Real world evidence

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Primary care is associated with a more equitable distribution of health in populations.

It can deliver cost-effective:

- Care
- Smoking cessation
- Vaccination: flu, pneumococcal
- Maternal health and information about smoke exposure
- Diagnosis and management of multi-morbidity
- Diagnosis and treatment of allergic rhinitis in children and adults
- Diagnosis and treatment of asthma in children and adults, action plans, routine monitoring and referral where appropriate
- Diagnosis and treatment of COPD, including smoking cessation, inhaled medicines, referral for pulmonary rehabilitation and to hospital specialists where necessary
Working locally, collaborating globally to improve respiratory health in primary care

Research capability & coordination
- Build critical mass & common purpose
- Promote research
- Research Fellow (Ho Chi Minh-Leiden-Southampton)
- National workshops
- E-Faculty – small grants programme
- Prize-winner support
- Abstract review

Evidence-generation
- Needs led
- Multi-national
- UNLOCKing primary care data
- Implementation eg FRESH AIR

Dissemination of collective intelligence
- Publication – peer & lay
- Education: International Teach the Teacher
- Education: In-country programmes

2 year cycle creating opportunities, building capability and increasing motivation to carry out, enable and organise research into prevention, diagnosis and care, and to make results available for public and professional benefit

May 2016/2018 world conferences
- Presentation of evidence
- Abstract peer review
- Discussion about best practice
- Improve confidence and elevate importance of specific actions
- Develop cooperation
- Review of need

Membership development
- Build community:
  - Associate Corporate members
  - National country members
  - Individuals

| IPCRG | International Primary Care Respiratory Group | Primary Care Respiratory Medicine | npj | 9th IPCRG World Conference | Porto, Portugal | 30 May - 2 June 2018 |
We generate respiratory questions and evidence in primary care

2010 145 questions

March 2012: 62 questions:
80% consensus for 4 or 5 priority score
7 questions achieved 100% agreement:
46% about how to improve diagnosis;
19% practical management strategies
And in new regions

- First scientific meeting in Asia Pacific
- First respiratory research school
- First school prize winner
- First meeting in South Asia last year
- Slovenian meeting: primary care KOLs
- Three IPCRG directors on WHO-GARD
- President attended WHO CRD Technical Meeting including revision of WHO-PEN
We build research capacity E-Faculty, Research Fellow

Vietnam, Romania, Chile
We mentor and support the new generation
We started the FRESH AIR movement: now a EU Horizon 2020 implementation science project in 4 countries, 3 years
An implementation science project to improve prevention, diagnosis and treatment of chronic lung diseases where resources are limited

- Around 90% of deaths from COPD and 80% deaths from asthma occur in low and middle-income countries (LMICs) [WHO]
- In 2010 the IPCRG established the FRESH AIR programme to explore this issue
- The European Commission has awarded Horizon 2020 funding to extend FRESH AIR
- A FRESH AIR Consortium of 14 partners has been set up to undertake research in Uganda, Greece, Vietnam and Kyrgyz Republic
- Over the three years 2016–2018 FRESH AIR will explore why so many people in LMICs are dying from chronic lung diseases and how the burden of disease from birth to death can be reduced
- FRESH AIR will use implementation science to study how to adapt evidence-based interventions in different low resource settings

To receive updates on emerging results from FRESH AIR:
Sign up at www.theipcrg.org/freshair/newsletter

www.theipcrg.org/freshair
@FRESHAIRTeam
Indoor air pollution from cooking **Masindi, Uganda**

Smokers – the problem of tobacco dependence **Crete**

Spirometry testing, **Highlands Kyrgyz Republic**

Patient asthma and COPD club, **Ho Chi Minh City, Viet Nam**
The FRESH AIR concept

Continuum of action for lung health

Awareness raising

Promoting and protecting children's health

Prevention

Diagnosis

Treatment and support for patients
• IPCRG initiated programme
• To improve understanding of the prevalence of chronic respiratory diseases and their risk factors, including all types of smoke
• To develop capacity to implement evidence-based interventions for prevention, diagnosis and treatment of these diseases in low-resource settings
Progress so far

