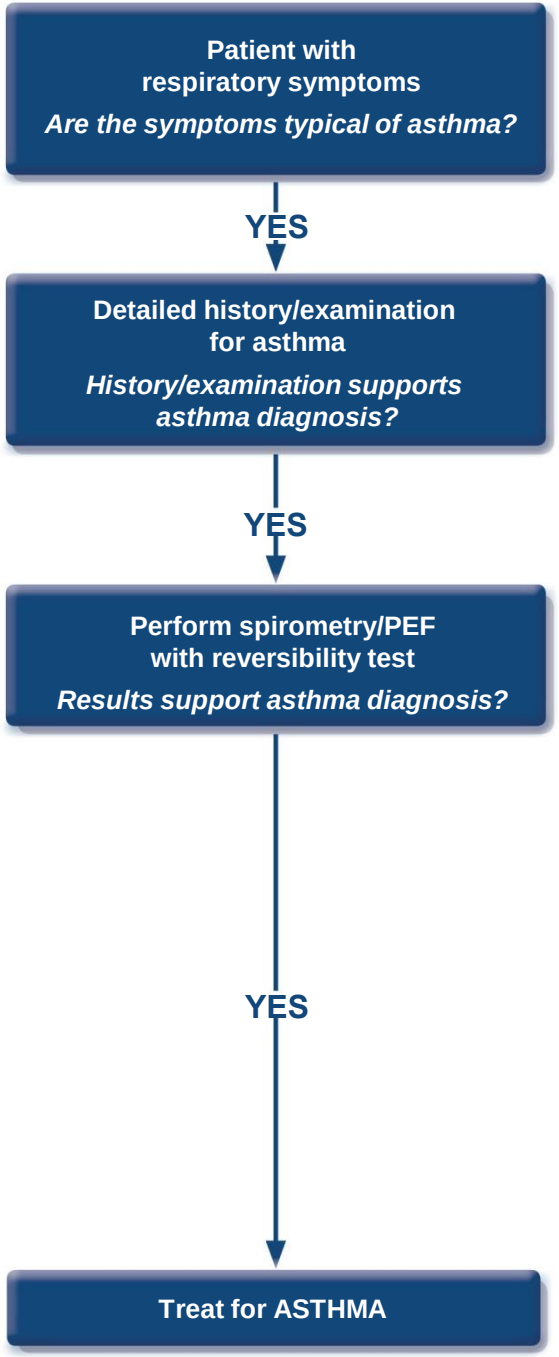
- Confirm that variation in lung function is greater than in healthy individuals:
  - Excessive bronchodilator reversibility
    - Adults: increase in FEV_1 >12% and >200mL
    - Children: increase >12% predicted
  - Excessive diurnal variability from 1-2 weeks' twice-daily PEF monitoring

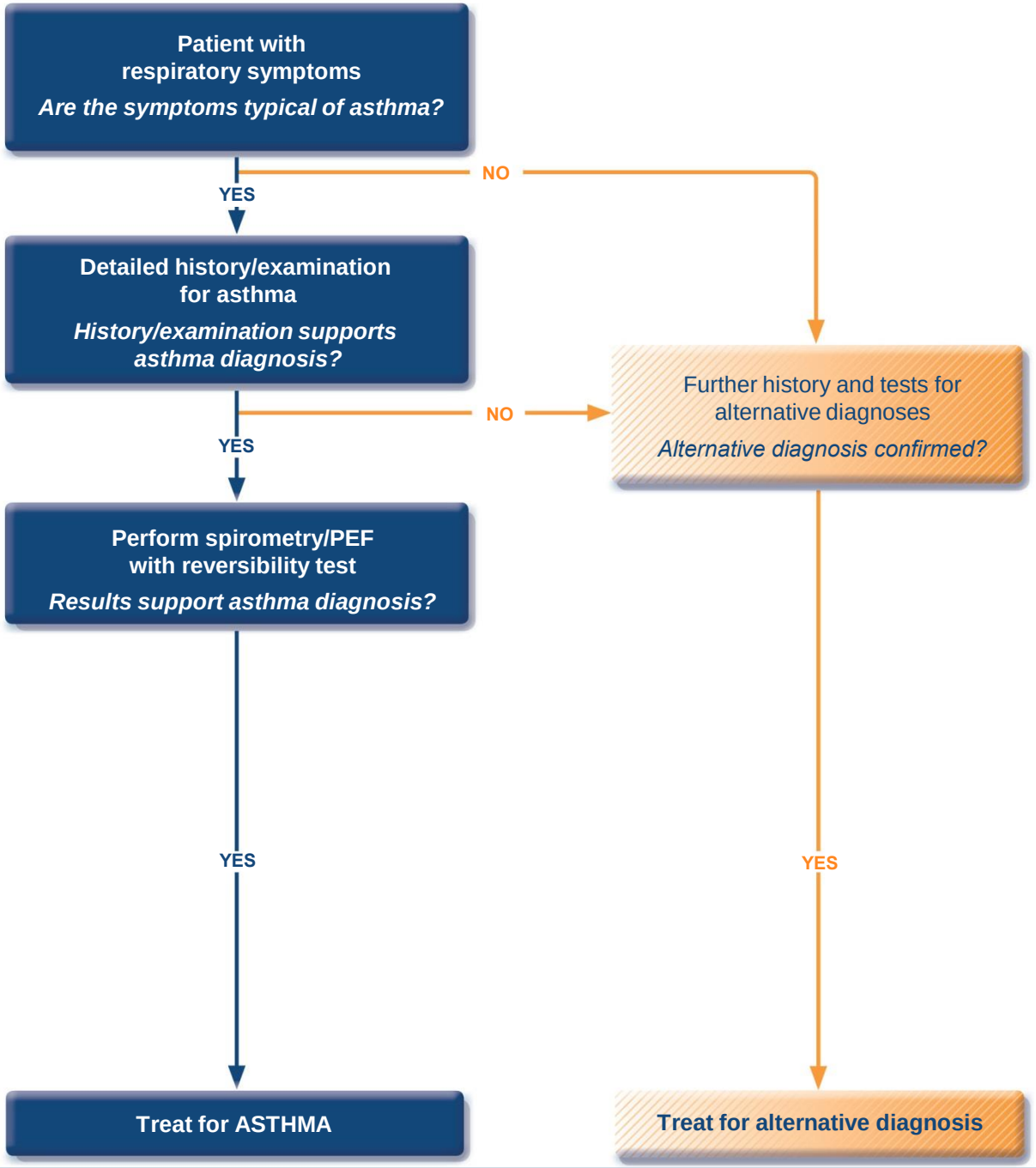
  - Significant increase in FEV_1 or PEF after 4 weeks of controller treatment

