Removing variations in practice to improve asthma care

Asthma Right Care: what will you commit to?

Some clinical issues never seem to reach the top of clinical or health policy priority lists, and asthma is one of them. The International Primary Care Respiratory Group (IPCRG) has initiated a social movement, Asthma Right Care, to disrupt this. For us, right care means 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. This piece summarises what we have learnt, what tools we have created, and what progress we have made. It invites you to join the Asthma Right Care movement by committing to have a different conversation about asthma with at least one colleague and person with asthma.

WHAT IS THE PROBLEM?

Despite many clinical education programmes, shocking headlines and strong patient advocacy in many countries, management of asthma illustrates all five of the problems in global health as described by Professor Sir Muir Gray (King's Fund):

1. Variation in quality, safety, outcomes and cost that is not due to disease difference but to variation in practice ('unwarranted variation') (Royal College of Physicians, 2018a))
2. Patient harm — through over- and under-treatment
3. Failure to prevent disease and disability — missed diagnosis, reviews, patient education and personalised action plans
4. Waste of human and physical resources, such as people's time and energy and medicines through activity that is of low value to patients or populations
5. Inequalities and inequity between countries and between populations in the same country. For example, people with asthma in deprived areas being more exposed to asthma triggers such as tobacco smoke, air pollution, poor housing with mould and damp, or occupational triggers of dust generated in manual jobs such as flour milling, grain harvesting and processing (Global Asthma Network, 2018).

What makes this particularly unacceptable is that there are effective interventions. Asthma is an inflammatory condition and therefore inhaled medicines and spacers, in particular inhaled corticosteroids (ICS), should be available to all, accompanied by personalised asthma action plans. Since 2019, the Global Initiative for Asthma (GINA) no longer recommends treating adolescents and adults with as-needed short-acting beta agonist (SABA – in the UK often called the 'blue/reliever') alone without ICS (GINA, 2021).

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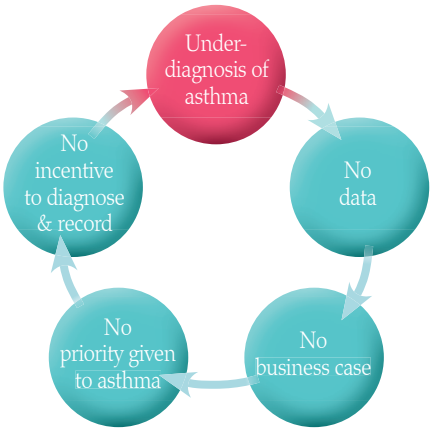

FIGURE 1.
The vicious cycle of under-diagnosis.

The variation in practice manifests itself in different ways. In low and middle income countries, asthma may be regarded not as a long-term treatable condition, but as an acute condition managed episodically through outpatient administration of oral steroids, nebulisation or hospitalisations. Solutions will require not only improved access to affordable medicines, but also long-term social marketing campaigns to address community health literacy and stigma.

In some countries the problem is underdiagnosis, which becomes a vicious cycle (*Figure 1*).

However, the issue that the IPCRG started to address in 2017 was one identified as a significant problem by primary care colleagues in many countries. This was over-reliance by both patients and prescribers on symptom relief — inhaled SABA — and underuse of anti-inflammatory inhaled corticosteroids. In addition, patients often self-manage by buying SABA canisters directly over the counter in pharmacies without needing a prescription. This is possible in a surprising number of high income countries, including Australia, as well

FIGURE 2.
Asthma slide rule.

as many middle income countries. In 2017, we chose to define over-reliance as three or more canisters of SABA in a year. New data have strengthened this case (GINA, 2021). Recent studies in Europe, show over a third of people with asthma use three or more SABA canisters in a year (Janson et al, 2020). The data also show an association between this high use with increased asthma exacerbations and use of primary care and hospital outpatients (Bloom et al, 2020; Janson et al, 2020). The reason, the IPCRG chose the term 'over-reliance' not 'over-use' is because we believe there is a type of trust or dependency on symptom relief that needs understanding and influencing.

IMPLEMENTATION

The IPCRG decided to test whether approaches other than more education could have an impact on these problems. The hypothesis was that as asthma is not seen as a priority, the level of discomfort with the present state first needed to be raised, before people would be ready to receive and act on more education. Four countries were invited to work with the group to develop and pilot their approach: UK, Spain, Portugal and Canada.