• Started with prevalence study in Vietnam
• Moved to Uganda with pilot, then 3-year study
• Won European Lung Foundation grant to commence some public awareness programmes in Kyrgyz Republic
• Won Horizon 2020 grant to work in these + Greece, and to build engagement in additional countries
• Interest in Georgia – developed a protocol, Hungary, Kazakhstan, sub-Saharan Africa including Eritrea, Bangalore slums
Consortium

- Leiden University Medical Centre (*Coordinator*), Netherlands
- International Primary Care Respiratory Group (*SME*), UK
- Makerere University College of Health Sciences, Uganda
- Ministry of Health Kyrgyz Republic, Kyrgyz Republic
- University of Medicine & Pharmacy, Ho Chi Minh City, Vietnam
- University of Crete, Greece
- ARTEG (*SME*), Netherlands
- European Lung Foundation, UK
- University of Washington, USA
- National Centre for Smoking Cessation and Training (*SME*), UK
- University of Groningen, Netherlands
- University of Copenhagen, Denmark
- (European COPD Coalition, Belgium)
- Plymouth University, UK
Overall aim

To improve health outcomes for people at risk of or suffering from non-communicable lung diseases in low-resource settings by developing capacity for implementation of evidence-based interventions for prevention, diagnosis and treatment in these contexts.

Scope

• Kick off October 2015
• End September 2018
• 7 work packages
• Activities over 36 months
• Budget of €2.99m
There are other IPCRG Projects related to FRESHAIR

Two major partnerships with UK centres of academic respiratory excellence

• The University of Birmingham - **BREATHEWELL**.

• The University of Edinburgh - **RESPIRE**
  – to build research capability in respiratory care in LMICs,
  – as part of new global health research initiatives funded by the National Institute for Health Research (NIHR).
We collaborate using routine primary care data: 216k COPD records; 800k asthma; 3.8 million primary care in 15 countries
UNLOCK - Who is involved?

• Initially conceived of as membership conditional on access to a dataset, in practice based on interest
• 27 individuals over 6 years
• Most have combined research/academic and clinical role, some have a research/academic role and some have a clinical role
• 15 countries: Sweden, Spain, Ukraine, Canada, Greece, UK, Netherlands, Norway, Portugal, Germany, India, USA, Australia, Uganda and Chile
• 15 have attended five or more meetings, 21 two or more
• 14 have contributed data to an UNLOCK study
The data available to UNLOCK

- Participants in the UNLOCK Group have access to 14 datasets
- One has become outdated and five have been added
- From 9 countries
- 10 datasets have been used in at least one UNLOCK study
- 3.8m primary care patients, 800,000 patients with asthma and 216,000 patients with COPD
- Variations in dataset size, purpose and variables included
- Some common variables (demographics, diagnosis, medication, smoking status)
- Routine data, cohort studies, pragmatic clinical trials
- Different ownership and governance arrangements
UNLOCK achievements

- 9 studies on the diagnosis and management of COPD, asthma and ACOS in primary care
- 9 publications
- Many presentations at conferences
- Access to data from 3.8 million PC patients across 10 countries
- A sustained network of primary care researchers from 15 very different countries
Challenges and constraints

Time, or lack it!

- Many demands on the time of UNLOCK participants due to their clinical and/or research priorities
- Studies progress as fast as the slowest responder
- Analysis, write-up and submission hugely time consuming
- UNLOCK model requires too much input from very busy people
- Ideas people vs doers
Education needs same academic rigour

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 McDonnell, Sian Williams, Niels H Chavannes, Correira Jaime de Sousa, H John Pardy, Monica Fletcher, James Stout, Ron Tomlins, Osman M Yusuf & Hilary Pinnoch

Building capacity to improve respiratory care: the education strategy of the International Primary Care Respiratory Group 2014–2020

This article has been corrected since publication and a corrigendum has also been published

Juliet McDonnell¹, Jaime Correia de Sousa², Noel Baxter³, Hilary Pinnoch⁴, Miguel Román-Rodríguez⁵, Thys van der Molen⁶ and Sian Williams⁷

