Asthma Right Care case studies

In these three case studies clinicians explain how practices can help their patients to reduce their over reliance on short-acting beta2 agonists (SABAs).

Case study 1: The importance of system change in the practice

Noel Baxter *Locum GP and PCRS Policy Lead*

All GPs will be familiar with the duty of reviewing and reauthorising repeat prescriptions. If you are reviewing a prescription request for an inhaler used for asthma it is an important opportunity to communicate the right thing and this must be done in a positive way.

However GPs normally do their repeat prescriptions at the end of a session or working day and often there is no time allotted for this task, despite its importance. You may have five or 50 to do, ranging from a complex request for 10 or more medicines from a frail elderly person or carer or a 'straightforward' request for 'my blue inhaler'. You can imagine which slips past the quality control filter!

Fortunately many practices now realise that getting medicines right from the start and being effective in reviewing them can save time and reduce the stress on GPs working late into the evening. The rise of the practice pharmacist is making a big difference and giving clinicians with the right skills and interest the time to do virtual medicine reviews and means Asthma Right Care has the space to happen.

I have led the system change option just described and ensured that the right people have the right time to review peoples' medicines. You can do this if you are a partner or clinical leader in a practice which I have been but I am now a locum so have had to find a different way.

How I tackle SABA overuse as a locum

When a 'blue inhaler' request comes in for someone with asthma but not COPD I normally do a quick count up of how many SABA devices they have had in the last six months or one year and also how much reliever inhaler they have had. I am generally looking at what the ratio is – ideal is better than 3:1, preventer: reliever.

I know that sometimes the blue is requested automatically at the same time as the preventer – even though the patient isn't using it – so if I can see a reasonable amount of reliever being requested, for me that is about six devices per year, I worry less about the SABA request. If the reliever request is less than six and it seems the default is to request SABA then I take action.

Many practices have now set up systems to easily text patients about a need for an appointment for a result or a medication review so this makes direct contact easier and it isn't time consuming. An alternative is adding some text to the prescription as a communication to the patient. This needs careful wording.

Another option is to leave the dispensing pharmacist a note on the prescription asking them to check when dispensing that the patient is using their inhalers safely. Often the pharmacist won't know what the inhaler is for so letting them know it's for asthma can really help them do the right thing.

The importance of getting the language and tone right

I think that issuing the SABA requested sends a message that you are not trying to restrict access to what they feel they need and this helps avoid conflict. Experience has told me that saying 'NO'

doesn't move you forward. Then with this positive step should come a boundary creating statement about your responsibility as prescriber and that it is for their safety.

For example:

"Dear X. I can see that you have been prescribed x blue inhalers over the past x months. People usually request more blue inhalers when they are having more symptoms and their asthma is uncontrolled. I am worried that this puts you at risk of an asthma attack. Blue inhalers don't treat the underlying cause of asthma. It seems you are underusing / not using your preventer. I have also issued your preventer as it has been a long time since you have requested it as your request for a blue now suggests you should restart this now. Please make an appointment to see the asthma nurse / pharmacist or GP as soon as possible so we can help you get your asthma back under control. When you contact reception explain that you have received a message that you may be at risk of an asthma attack and that you need a review soon."

Practically speaking it's good to have a bank of these frequently written messages on a word document so you can copy and paste them in – every 30 seconds counts when you are doing your repeat prescriptions.

Of course sometimes you get a request for SABA with neither asthma or COPD coded which is also a flag for a review. I am fairly explicit here in my prescription note message:

"Please find attached a prescription for your inhaler. I am concerned that you do not have a diagnosis on your record for this type of medicine. This is a medicine for people with asthma or COPD so if you do not think you have one of these conditions then you should book in to see a GP, asthma nurse or practice pharmacist soon. If you do have one of these conditions then please ask your usual health professional to update your records next time you are seen."

Once you have sent your message you need to decide what to do with the current prescription. I generally take one of two options:

a) Move the SABA to acute to prompt the prescriber to review why there has been no response.
b) Restrict the SABA repeat to a 'safe limit'. I usually switch the number of devices from two to one and restrict the number of issues to three per year. Then any request outside these limits ensures that a prescriber will look and consider what is happening, precipitate another call, text or message and keep reinforcing that the practice prescribers are trying to support the patient to do the right thing.

The outcome of this approach

People really appreciate that you are thinking about their care and safety and that the person reading their request for their repeat medication is being thoughtful.

These days I don't always see the outcome because the chances are patients may not see me again as a locum. But I hope that it starts a helpful conversation about right asthma care when they do see their community pharmacist or practice health professional.

I know that dispensing pharmacists really appreciate the communication because they often find it hard to get to speak with us. Building bridges with colleagues in your network can only be a good thing.