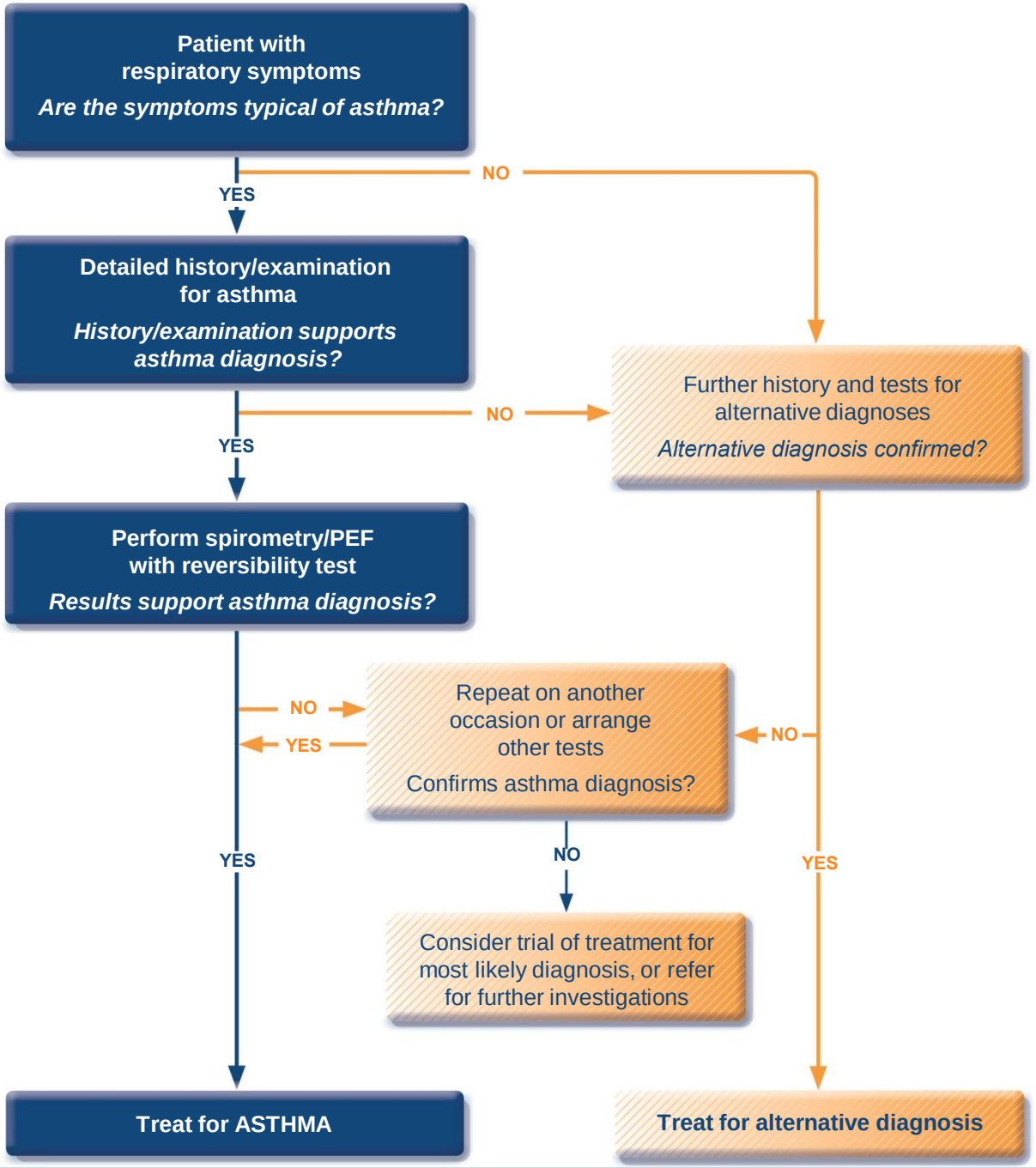
PEF variability

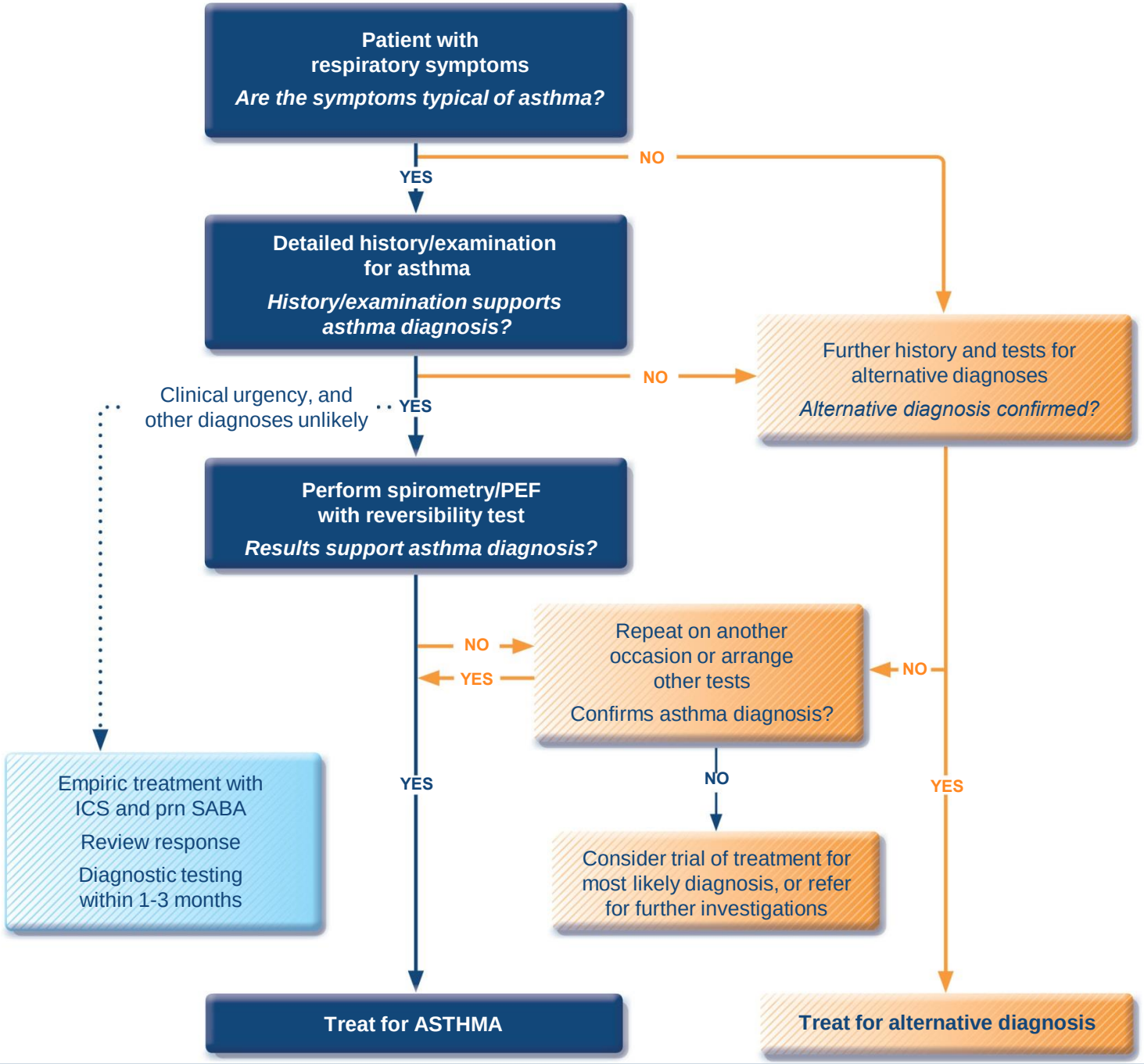


$$\textbf{PEF variability} = \frac{\text{Highest (310)} - \text{Lowest (240)}}{\text{Average (1/2 x 310+240)}} \times 100 = \textbf{25,5\%}$$





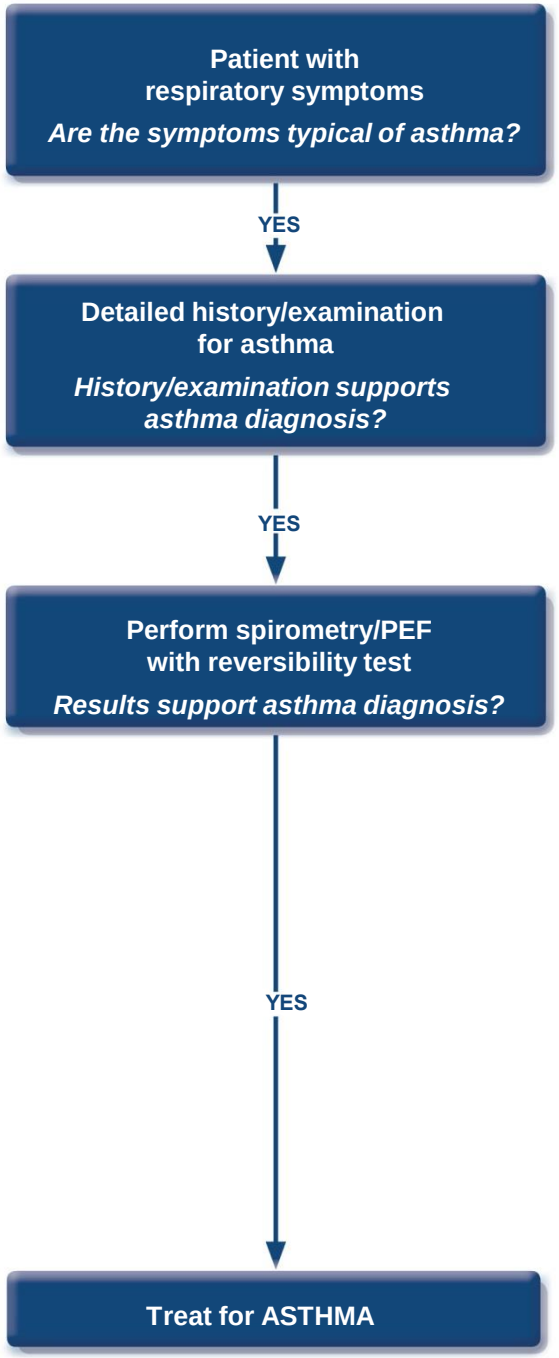




Challenge during the pandemic:

- Lock-down depending on the local/national status:
  - Not possible to have physical consultations.
  - Can see patients without symptoms of Covid 19, but with PPE (if available).

- What forms of electronic communication exists:
  - Telephone
  - SMS dialogue/messages/e-mail
  - Video consultations



During Covid 19 pandemic:

How to obtain a patient history?

How to assess patients clinically?

Objective tests, are they possible?

Is it safe to treat – then re-evaluate?

Diagnostic aids:

- Breathlessness:
  - Patient can count number of breaths pr minute.
  - mMRC: can be asked in all cases.

- PEF:
  - Cheap
  - Used to be what we had (…in the really old days)
  - Need to instruct patient, but can be done over video (maybe telephone)
  - Diary for 2 weeks.

- Spirometry:
  - Some hand held with mobile app.
  - Few based on mobile phone.
  - In office – need PPE and suitable space.

Diagnosis of asthma during the pandemic:

Mode of communication.	Patient history	Patients symptoms	Objective measurements	? Good enough
Telephone	Possible	Indirect evaluation: can hear breathlessness, cough. May use mMRC.	May use PEF meter	No

Treatment trial with re-evaluation:

- 4 weeks of anti-inflammatory treatment:
  - ICS and SABA prn, re-evaluate symptoms.
  - PEF or spirometry if possible.

- If in doubt or inconclusive may extend or repeat trial.

- Remember patient education, patients are great assets!

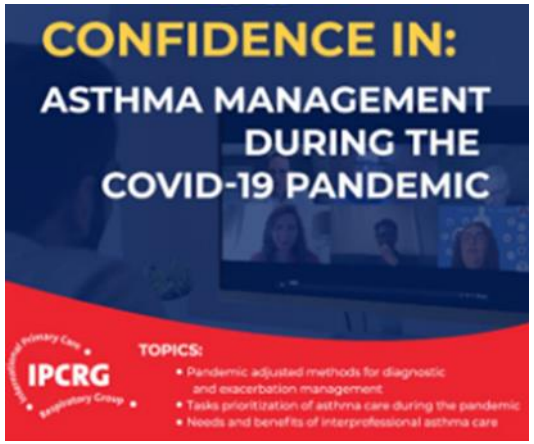
COMMON SYMPTOMS FOR ALLERGIES, COLD, FLU & COVID-19

SYMPTOMS	ALLERGIES	COLD	FLU	COVID-19	**Astma**
BODY ACHES	Rarely	√	√	√	Rarely
CHILLS	No	No	√	√	No
FEVER	No	Rarely	√	√	No
HEADACHE	Sometimes	Sometimes	√	Sometimes	No
NASAL CONGESTION	√	√	Sometimes	Rarely	No
RUNNY NOSE	√	√	Sometimes	Rarely	No
SNEEZING	√	√	Sometimes	Rarely	No
ITCHY/WATERY EYES	√	No	No	No	No
DRY COUGH	Sometimes	√	√	√	√
SHORTNESS OF BREATH	Sometimes	Sometimes	Sometimes	√	√
WHEEZING	Sometimes	Sometimes	Sometimes	Rarely	√
LOSS OF SMELL	Mild	Rarely	Rarely	√	No
SORE THROAT	Sometimes	√	√	Sometimes	No
NAUSEA, VOMITING, DIARRHEA	No	Sometimes	Sometimes	Sometimes	No

www.emersonhospital.org/articles/allergies-or-covid-19

Conclusion:

- Diagnosing asthma during the pandemic can be challenging.
- We must make use of the resources that are available in our context.
- **Remember; the pandemic will end and normality will return!**

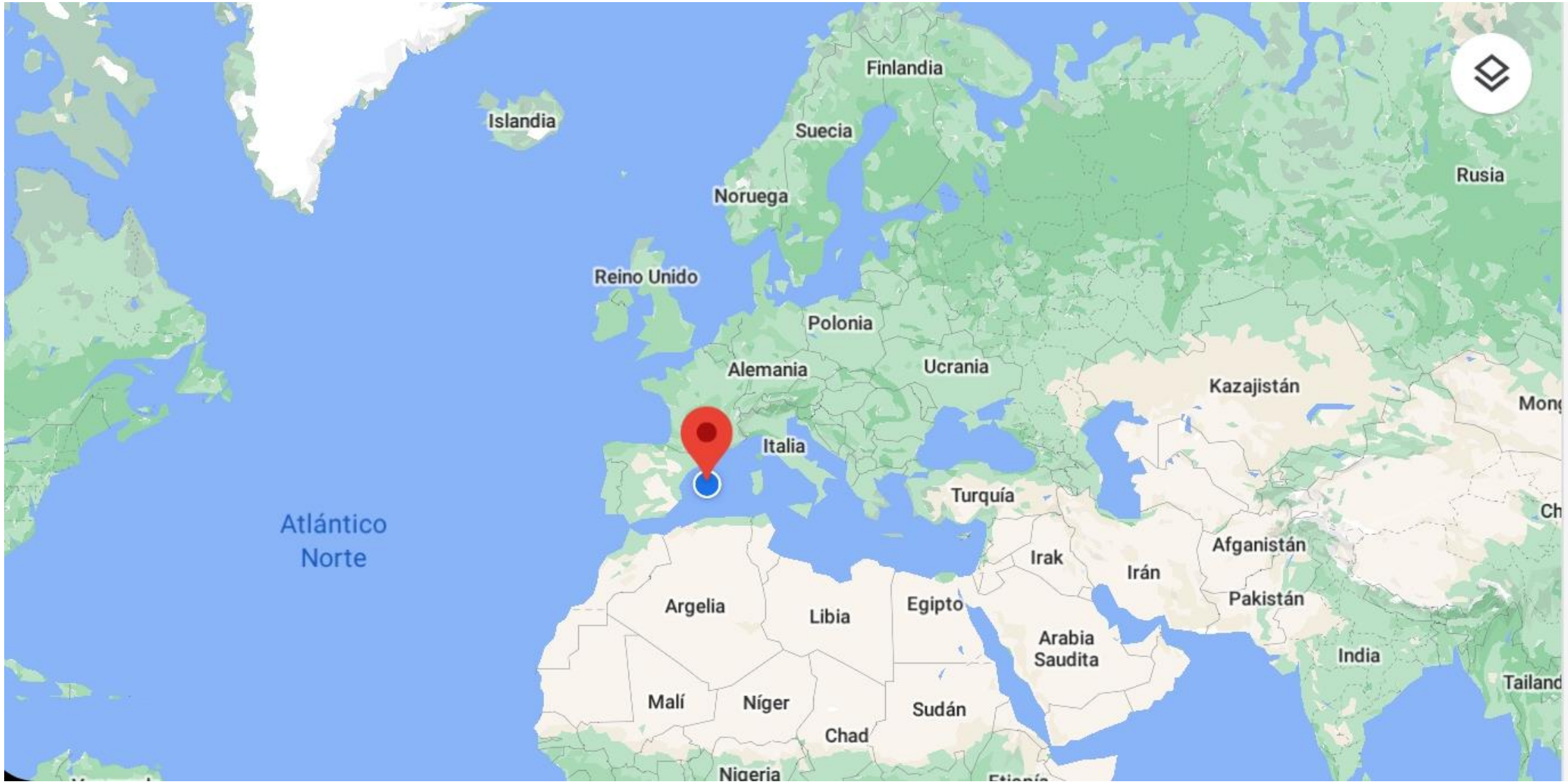


Presentation 2

The acute management of asthma during the COVID-19 pandemic

Marina García-Pardo, Mallorca, Spain

Mallorca, Spain - Working in the emergency room of a primary care setting in a small city of Mallorca