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 .

Three sources of evidence about change were considered: *Leading large-scale change: a practical guide* (NHS England, 2017); *We change the world: what can we learn from social movements for health?* (del Castillo et al, 2017); and followership. (McKimm and Vogan, 2020; Sivers. 2010). Together, these suggest that it is important to distribute power more evenly, engage and mobilise multiple stakeholders in multiple systems, frame issues, hone messages and bring pressure to bear. Consider Black Lives Matter, Disability Rights, or the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) movements. Followership celebrates the importance of early adopters and followers and rebalances the focus on leadership. To frame the issues, the theme of Right Care, as described in *The Lancet* (2017), was adopted.

KICKSTART ACTION

Action was kickstarted by setting up international and local delivery teams who collectively agreed that the focus should be on stimulating conversations about over-reliance on short-acting beta agonists,and several prototype tools to trigger conversations were developed, including:

- The SABA slide rule, inspired by the Readiness Ruler (Center for Evidence-based Practices at Case Western Reserve University, 2010). This is a cardboard visual analogue scale with a slider (*Figure 2*). The user is asked: 'How much SABA would you think acceptable for a person with asthma to take in a year (or week or day) before you thought a review was necessary? The value of the physical slider is that it externalises the thought process: you can see how sure someone is of their decision. They are then asked: 'What made you choose that number?' On the reverse side, the slide rule asks two motivational interview questions based on the number the person settled on: 'Given that number: 1. How important do you think it is to have an asthma review? and 2. How confident do you feel asking your clinician for an asthma review?' They use the slider again on a visual analogue scale from 1–10
- Question and Challenge cards. Narrative medicine is a powerful part of primary care, so we were also inspired by the Maternity Experience 'Whose Shoes' work (http://matexp.org.uk/category/whose-shoes/), which aims to identify and share best practice across the UK's maternity services and triggering discussions about what needs to improve. They created a board game to be used with women and maternity team stakeholders. The question and challenge cards (*Figure 3*) can be used in the same way: in practice meetings, in education events and with people with asthma
- A template for stakeholder mapping was also created.

NURTURE DIVERSE VOICES

Each country was invited to nurture diverse voices and motivations by using the template to map stakeholders and invite them to a design charrette. Design charrettes are participatory, hands-on events where different stakeholders come together to explore design options (www.involve.org.uk/resources/

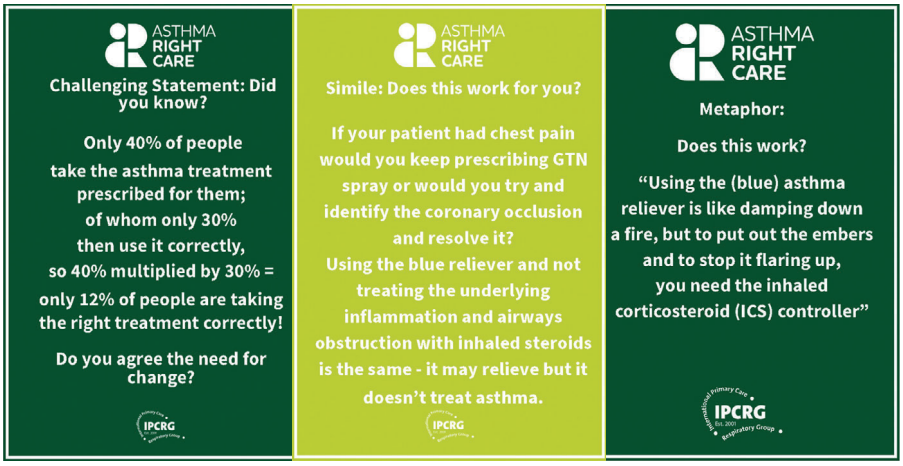

FIGURE 3.
A selection of question and challenge cards.

methods/design-charrettes). In this case, each charrette explored the consensus around the problem definition, and tested out the prototype slide rule and Question and Challenge cards. They also generated new ideas. For example, the Portuguese group chose a new name: CAPA, which means Asthma Right Care in Portuguese, but also a protective cloak. At the end of the design charrettes, the delivery teams made plans to develop and circulate the materials in their language, and asked for commitments from participants to test them with other asthma stakeholders. CAPA now has an Asthma in school work group, aiming for a cultural shift by promoting right care for children with asthma.