What I have learned about reviewing SABA prescriptions

- Better asthma care comes when you work positively and in a caring way with people who are using medicines. You need to understand why they do what they do then work with that information.
- Sometimes it is very hard to shift people's beliefs about their SABA and that you can't win them all. Some people seem to be truly addicted to SABA but this is an extreme minority and we shouldn't avoid doing the right thing just because this happens. When it does occur, get help from colleagues, think about any mental health and social issues and if you have a primary care friendly respiratory specialist then speak with them too.
- Every new diagnosis of asthma should begin with an agreement between the prescriber, the patient and the dispenser about what is right and safe and what is not. We should all be in agreement about when a review should happen.

Case study 2: A one off project to tackle SABA overuse in a practice

Frances Barrett *Independent respiratory specialist nurse for General Practice, associate university teacher, Director and Respiratory Trainer for Barrett McGrath EMS Ltd.*

In September 2015 Frances was invited into Loughbrickland Health Centre in County Down, Northern Ireland, to help address their concerns around the high levels of SABA overuse in their practice.

The first step was to get the practice IT specialist to search for all patients with a read code of asthma who had been prescribed 12 or more SABAs in the previous year.

This search identified 96 people with an age range of between seven and 88 years. The numbers of prescriptions issued to this cohort ranged from 14–56 in the preceding 12 months.

"This problem was found to be compounded by the fact that all asthma patients' medications were on repeat prescriptions, which meant when they phoned in to request their medications 'all items on the repeat list' were inadvertently being issued – and that was a big learn for me," says Frances.

The second stage of the process was to invite in all 96 patients identified for a specialist review.

However, this is a notoriously challenging group of patients to entice in for review, so a bespoke invitation letter was compiled in an effort to encourage as many people as possible to attend.

This letter explained to each patient that the practice had some concerns regarding their asthma control and in an effort to address this they were being offered a 45 minute appointment with a respiratory specialist nurse. It acknowledged that this appointment might not fit with the patient's diary, but said the practice was happy, where possible to accommodate them as this review would be well worth attending.

The response to this letter was unprecedented with a high attendance rate at clinic being achieved – only seven patients declined to attend. In total 84 patients attended for an initial review with 45 needing a further follow-up review.

The first stage of the review process was to confirm or negate the patient's diagnosis of asthma: subsequently 65 patients had a confirmed diagnosis of asthma, 12 were diagnosed with varying classifications of COPD and four had an asthma COPD overlap syndrome (ACOS). The diagnosis of three people was determined as 'unsure' – two patients had a BMI of greater than 40 which may have been a factor contributing to their respiratory symptoms and one patient was thought to be suffering from anxiety.

Frances conducted a holistic assessment of each patient which included a subjective review of PMH, social history, family history, symptom history and smoking history, in conjunction with objective assessments including serial peak flow testing, exercise testing, spirometry including, where appropriate reversibility, fractional exhaled nitric oxide (FeNO) testing and trigger identification.

Five hundred and three interventions were then made across the 65 asthmatic patients reviewed.

The outcomes

After 18 months only 30 of the 96 patients identified in September 2015 as over relying on their SABAs were using 12 or more inhalers, but it takes a few months for this to be corrected via compass which was substantiated when one year later this number had further reduced to 10.

The interventions that achieved these results included:

Education of patients in:

- Understanding the underlying pathophysiology of their asthma
- How asthma therapies work – broadly simplified into preventors vs relievers

- The uncomfortable outputs of the NRAD[1] report – why overuse of SABA can be indicative of poor asthma control
- Understanding the signs and symptoms of asthma and early recognition of increasing symptoms – effective self-monitoring
- Use of the Asthma Control Test and understanding of the scores
- Training in the effective use of the peak flow meter
- The importance of their adherence to preventer therapy
- Appreciation and understanding of the need for optimal inhaler technique

In addition:

- Patients were advised that their SABA would no longer be on their repeat list of medication but would be placed on the 'acute' list – and only available if they specifically requested it for all the reasons discussed with them
- Patients were involved in collaborative development of a bespoke personalised self-management plan

This practice is now one of the lowest SABA prescribers for asthma in their Federation.

What could have been done differently?

Frances says: "I could have mentored or facilitated the nurse from the practice during the project to ensure a legacy remained. This work is something any practice nurse, who has had some respiratory training could do in a practice, as QOF reviews present the perfect opportunity for noting potential red flags of inappropriate asthma self-management with poor levels of symptom control and to strive towards reducing SABA usage in asthma management. This is very rewarding work."

What Frances has learned:

"If you clearly explain to patients the potential dangers of over-reliance on SABA inhalers emphasising why it is important that they should monitor how many doses of SABA they are using regularly per week and help them to develop a strategy to recognise potential over-reliance – they will effectively accept this rationale. They will start to optimally measure their own asthma symptoms in conjunction with peak flow readings to note any variability and will subsequently make a concerted effort to reduce over-reliance on their blue inhaler."