International Primary Care Respiratory Group
IPCRG work locally collaborate globally

Safety

Separate routes in the ER

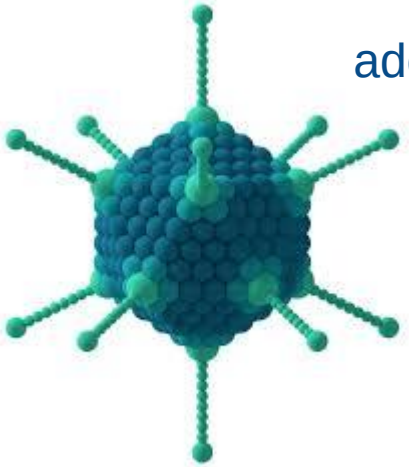
COVID area

General

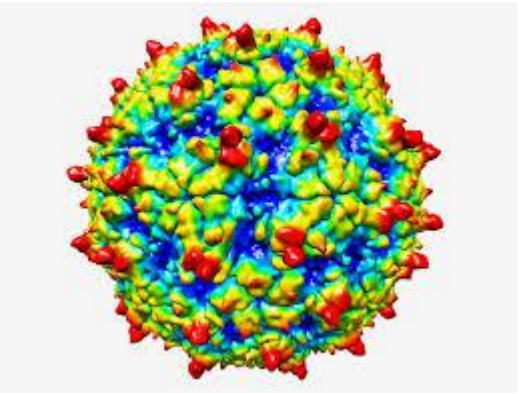
Triggers of an asthma crisis can be viruses

Adults only
Symptoms < 5days

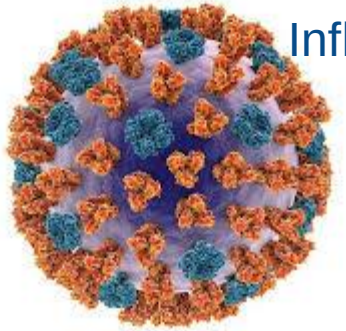
adenovirus

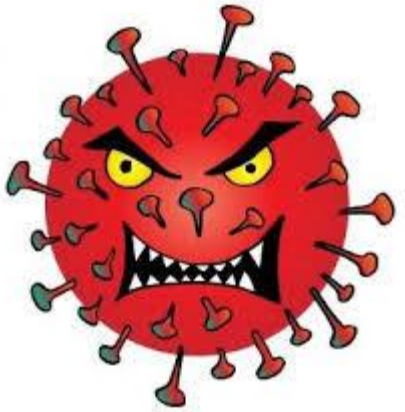


rhinovirus



Influenza A





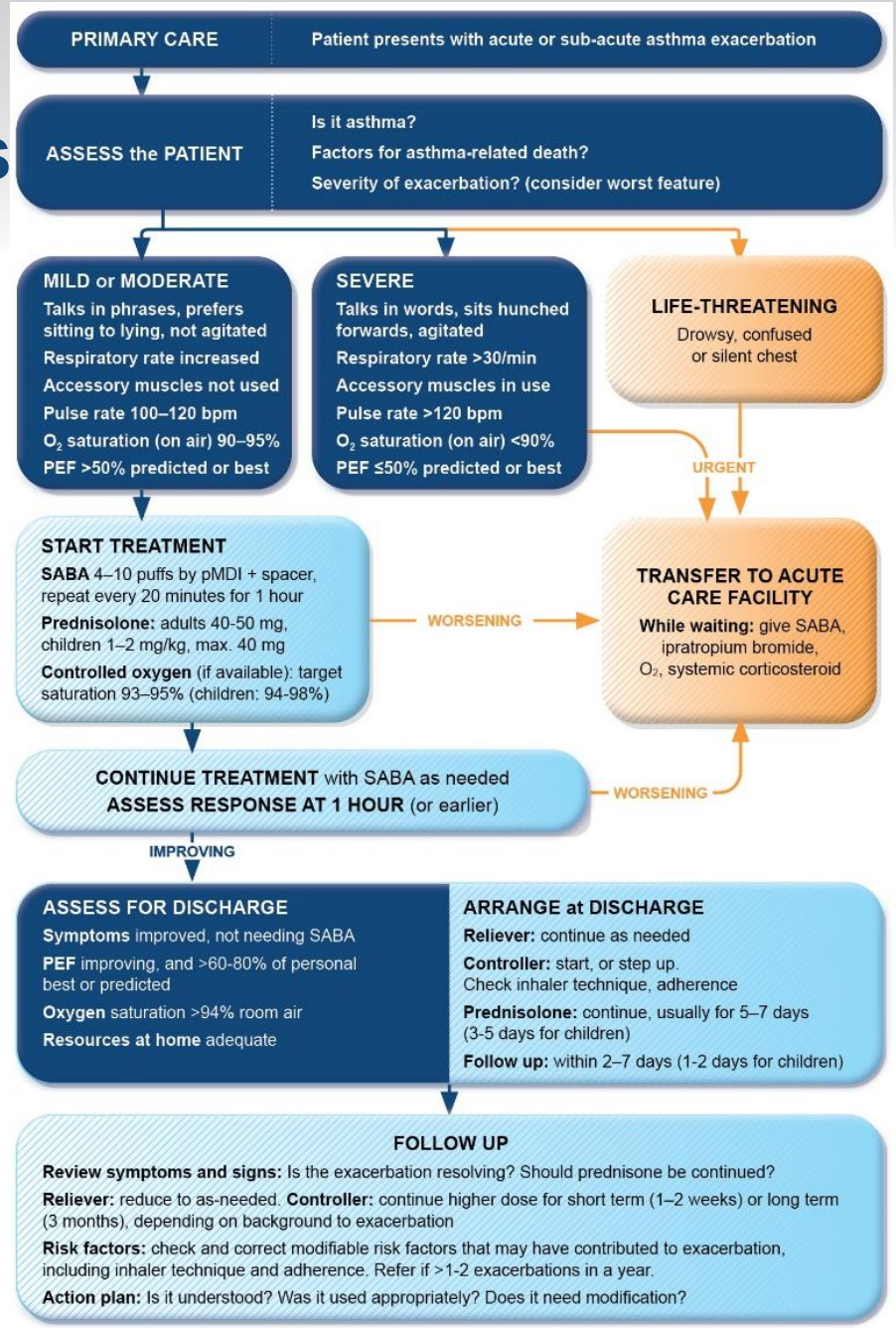
SEVERITY ASSESSMENT: objective

- Respiratory rate
- Accessory muscles use
- Talk: phrases, words
- Position: sitting, lying, hunched forward
- Pulse oximetry
- Heart rate

Risk factors for life-threatening asthma

- Quick onset
- Previous hospitalisations
- Poor periodic assessment
- Over use of SABA
- Co-morbilities:cardiovascular
- Psychological/psychiatric

Management of asthma exacerbations in primary care (adults, adolescents, children 6–11 years)



Oxygen Therapy

- Low flow devices
  - Nasal cannula
  - Simple mask
  - Reservoir mask (O_2)

- High flow devices
  - Venturi (Ventimask)
  - High Flow Nasal Prongs
  - Face/head Tent