Over time, the teams have developed new ideas. For example, the UK group tested out adapting the idea of 'Three Billboards' asking why there had been no action. The Portuguese and Spanish teams have experimented with role plays and 30-second videos, which has generated a sense of fun and hope.

The tools are helping to start the conversation about Asthma Right Care. The conversations have highlighted some important findings about how we talk about asthma, for example:

- A dose is not a puff: a dose is two puffs
- There are 200 puffs in most inhalers.

We started to talk about a puff being a 'breathless moment' — imagine that if you take 12 inhalers in a year (as opposed to no more than three), that is 2,400 puffs or breathless moments in a year. That is a strong signal that your asthma is not under control, and you should seek an urgent review. 'PRN or as needed' may be an unhelpful direction. Words such as 'relieve' and 'rescue' have distinct meanings but are used interchangeably. 'Stops asthma' and 'Stops asthma attacks' manage expectations in different ways. In summary, we need more precision in the language of asthma and it should be the same language spoken by everyone in the care pathway: people living with asthma, doctors, pharmacists and nurses.

INFLUENCING AND INTERACTING

At a national level, the teams have navigated through the complexity of power relationships between GPs and pharmacists, between national and international guideline groups, between primary and secondary care, to start to build momentum for Asthma Right Care. All the pilot countries have generated sufficient discomfort that they are now running educational events where they can talk about Right Care to engaged audiences. Since 2019, the GINA strategy has made the message simpler to explain, although national guidelines have not yet all changed.

A series of five teaching case studies have been developed, namely:

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

The IPCRG are starting to consider how to test a new tool, the SABA Questionnaire (Chan et al, 2020), which tries to identify the underlying beliefs that will need to be addressed before a patient is likely to start using a different treatment regimen. It has been integrated into an accompanying set of scripts that a clinician might use — 'Reliever Reliance Test' — and we want to test how it might be used. As so many routine asthma consultations have been postponed due to Covid-19, could it contribute to the identification of who should be prioritised for review?

The IPCRG are keen to collaborate with colleagues in London to kick off 'Asthma Right Image', which starts to challenge the use of wrong images of asthma

IPCRG

The IPCRG is a clinically-led primary care charity with a vision that through universal access to right care everyone can breathe and feel well. We are an alliance of 34 national primary care organisations with a special interest in respiratory health, reaching over 150,000 primary care professionals around the world. We are also a community of practice, collaborating globally on respiratory research and innovation, and exchanging knowledge about best practice and impact. In many countries we work within a family medicine model and are a Special Interest Group (SIG) of the global family doctor association (WONCA) in Europe, and also have a collaboration with WONCA global. In others, often low and middle income countries, and in rural and remote areas, we work with broader models of primary care often delivered by community nurses and community health workers. We welcome engagement of more nurses. To learn more, visit: www.ipcrg.org

in the media: which inhaler is being demonstrated, is it being demonstrated correctly, are children and adults represented, are the clinical team representative of primary care and multidisciplinary? Too often images portray white white-coated clinicians watching people with asthma misuse the wrong inhaler. Pressure needs to be put on the system to change by making it easy to do the right thing.

Stakeholders have been asked where people with asthma first receive information and guidance about their asthma, with the conclusion being that this might include pharmacists and emergency departments and therefore it is important to engage with them as much as possible. Pharmacists have been keen to get involved and to demonstrate the role that they can play in the asthma pathway, despite the lack of attention and reimbursement in many countries (www.ipcrg.org/news-and-events/a-response-to-the-potential-role-of-local-pharmacies-to-assess-asthma-control-an).

A new poster is also available for emergency departments and urgent care centres which summarises Asthma Right Care for these settings (www.ipcrg.org/asthmarightcare).

Testing is also underway to see if a paradigm shift in how asthma is perceived and treated is being achieved. We want to see a shift in the ratio of SABA: inhaled corticosteroid. But for now, more noise and more commitment to change are needed.