"Although I was happy when I left the practice that we had achieved the target of reducing the number of patients receiving 12 or more SABA prescriptions a year, I would now reduce that to a maximum of between two and three SABAs. As Noel Baxter has pointed out – theoretically anyone using more than six puffs per week is overusing (two puffs three times per week) – this amounts to just over 300 puffs per year which, at 200 puffs per device equates to a maximum of two devices per year. So it could be said that 12 devices per year is already six times over generous."[2]

References

1. Why Asthma Still Kills. National Review of Asthma Deaths. August 2015 https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills
2. Noel Baxter, *Primary Care Respiratory UPDATE*, Volume 3, Issue 1 SPRING 2016

Case study 3: A QIPP project to incentivise a reduction in SABA prescriptions

Dr Katherine Hickman *GP, Low Moor Medical Practice and Respiratory Lead for the Leeds and Bradford area*

In her role as respiratory lead Katherine persuaded Bradford City and Bradford District CCGs to run a QIPP (Quality, Innovation, Productivity and Prevention) project in 80 practices to reduce the number of patients overusing SABA medication.

For year one they focused on those patients who were receiving more than 12 SABA inhalers a year. The target of the project was to reduce the number of SABAs being issued to 80% of these patients from 12 or more down to six a year.

Katherine explains: "The 80% target was decided because a one hundred percent success rate is not achievable. It is very difficult to reduce the SABA use of a small group of patients who have issues such as uncontrolled asthma, dysfunctional breathing, anxiety or mental health issues – we will go back next year to help practices to further unpick the more complex issues of these patients."

The project was launched in April this year and will run for 12 months. Practices have been given audit report software designed by the CCG's medicines management team which will enable them to identify how many patients with asthma have been prescribed 12 or more SABAs a year.

After the report has been run practice pharmacists will work manually through the notes of the patients identified. Patients receiving 12 or more SABAs a year will be given only one SABA inhaler on repeat, instead of two. If patients are getting a SABA inhaler every 28 days that will be changed to 56 days, automatically extending the time the SABA inhaler should last. Review dates are also changed. So instead of an annual review patients will be called in after they have received three SABA inhalers.

Receptionists have been trained to explain the changes to patients and have been given patient information leaflets to hand out.

The message being given to patients is that nobody will be denied a salbutamol inhaler but a repeat prescription will trigger a review or a phone call from a GP to inform them that a lot can be done to help them with their asthma.

When the patients come in for review the GP or nurse will help them to improve their self-management by making sure they are remembering to take their inhaled corticosteroids, that they have good inhaler technique and have got the right inhaler that suits them. Patients will also be educated about the pathophysiology of asthma and what the different roles are of the blue and the brown inhalers and they will have their smoking history checked.

The hoped for outcomes

The project will run until 30 April 2020. Katherine says their aim is to prove that patients using 12 or more SABAs a year can be persuaded to cut down to 6 or less.

Practices are incentivised financially to achieve this respiratory target because it is part of the CCG's Quality Improvement Plan. However Katherine is concerned that the respiratory QIPP will have to compete with other QIPP targets. Katherine is running two training events in November and December and will be highlighting the project and hopes this will incentivise practices to start doing the work.

"If you get it right this work is absolutely transformational for patients. I can sort out over 95% of patients who have been over using SABAs in a ten minute consultation just by doing the simple things that will improve their self management. It is without doubt the most satisfying consultation that I do."

What Katherine has learned

Katherine says: "It has been an education for me to realise that patients think it's the norm to have

12 salbutamol inhalers a year and that plenty of clinicians think that too. So what we are doing with this project is putting the onus back on the clinician to say to patients – we are failing you, there is so much we can do to help you to manage your asthma in a better way.

"Almost always when I check the patient's inhaler technique I find that they aren't getting any or much of the drug in their lungs. So if they understand how to get their inhaler technique right they can be stepped down to a lower dose and also a less frequent dose. This is better for their health because there are potentially less side effects. It also reduces costs and waste. Once you have educated the patient and you've got them on the right track then the cost savings continue.

"However the main aim of this initiative is not to reduce costs but to give the patient their life back and that's the message I sell them. I ask them – what is your asthma stopping you doing, for example going for a run, playing football, going for a walk or playing with the kids in the park? I frame the conversation around – what did you previously do that you can't now do because of your asthma and what would you like to be able to do? Often patients have normalised their lifestyle and haven't stopped to ask, what should my life be like?

"Seeing patients after they have reduced their reliance on their SABA and how it has transformed their lives it makes this job really worthwhile. I hope this initiative gets the message across to GPs and nurses that there is so much they can easily do to improve the lives of their asthma patients.

"This work is about encouraging practices to make a very small change, almost like a nudge, in the system that will then trigger a bigger change. If I can prove that this can be achieved I hope it will encourage more practices to get on board."

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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