Surgical mask over Oxygen device

The way of administration has changed

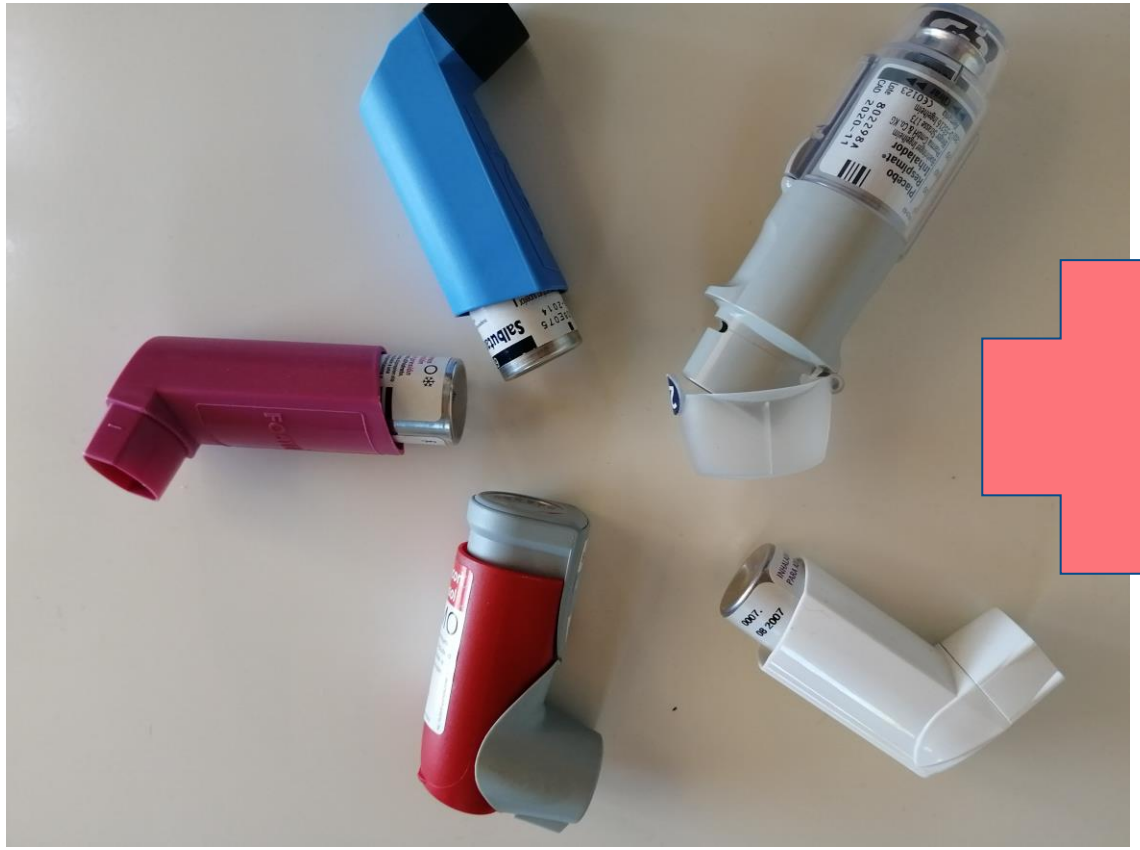
Pre-COVID

Post-COVID
exceptionally

Nebulisers

Mouth pipe

Recommended way

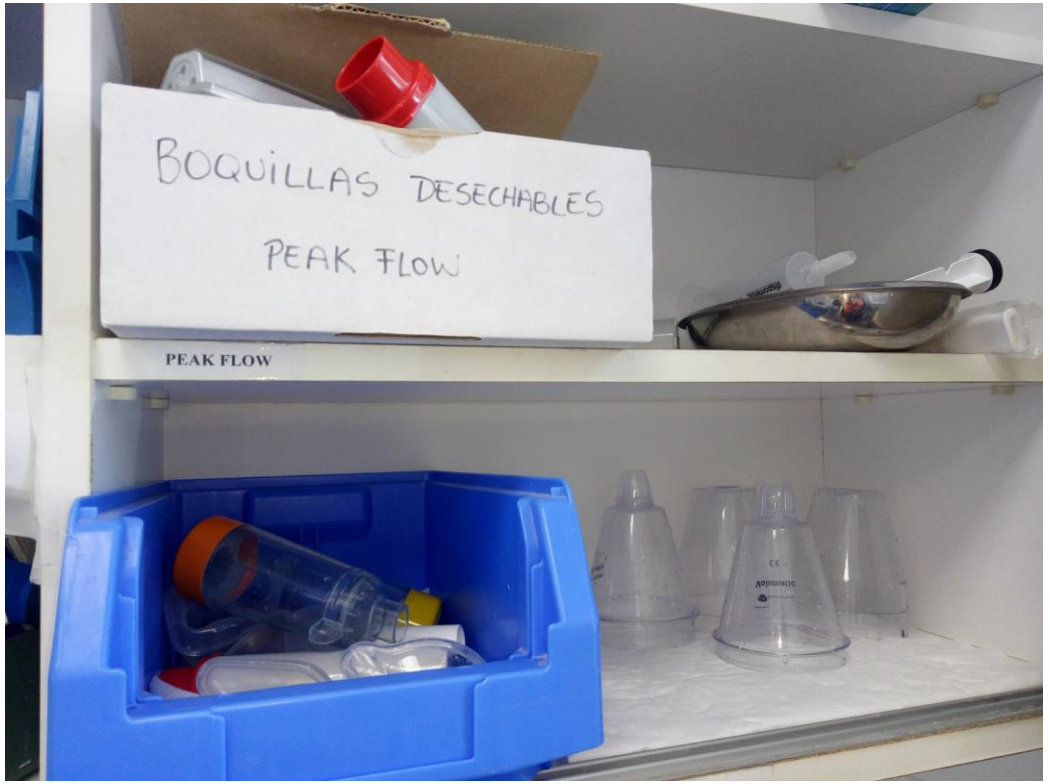


Metered dose inhaler

Valved holding chamber

High level disinfection = sterilisation

chambers and Peak Flow meter



Continue monitoring and recording

- Make sure improvement PEF >70%
- Clinical improvement
- If moderate/severe, add a short course oral corticosteroids
- Check adherence to inhaled corticosteroids. If not, set up.
- Check SABA use/overuse. Asthma Right Care rule.
- Investigate a non controlled asthmatic. Refer to GP/nurse

Before discharge (with confidence)

- Check inhaler technique
- Add a chamber to pMDI
- Do not prescribe a new inhaler without confirming the patient can use it
- In smokers, give brief advice
- Give written asthma action plan
- Refer to GP/nurse/HCP as soon as possible

Thank you!!

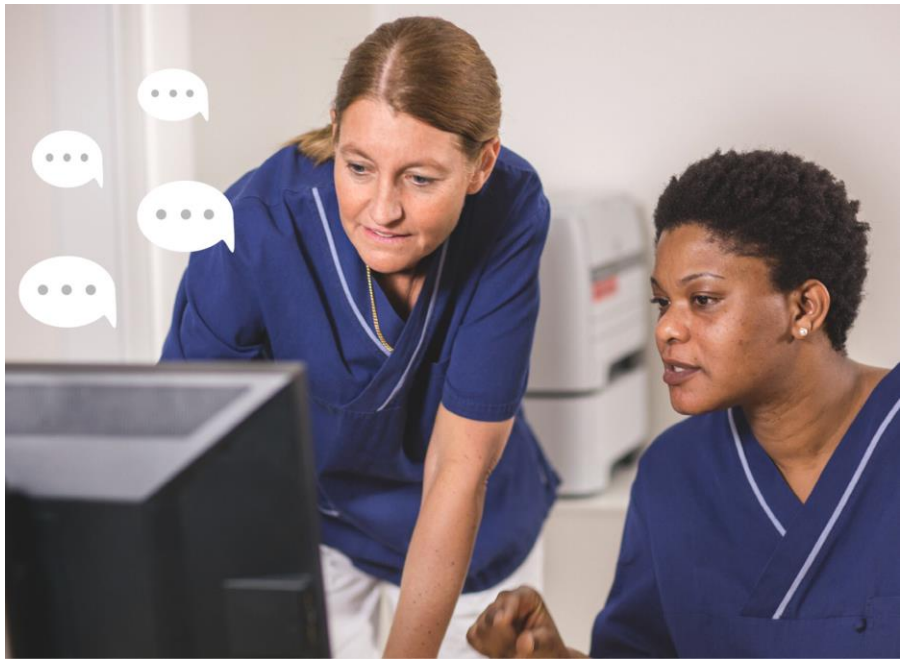
Presentation 3

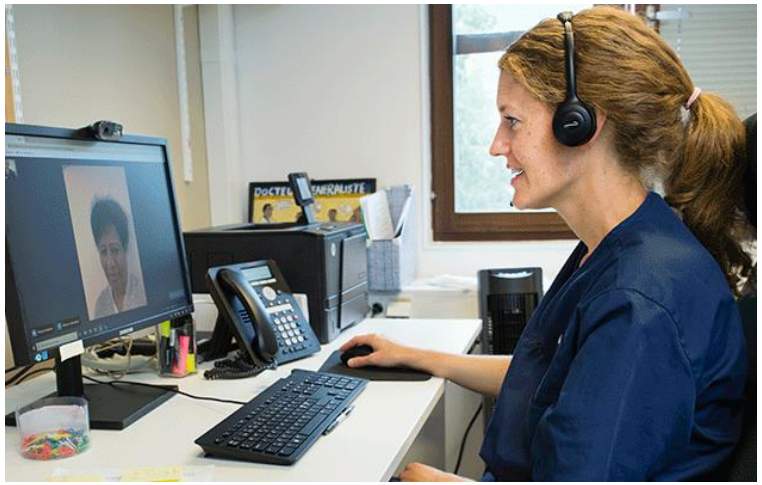
How do you organise and prioritise routine asthma care

Hanna Sandelowsky, Sweden

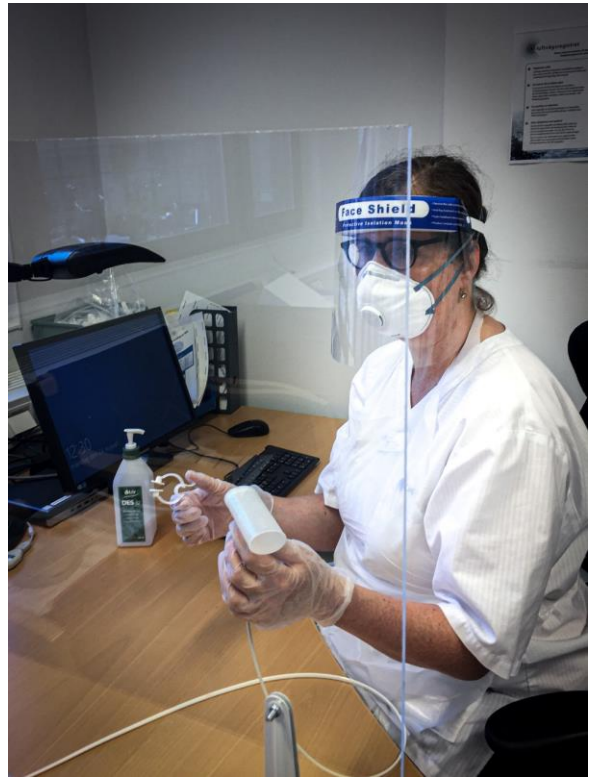
International Primary Care
IPCRG
Respiratory Group

Astma Allergi, KOL Allmänmedicin
Nätverket för Astma- Allergi- och KOL-intresserade Allmänläkare






PROVTAGNINGS-
MATERIAL


Face Shield

Prioritisation of tasks in asthma care

	HIGH PRIORITY →				LOW PRIORITY						
	"Should be done"			*"Could be done"*				*"Could be done as an exception"*		
Diagnostics	Spirometry: FEV1/FVC	Children with obstructive episodes: Spirometry, allergy test, ACT, length/weight	Patient history of allergen exposure		Allergy test (adults)	PEF registration Mannitol challenge	Methacholine challenge Diff Cap	NO Standradised Exercise challenge Irritant challenge		Non-standardised exercise challenge (children) Spirometry: FEV1/SVC
Treatments	Smoking cessation support	Smoking cessation support to parents								
	Optimise medication: Switch from SABA as needed to fixed or as needed ICS (+LABA) Continued medication during pregnancy Spray+Spacer at AEA				Nebulizers at AEA					
			Asthma Action Plan Patient/parent education	Inter-professional care						
		Follow-up, uncontrolled asthma	Follow-up, controlled asthma (steps 2-4)	Follow-up, controlled asthma (step 1)						

= Pragmatic prioritisations during Covid 19 pandemic

Modified after the guidelines from The Swedish National Board of Health and Welfare 2015, rev 2017

Organisation of asthma care in primary care

– The Asthma/COPD team

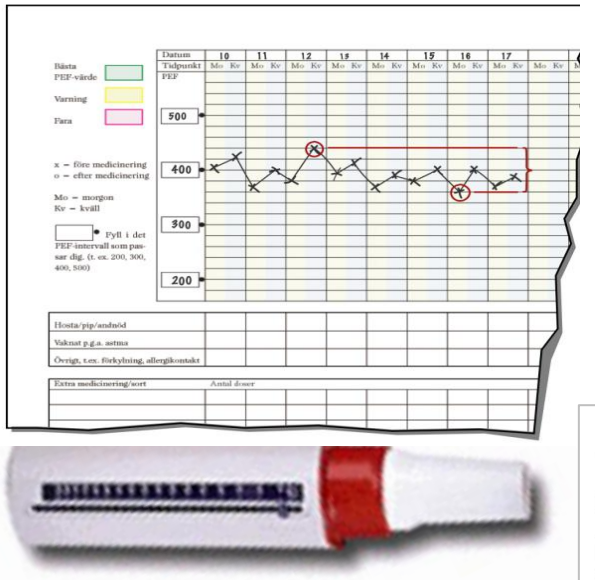
Certified Asthma/COPD clinics

	Doctor 	Respiratory/allergy nurse 	Physiotherapist 
Competence			
Formal	Specialist in Family Medicine (=GP)	Specialist competence in respiratory medicine (university level)	Specialist competence in respiratory medicine (university level) recommened
Spirometry Driver's Licence	Mandatory	Mandatory	Mandatory
CME	Two days/year for "external CME", preferably based on interprofessional learning		
Interprofessional co-operation	Occupational therapist, nutritionist, social worker, smoking cessation councellor		
Time	2 hours/week (for management of team)	4.8 hours/week/1000 registered patients (any patients) at the PHCC	1.3 hours/week/1000 registered patients (any patients) at the PHCC
Equipment	Spirometry, FEV_1/FEV_6-screening device, PEF meter, pulsoxymeter, spacer, nebulizer, oxygen, allergy tests (in vitro or/and intracutan) information and patient education material		
National Airway Register	Mandatory regular registering and regular analysis of own results		

How do we diagnose asthma during the pandemic?