Significant attention has been given to the global burden of noncommunicable diseases including respiratory diseases and the potential of primary care to address this challenge. The International Primary Care Respiratory Group (IPCRG) has a potentially significant role to build capacity through research and education in a complex global network with varying degrees of capability. In this paper we outline a comprehensive strategy, which revisits the IPCRG’s educational role, our aims, audiences and approach in
Improving the care of adults with difficult to manage asthma: a practical guide for primary healthcare professionals

**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 frequent exacerbations despite appropriate treatment.

There are two main groups of patients with difficult to manage asthma:

- People whose asthma has been controlled in the past but who now have poor control.
- People whose asthma has never been controlled.

Interventions and management should aim to:

- Identify when asthma control is lost and asthma management should be reviewed.
- Achieve control and maintain control of asthma with effective, well-tolerated treatment.

**HOW TO REVIEW A PATIENT WITH DIFFICULT TO MANAGE ASTHMA**

Regular structured reviews is the key to measure the effectiveness of treatment goals are achieved, and to identify when asthma control is lost.

**Before the review**

- Encourage patient to use a quick checklist before each visit to provide key information quickly and plan what they want to discuss with you.

**At the review**

- **SIMPLE** provides a useful acronym for the main factors to check:
  - **S**tabilization
  - **I**nspection
  - **M**easurement
  - **P**atient history
  - **L**ifestyle
  - **E**ducation

- **S**tabilization: Is the patient stable and able to breathe comfortably?
- **I**nspection: Are the patient's day-to-day activities affected by asthma?
- **M**easurement: Are the patient's peak flow readings within the normal range?
- **P**atient history: Does the patient have any new symptoms or concerns?
- **L**ifestyle: Does the patient have any new or changing lifestyle factors?
- **E**ducation: Does the patient understand their treatment plan and how to manage their asthma?

**SUPPORT**

- Ask patient to identify what makes their asthma worse and how they manage it.
- Ask patient to identify any recent changes in their treatment plan.
- Ask patient to identify any new environmental factors that may be contributing to their asthma.

**EDUCATION**

- Check patient understanding of their treatment plan.
- Check patient's knowledge of their asthma and what they can do to manage it.
- Check patient's knowledge of their medications and how to use them effectively.

**RESOURCES**

For tools, resources and references go to www.ipcrg.org/difficultasthma

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**Difficult to manage asthma**

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**TEACH THE TEACHER**

No. 2 April 2012

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**DESKTOP HELPER**

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**For tools, resources and references go to www.ipcrg.org/difficultasthma**
Helping patients quit smoking: brief interventions for healthcare professionals

How to help smokers quit: flowchart

1. ASK:
   - Have you used tobacco in the last 12 months?

   No: Congratulate. Reinforce non-use. Patients should be asked about smoking for 5 years after quitting. People seldom relapse after 5 years' abstinence.

   Yes – quit in the last 12 months: Congratulate. Ask if they need help. Help them quit smoking. Encourage them to contact you or seek other counselling if they have any difficulty quitting, smoking cessation clinic or other.

   Yes – current smoker: Take brief smoking history: number of cigarettes smoked a day, years of smoking, time to first cigarette; presence of smoking-related disease; previous quit attempts and what happened? Use a non-judgemental question such as “How do you feel about your smoking at this moment?” Express concern/interest not criticism.

2. ASSESS: MOTIVATION TO QUIT
   - On a scale from 1 – 10 how interested are you in trying to quit?

   1 2 3 4 5 6 7 8 9 10

   NO, not ready!
   - ADVISE
     - Focus on motivation, remember motivation can be influenced by CO testing can be useful
     - Advise the patient on the benefits of quitting without criticism/confrontation
     - Respect the patient’s decision
     - Ask if you may ask the patient about their dangers of smoking
     - Ask, “Is there anything that might help you consider quitting?” or “Can you imagine any benefits of quitting?”
     - Offer help if the patient should change his/her mind

   YES, but not yet... unsure:
   - ADVISE:
     - Focus on their ambivalence, help them motivate themselves
     - Offer help by asking: “What are the things you like and don’t like about quitting?”
     - “Have you tried to quit before?”
     - “How did you get on when you last quit?”
     - “What would have to happen for your motivation score to increase?”
     - “How can I help you increase your confidence in quitting?”