Messaging and framing the messages for frontline clinicians and people with asthma is only part of the story. Pressure also needs to be put on healthcare systems to make it easy to do the right thing. This might mean funding clinical and education time for nurses and pharmacists, providing affordable inhalers and spacers, and helping people protect themselves from asthma triggers, such as air pollution (RCP, 2016; 2018b). It means finding appropriate ways to improve the proportion of people with asthma who have personalised asthma action plans (Morrow et al, 2017). It also means ensuring that asthma diagnosis is done and communicated well to improve health literacy and break down the long-established stigma of asthma and chronic disease in some communities (www.ipcrg.org/personalisation).

The IPCRG wants everyone to know that Asthma Right Care is not yet a reality, that this is a problem that results in harm, that it is possible to do something about it, and that it is everyone's responsibility to make Asthma Right Care a reality.

HOW CAN YOU GET INVOLVED?

If you work in a country that is already part of Asthma Right Care, please contact us to be introduced.

If you are in a country that is keen to start, an implementation pack that helps you through the stages has been developed (www.ipcrg.org/asthmarightcare/asthma-right-care-implementation-pack-introduction).

REFERENCES

Bloom CI, Cabrera C, Arnetorp S, et al (2020) Asthma-related health outcomes associated with short-acting ß2-agonist inhaler use: an observational UK study as part of the SABINA Global Program. *Adv Ther* 37(10): 4190–4208

Center for Evidence-Based Practices at Case Western Reserve University (2010) *Readiness Ruler*. Available online: www.centerforebp.case.edu/resources/tools/readiness-ruler

Chan AHY, Katzer CB, Horne R, et al (2020) SABA Reliance Questionnaire (SRQ): Identifying patient beliefs underpinning reliever overreliance in asthma. *J Allergy Clin Immunol Pract* 8(10): 3482–89

Del Castillo J, Nicholas L, Nye R, Khan H (2017) *We change the world. What can we learn from global social movements for health?* NESTA. Available online: https://media.nesta.org.uk/documents/we_change_the_world_report.pdf

Global Asthma Network (2018) The *Global Asthma Report*. Available online: www.globalasthmareport.org

Global Initiative for Asthma (2021) *Global Strategy for Asthma Management and Prevention*. Available online: https://ginasthma.org/

King's Fund. *The third health care revolution: a new paradigm for better value health care*. Available online: www.kingsfund.org.uk/sites/default/files/Muir-Gray.pdf

Janson C, Menzies-Gow A, Nan C, et al (2020) SABINA: an overview of short-Acting ß2-agonist use in asthma in European countries. *Adv Ther* 37: 1124–35

Lancet journals (2017) *Right Care*. Available online: www.thelancet.com/series/right-care

Maternity Experience. *Whose shoes* Available online: http://matexp.org.uk/category/whose-shoes/ http://nutshellcomms.co.uk/

McKimm J, Vogan CL (2020) Followership: much more than simply following the leader. *BMJ Leader* 4: 41–4

Morrow S, Daines,L, Wiener-Ogilvie S, et al (2017) Exploring the perspectives of clinical professionals and support staff on implementing supported self-management for asthma in UK general practice: an IMP2ART qualitative study. *NPJ Prim Care Resp Med* 27(1): 45

NHS England Sustainable Improvement Team and the Horizons Team (2017) *Leading Large Scale Change: A practical guide*. Available online: www.england.nhs.uk/wp-content/uploads/2017/09/practical-guide-large-scale-change-april-2018-smll.pdf

Royal College of Physicians (2014) *National Review of Asthma Deaths*. Available online: www.rcplondon.ac.uk/projects/national-review-asthma-deaths

Royal College of Physicians (2016) *Every breath we take: the lifelong impact of air pollution*. RCP, London. Available online: www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

Royal College of Physicians (2018) *Wales primary care clinical audit report 2017/2018*. Available online: www.rcplondon.ac.uk/projects/outputs/wales-primary-care-clinical-audit-report-20172018

Royal College of Physicians (2018) *Reducing air pollution in the UK: Progress report 2018*. RCP, London. Available online: www.rcplondon.ac.uk/news/reducing-air-pollution-uk-progress-report-2018

Sivers D (2010) *First follower: leadership lessons from a dancing guy*. Available online: https://sivers.org/