Remote lung function measures

- PEF diary
- App based technology
- Remote consultations to guide and support



Few allergy tests

- Not priority during pandemic
  (shortage of staff + distancing recommendations)

How do we diagnose asthma during the pandemic?

Spirometry? Continue with stringent prioritisation!

× No:

- If patients (or HCP) show any symtoms of airway infection (1 week free of symptoms)
- Annual routine spirometries for COPD patients
- Annual routine spirometries for well controlled asthma patients
- New patients with clinically highly suspect asthma

✓ Yes:

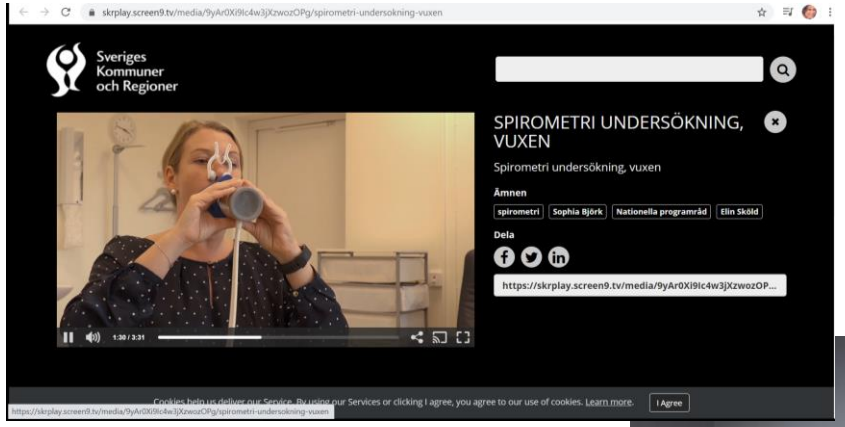
- Normally high priority spirometries but postponed in spring 2020:
  - Uncontrolled asthma under treatment adjustments
  - Unclear diagnosis in patients on new asthma medication
- Candidates for sublingual immunotherapy (hyposensitisation)

COPD6-meter®

Air Smart®

Advice for safe spirometry during the pandemic

- Demonstrate by watching a video
- Patient hand disinfection/wash
- Staff PPE:
  - Gloves
  - Apron
  - PPF 4 mask
  - Face shield
  - Glass protective barrier
- Placement of patient (exspiration away from the staff)
- Use a filter in the device
- No DPI:s (unless patient's own). Use spray+spacer, disinfect afterwards.
- If obvious risk for coughing: perform only 1-3 forced outblows for FEV1 and slow outblows for VC
  (i.e., use FEV1/SVC instead of FEV1/FVC)
- Clean surfaces afterwards
- Evidence on the role of ventilation is unclear
  - Wait 15 min before opening the window or door
  - Keep your mask on during that time
  - Wipe surfaces off with disinfection after that time

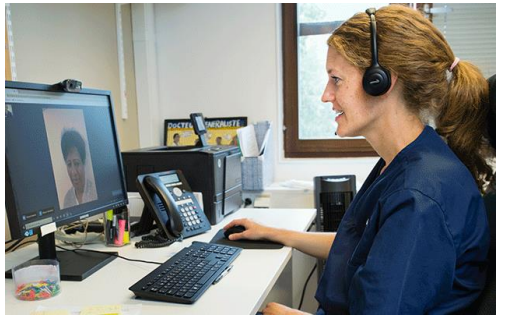


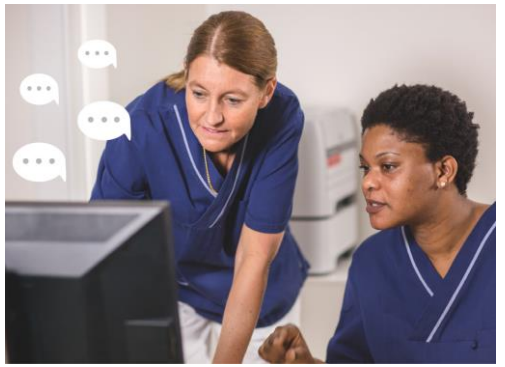
How do we assess patients during the pandemic?

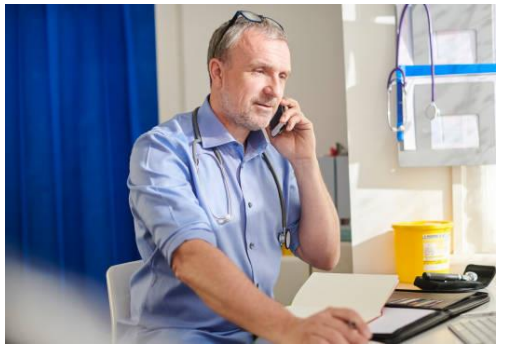
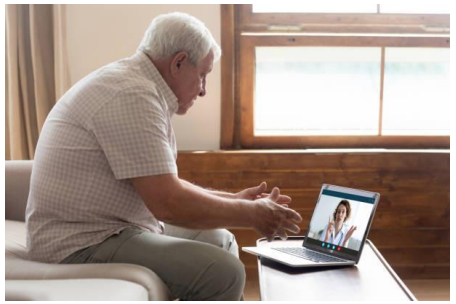
Remote consultations

Platforms currently used globally:

- Telephone
- Online services: national systems, Zoom, Skype, Facetime etc
- Smart phone/watch
- Smart phone apps: Whatsapp
- Chat (Sweden)
- Email



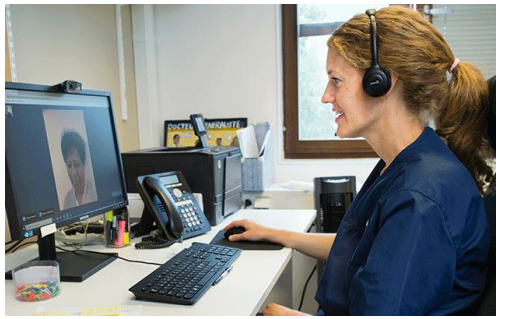


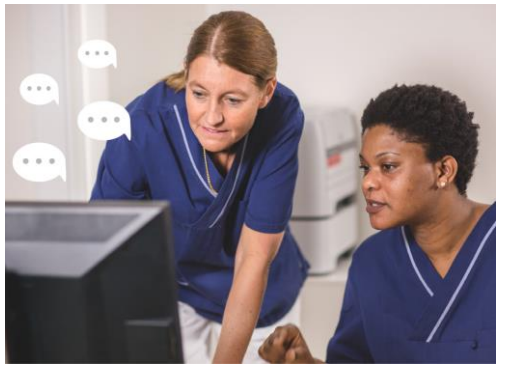



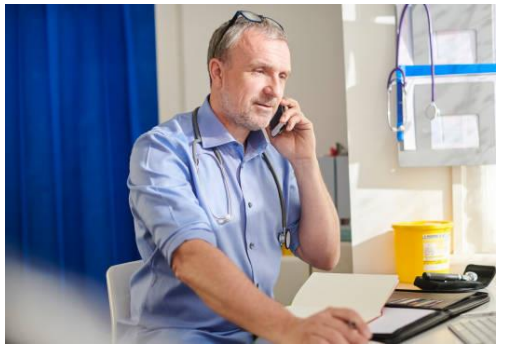
How do we assess patients during the pandemic?

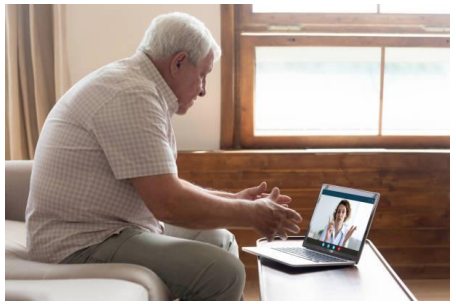
App based technology examples

- ***MyHealth*** (UK; paid for) eg myCOPD and myASTHMA:
  - education (including inhaler technique)
  - PR, lung function reporting
  - self-management plan
- ***SaniQ*** (Germany; paid for):
  - digital health diary an allows documentation of PEF, FEV1, weight and O2 saturation
- ***Hailie™*** (free):
  - medication monitoring for asthma and COPD including analysis of inhaler use
- ***SMART PEAK FLOW*** (free):
  - Smart sensor technology to track PEF
- ***AsthmaTuner*** (Swedish and English):
  - Clinically validated service for at-home treatment of asthma, and diagnostics. Treatment plan combined with a decision support tool, digital PEF monitoring, spirometry, patient education.

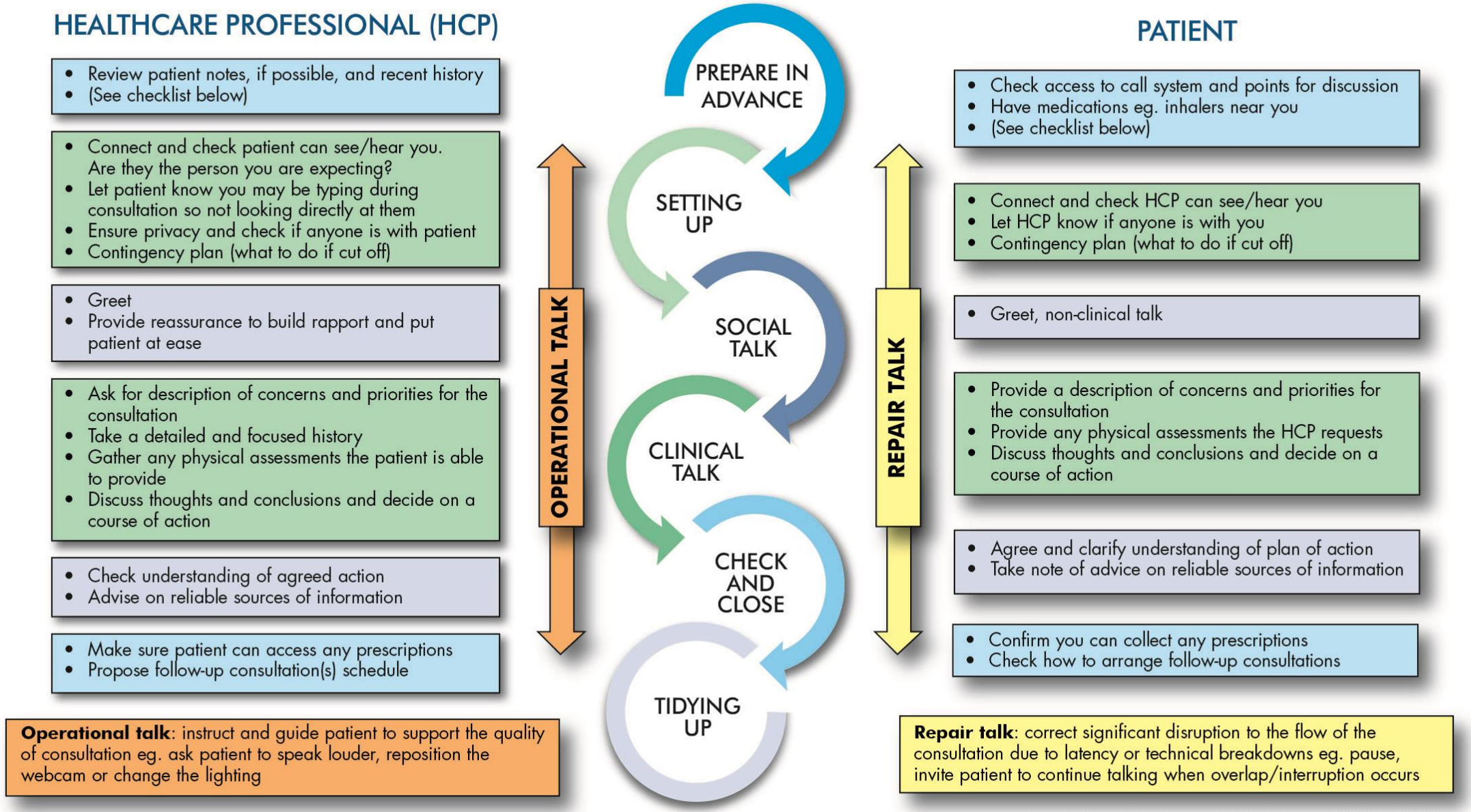








DELIVERING EFFECTIVE RESPIRATORY REMOTE CONSULTATIONS IN PRIMARY CARE

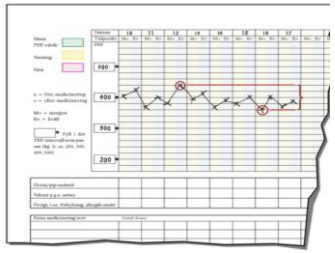


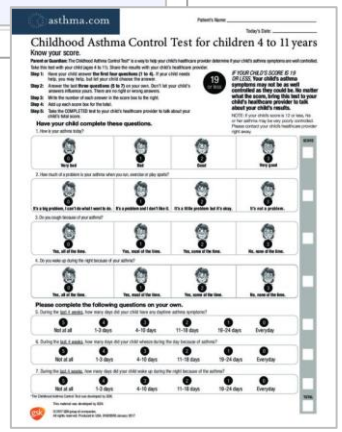
Adapted from Wherton J, et al. BMJ Leader 2020;4:120-123.