   YES, ready to quit:
   - ASSIST:
     - Provide assistance in developing a quit plan
     - Help patient set a quit date
     - Advise on pharmacotherapy for smoking cessation: nicotine replacement therapy (NRT) or a prescription for varenicline or bupropion when indicated
     - Include the following as needed:
       - Discuss abstinence and suggest coping strategies
       - Encourage social support
       - Assist in dealing with barriers such as fear of failure, stress coping, weight gain, social pressure
     - Give nutritional advice: sleep well, avoid caffeine and alcohol
     - Physical activity may help
     - Withdrawal symptoms occur mostly during the first 2 weeks and are less so after 6-7 weeks

   ARRANGE:
     - Follow-up consultation or telephone contact within 6 months or remember to ask when you next see the patient.

5 As of helping smokers quit: ASK ASSESS ADVISE ASSIST ARRANGE

MEDICATION
Medication should be offered to every adult patient with nicotine dependence if:
- They smoke more than 10 cigarettes a day
- And smoke within half an hour of waking they are particularly likely to benefit from withdrawal symptoms and should be offered pharmacological support even if they set a quit date

Nicotine Replacement therapy (NRT)
Its main effect is to reduce withdrawal symptoms and help the patient through the first 2 months of quitting. Most patients use low dose for 1-3 months and then can gradually reduce the use over some months. Added success has been shown if they start NRT 14 days prior to their quit day.

Dosage: is often wise to combine two different NRTs – a patch to last most of a 24 hour period and gums or other oral forms of NRT for craving situations during daytime.
Patch: The most common dosage forms are 14/24 hours or 16/16 hours for lighter smokers. Some patients need more or less than this. It is usual practice to start some patients on an extended-release nicotine patch, 15 mg/24 hours.

Nausea, dry mouth, headache, dizziness, anxiety and depression are the most common side effects associated with NRT. These are usually manageable, except very occasionally where large doses are needed.

Bupropion
Bupropion was originally developed as an antidepressant. It reduces the urge to smoke as well as symptoms from nicotine withdrawal.

Dosage: Twice daily starting with one tablet a day for a week or two prior to quit day, then gradually 150 mg from quit date for 7-12 weeks.
Possible side effects: insomnia, headache, dry mouth, dizziness, anxiety, elevated blood pressure if combined with nicotine.

HARM REDUCTION
Other nicotine products have been suggested as useful to reduce the harm of cigarette smoking. Chewable nicotine, snuff and nicotine lozenges have had limited use and are not highly recommended. These methods are less harmful than smoking but...
E-Quality Projects
2013 - 2016

- Spirometry 360
  US/Australia – 2013
  (now working in Sri Lanka, Bangladesh)

- Matrix Support
  Brazil - 2014

- Matrix Support/Telemedicine
  Brazil – 2015

- Transition to adult asthma care
  Germany - 2016

- Antibiotic Prescribing
  Macedonia - 2015

- Stop smoking education
  Bulgaria - 2016

- Evaluating asthma management training
  India - 2013

- Developing capacity for spirometry
  Sri Lanka - 2015

- Introducing diagnostic tools to HCP educators in Eritrea – on hold
The Asthma Right Care initiative

- The IPCRG is leading an international pilot that is exploring how to use social movement approaches to create a desire for change in the management of asthma, and testing how to create a sense of discomfort and dissatisfaction with this amongst all stakeholders.
- We set up a multi-national Delivery Team from four pilot countries, Canada, Portugal, Spain and the UK that includes patients, pharmacists, GPs and nurses.

- Our focus, in the first phase, is on the over-reliance on short-acting beta2 agonists (SABAs),
Respiratory Health: Adding Value in a Resource Constrained World

In collaboration with:

• GRESP Portugal
• GRESP Brazil
• GRAP Spain
• GRAP Chile
Thank you for your attention!