Team members: General practitioner

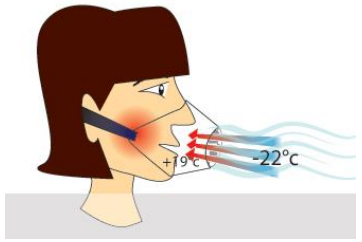
1. Diagnosis
2. The medical assessment
3. Initiate patient education
4. Prescribe medication
5. Initiate Asthma Action Plan
6. Refer to appropriate other HCP:s (e.g., nurse, physiotherapist, school nurse)
7. Plan for follow-up
8. Refer to pulmonary specialist if needed

Team members: Primary care Asthma/COPD nurse





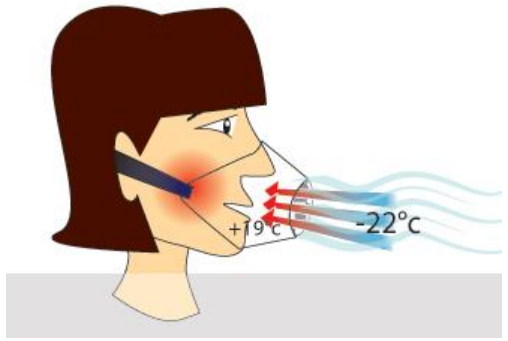
- Works together with GP
- Assessments and treatments
  - Asthma Controll Test, lung function tests
- Structured smoking cessation treatments and support
- Patient education
  - Advice about **symptom triggers** (e.g. allergens, air pollution, smoky environments, smoking, infections, exercise, NSAID/beta-blockers, stress), **exercise, medication/inhaler technique**
- Follow-up, support and preventive measures
- Own clinic with booked appointments



Team members: Physiotherapist

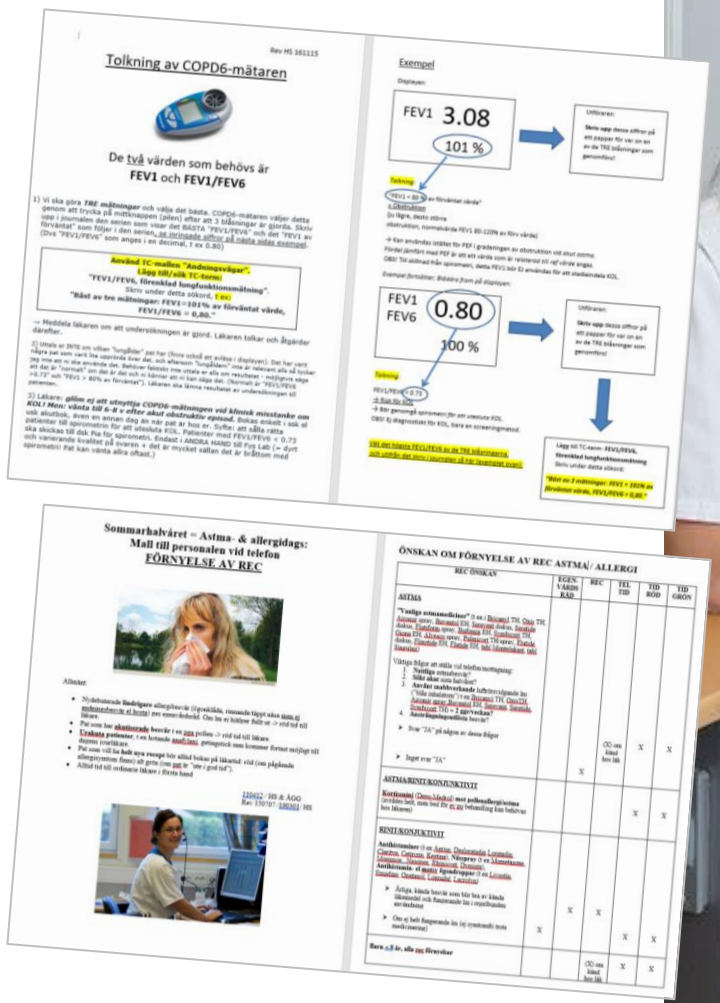
Exercise induced asthma

- Assessments: Exercise challenge with PEF
- Patient education
- Breathing aids and exercises
- Inhaler technique support



Team members: Asthma/COPD physician

- Supports the astma/COPD nurse
- Supports the other GPs
  - Scheduled weekly ”Open hour” for consultations + spontaneous dialogue
  - Weekly information at GP meetings / Staff meetings
  - Guidelines, cribs, local routines
- Dialogue with manager / stake holders
- Contact person with local pulmonologists
- Continuing medical education



Management of acute exacerbations during the pandemic in primary health care

Moderate asthma exacerbation

- Dyspnoea, O2-Sat >90%.

- ***USE*** PPE
- ***USE*** outdoor facitilities if you can
- ***AVOID*** nebulizers
- ***USE*** spray (MDI) inhaler + spacer
  - Perferably patient's own inhaler
  - Dosage of SABA: < 2 yrs: 4 puffs, > 2 yrs: 6 puffs, > 6 år: 6–10 puffs, adults 10-15 puffs
- Oxygen via nasal high flow (e.g. Optiflow)
  - *Risk for aerosols*
- Cleaning:
  - Spacers: follow manufacturer's instructions
  - MDI inhalers:
    - Take apart metal inhaler and plastic components
    - Metal inhaler: alcohol disinfection
    - Plastic: dish washing liquid & water → hydrogen peroxide 3% in 30 min (Caution! Use goggles!) → let air dry

APPENDIX: Useful tests that can be done remotely

- **Vital signs: temperature, pulse rate and respiratory rate**
- **Peak flow test** https://www.asthma.org.uk/advice/manage-your-asthma/peak-flow/
- **1 minute Sit to stand**
- **Inhaler technique:** https://www.asthma.org.uk/advice/inhaler-videos/
- **Pulse oximetry:** https://www.youtube.com/watch?v=Y-CWTqKiIhQ

Questionnaires:

- https://www.ipcrg.org/sites/ipcrg/files/content/attachments/2019-10-23/ipcrg_users_guide_to_copd_wellness_tools.pdf
- https://www.ipcrg.org/resources/search-resources/users-guide-to-asthma-control-tools-2016

Breathlessness questionnaires

- MRC Breathlessness Scale
- **Modified MRC**

COPD questionnaires

- COPD Assessment Test https://www.catestonline.org/
- CLINICAL COPD QUESTIONNAIRE (CCQ) www.ccq.nl

Asthma questionnaires

- Asthma Control Test https://www.asthmacontroltest.com/
- CARAT: https://core.ac.uk/download/pdf/62692897.pdf
- RCP 3 questions: https://www.guidelinesinpractice.co.uk/nov_99_bucknall_asthma_nov99/304385.article#.VliASa1dHIU

International Primary Care Respiratory Group IPCRG work locally collaborate globally

Questionnaires:

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- **Vital signs: temperature, pulse rate and respiratory rate.**
  - https://www.hopkinsmedicine.org/health/conditions-and-diseases/vital-signs-body-temperature-pulse-rate-respiration-rate-blood-pressure
  - Respiratory rate: https://www.youtube.com/watch?v=ccKGzZXNKYs start 0.47 and https://www.mayoclinic.org/how-to-measure-respiratory-rate/art-20482580

- **Peak flow test** https://www.asthma.org.uk/advice/manage-your-asthma/peak-flow/

- **1 minute Sit to stand:**
- **I**nstructions composed from this reference and others http://rc.rcjournal.com/content/63/8/1040
  - Use an armless chair with a height of 46 cm; you can put it against a wall to stop it slipping.
  - HCP needs a stopwatch used to measure the time and to count how many repetitions.
  - Demonstrate first then ask the patient to do it as correctly as possible for as many times as they can manage in one minute.
  - Put your hands on your hips or fold your arms across your chest to keep your arms still.
  - When I say “Go!” stand up and without delay sit down again as many times as possible within 1 minute.
  - Go at a speed which feels safe and manageable.
  - Stand up so your knees are straight, and when you sit, they'll be bent at right angles.
  - You may want to have your feet about 30 cm apart, and to push them back a little under your chair. Toes pointing forwards. Push down into your heels to stand up.
  - You can rest if you need during the minute.

  - Measurements before and after? Heart rate, oxygen saturation (SpO2), blood pressure, and symptoms of breathlessness and fatigue (rated with the modified Borg scale)

- **Inhaler technique:** https://www.asthma.org.uk/advice/inhaler-videos/

- **Pulse oximetry:** https://www.youtube.com/watch?v=Y-CWTqKiIhQ

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Breathlessness questionnaires
- MRC Breathlessness Scale https://www.blf.org.uk/support-for-you/breathlessness/diagnosis
- (or https://cks.nice.org.uk/topics/chronic-obstructive-pulmonary-disease/diagnosis/diagnosis-copd/#medical-research-council-dyspnoea-scale
- And here's an example of it in use https://www.wellingtonmedicalcentre.co.uk/information/forms/medical-research-council-mrc-breathlessness-scale/

Modified MRC https://bronchiectasis.com.au/wp-content/uploads/2015/09/BW-MMRC-Dyspnoea-Scale-doc.pdf

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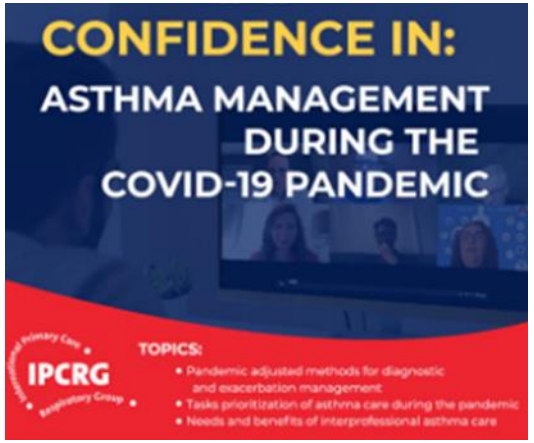
International Primary Care Respiratory Group IPCRG work locally collaborate globally

Thank you

hanna.sandelowsky@ki.se

1st IPCRG *Confidence In* Webinar & Abstract Presentations



Presentation 4

Collaborating with Colleagues: Where does Asthma Right Care fit in?

Mar Martínez, Spain

International Primary Care Respiratory Group
IPCRG work locally collaborate globally

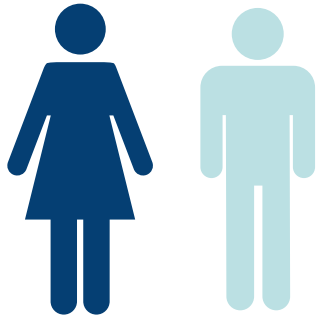
How confident do you feel managing asthma right now with the COVID-19 Pandemic?

Today's good news

ASTHMA RIGHT CARE

….is coming to you!

International Primary Care Respiratory Group
IPCRG work locally collaborate globally



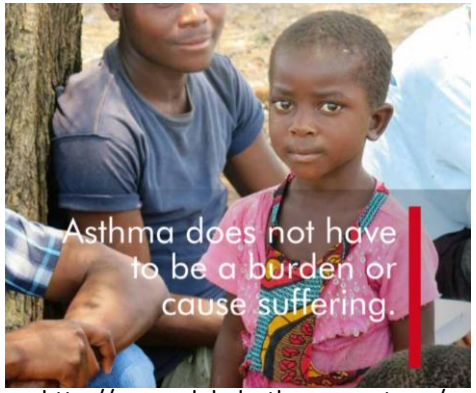
Asthma is global, in all communities, in all ages

Our hunches driving ARC programme are:

- There is Over-reliance on symptom relief and acute management instead of long-term, chronic disease anti-inflammatory management in Asthma
- Asthma is low priority for change in general health care professional despite evidence of:
  - -unwarranted variation in outcomes,
  - -avoidable mortality, morbidity and healthcare utilisation
  - -education programmes
- Previous approaches haven't really shifted that
- Need to want to change for messages about asthma improvement to be received & adopted
- Let's apply the evidence about achieving change at scale

Start discomfort with the current state!

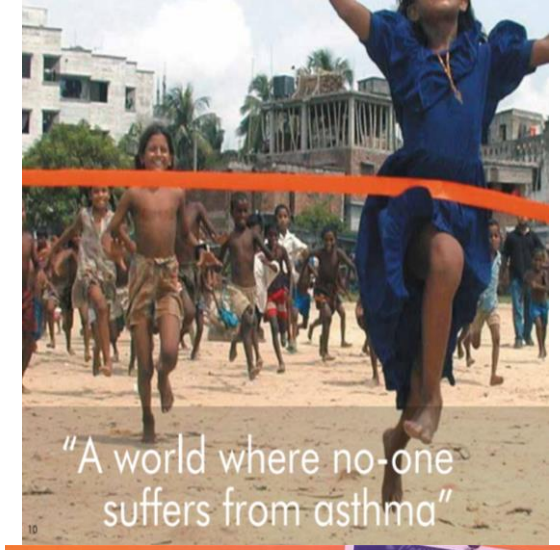
ASTHMA RIGHT CARE



http://www.globalasthmareport.org/

ASTHMA RIGHT CARE

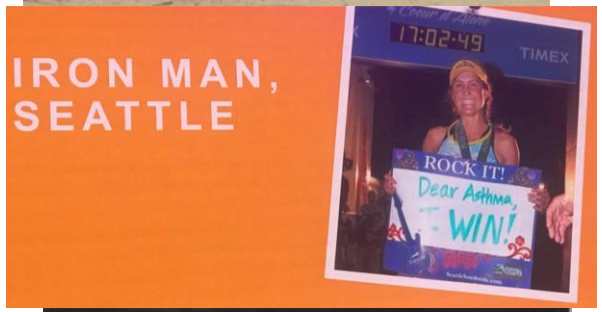
Doing the right things and only the right things in the right way for the right people at the right time in the right place, whatever that means in the local context.

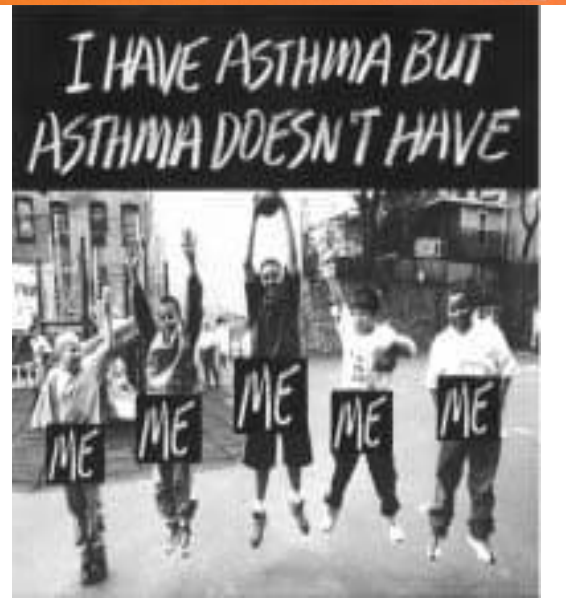


Asthma

Right

Care





Leading ideas about ARC

International leadership
IPCRG

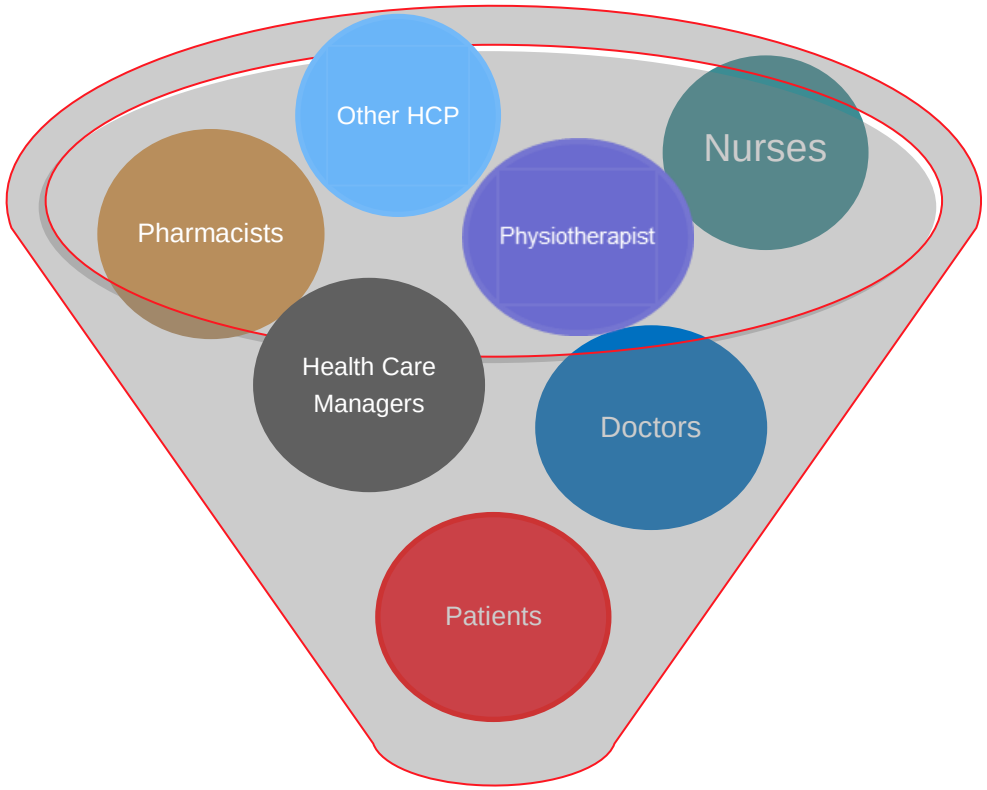
Primary Care
as a cornerstone

Multidisciplinary /
interdisciplinary
approach

ARC
Advocacy programme
for the right
management of
ASTHMA

ARC
Social movement for
Global Change

Multidisciplinary Teams



Working Team

Collaborating with colleagues

Is your asthma in the hands of the pilot or are you relying on the co-pilot three or more times a week?

The captain of your asthma care should be your regular preventer inhaler, not the co-pilot blue inhaler.

If you feel that you are reliant on your blue inhaler, then you are likely to have uncontrolled asthma.

Regular overuse of your blue inhaler puts you more at risk of having an asthma attack.[1]

If you are experiencing frequent asthma symptoms and taking 3 or more inhalations* a week of your blue inhaler, let's talk about your asthma care and how we can help you. **Book a review with your asthma nurse TODAY**

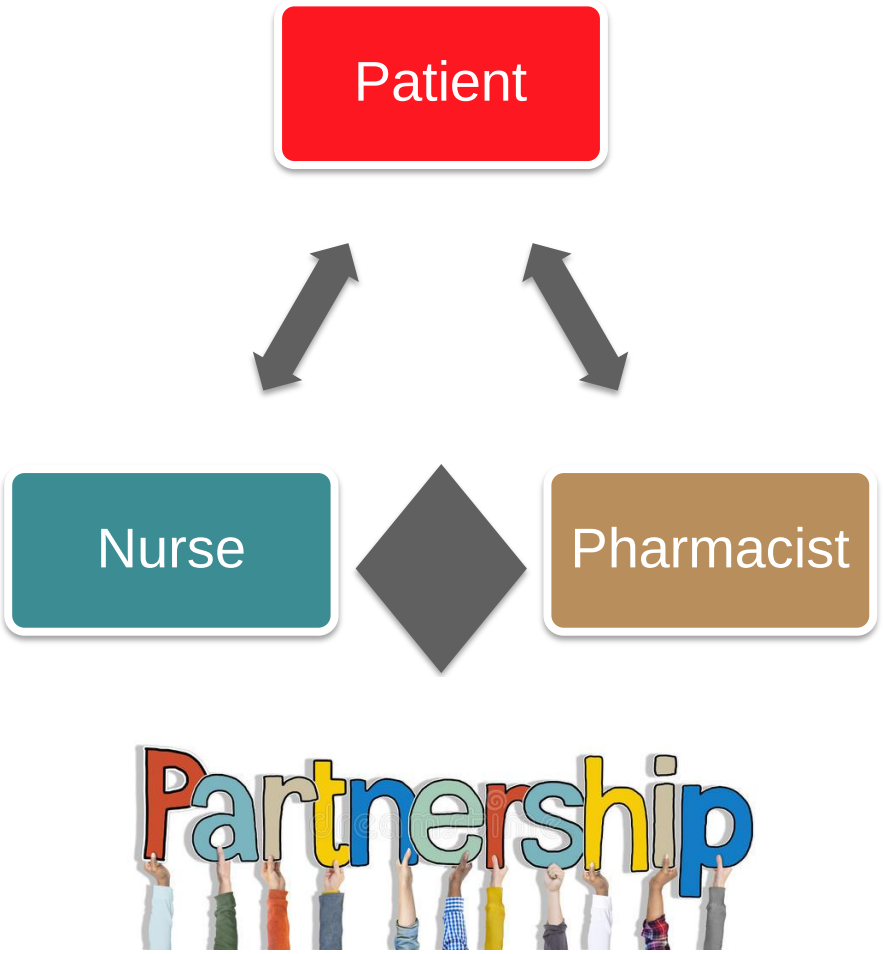
[1] Hull S A, *et al*. Asthma prescribing, ethnicity and risk of hospital admission: an analysis of 35,864 linked primary and secondary care records in East London. *NPJ Prim Care Respir Med* 2016;**26**:16049

* One to two puffs per inhalation (dose)

ASTHMA RIGHT CARE

PCRS

This resource has been produced as part of the PCRS Asthma Right Care (ARC) initiative, which is part of a wider global social movement initiated by the IPCRG; see https://www.pcrs-uk.org/arc for further information. The PCRS is grateful to AstraZeneca for supporting the ARC initiative in the UK through an educational grant and secondment of a programme manager. AstraZeneca played no part in the creation of the resource.
Primary Care Respiratory Society. Charity Number 1098117 Company Number 4298947 VAT Registration Number 866 1543 09 Registered office Miria House, 1683b High Street, Knowle, B93 0LL Telephone +44 (0)1675 477600 Email info@pcrs-uk.org Website https://www.pcrs-uk.org



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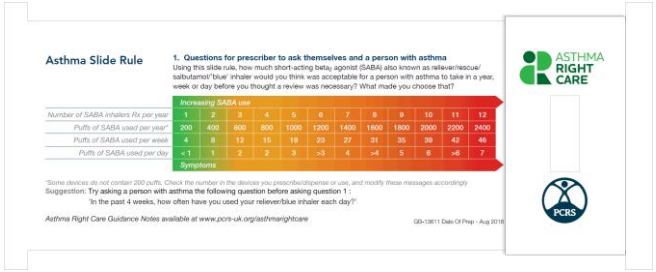
Asthma Right Care Tools

100% Progress



03

Reliever Reliance Test - helps a person with asthma explore why they use the amount they use, and gives some advice on whether a change might improve their asthma

02

Asthma SABA Slide rule - explores how many puffs of their short acting beta agonist (SABA) inhaler the individual is using, how this compares to the international guideline advice, and, on the reverse, explores importance and confidence to have a conversation about a review

01

Question and challenge cards - useful for icebreakers, chats, discussion fora, social media

Tools to get the conversation going between people with asthma and clinicians about Right Care for Asthma

All ARC resources are freely available from: https://www.ipcrg.org/asthmarightcare

ASTHMA RIGHT CARE

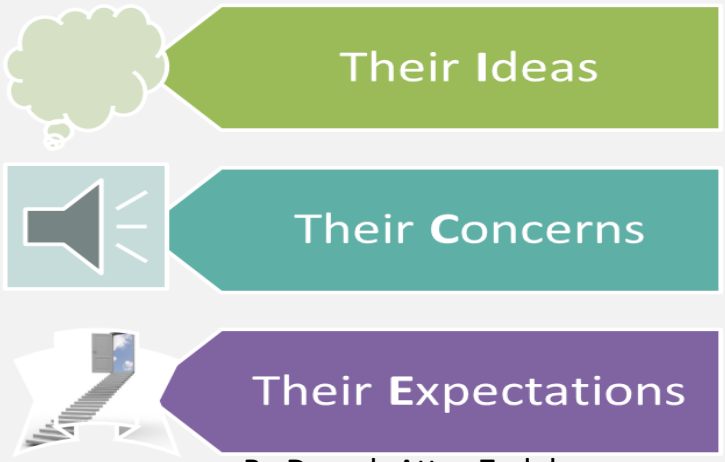
CHANGE THE CONVERSATION

www.ipcrg.org/asthmarightcare

Aim

Achieving behavioural change in regards to asthma management :

- **To face the problem of over-reliance on SABA**
- **To achieve adherence to preventive treatment with inhaled steroids**



I
C
E

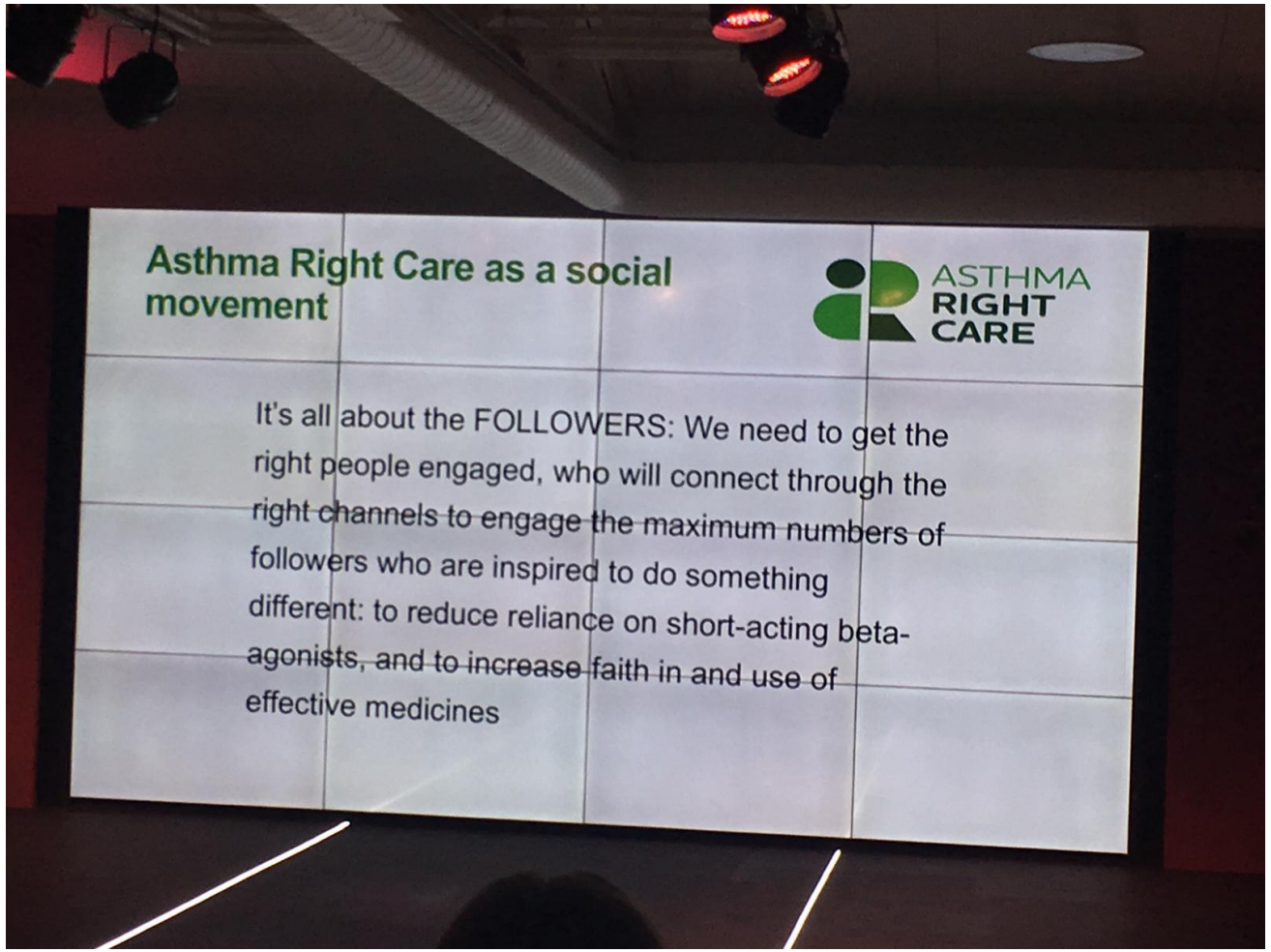
By Darush Attar-Zadeh
IPCRG Pharmacist

Focus on the patient

Find out the meaning of the symptoms or illness **for the patient**

ASTHMA RIGHT CARE

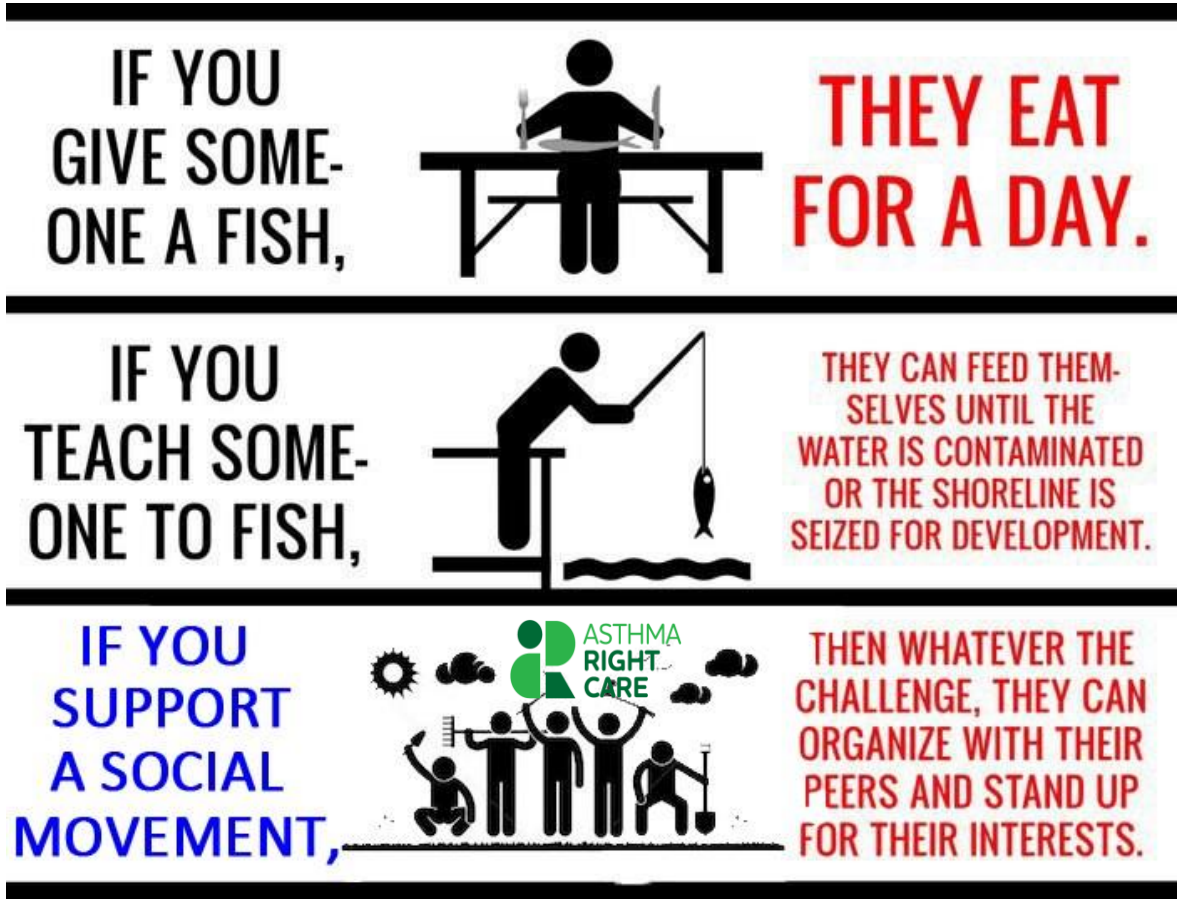
The power of one, the power of many



"We need to be activists in our work lives as much, or even more, than in any other sphere of our lives"

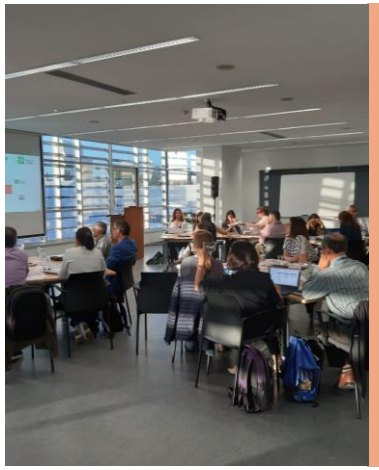
Quote from Dr Helen Bevan
Chief of Service Transformation
NHS Institute for Innovation and Improvement

ARC social movement



Messages for taking home

Knowledge-Skills-Collaborating with colleagues



A

R

C

…leads to manage asthma better than ever before

www.ipcrg.org/asthmarightcare

ASTHMA RIGHT CARE