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**Improving concordance in
Asthma Care**



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Education for Health

- UK not for profit educational and research organisation
- Founded in 1987 to improve the care of patients with asthma (National Respiratory Training Centre)
- Trained over 40,000 health professionals from more than 45 countries: Asthma, COPD, allergy, TB, smoking cessation, spirometry
- Merged Heartsave in 2005: Heart failure, CVD, diabetes



Have we really got asthma licked?



UK Asthma Statistics...

- 5.1 million people in the UK (150m - globally NIH 1995)
- 1 in 8 children, 1 in 13 adults currently being treated
- NHS costs £850 million per annum
- 74,000 emergency admissions annually
- 1,400 deaths a year

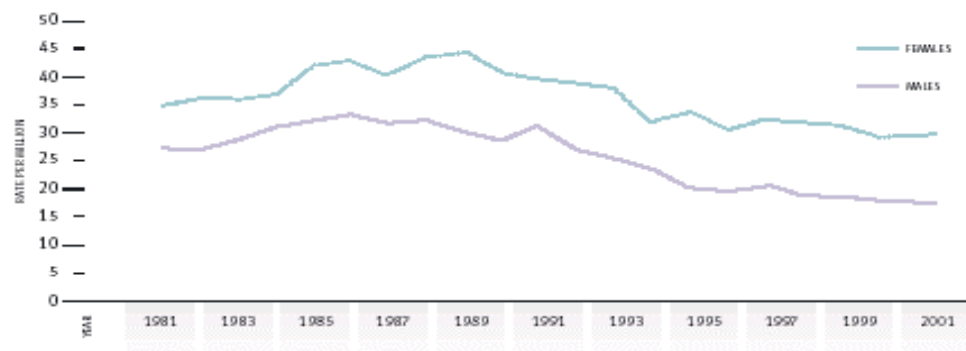


Figure 6: Asthma mortality rate by sex (all ages), UK



Asthma Paradox

Improvements

- Greater understanding of the pathogenesis and prevention
- Therapies and delivery systems
- International, national and local evidence-based guidelines
- Improved educational programs for health professionals
- More knowledgeable patients, care givers, and general public: access to information, internet



Asthma Paradox

But yet...

- Asthma continues to be poorly controlled
- Unacceptable levels of morbidity and mortality
- High utilisation of emergency health care
- Unnecessary hospital admissions



What's the problem?

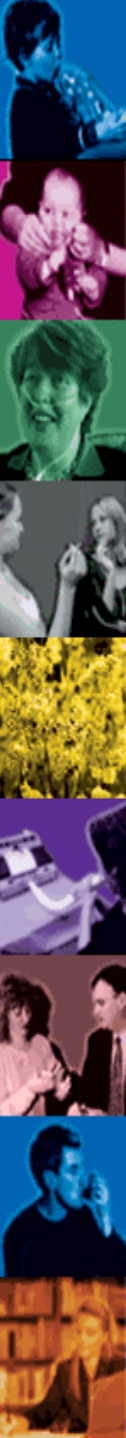
Yip, I can see exactly what
the problem is General



Possible Reasons Health Professionals

- Primary care managed condition - generalists
- Outdated knowledge base
- Training limitations
 - Learning facts alone does not change behavior
 - Communication skills key: **HPs frequently initiate discussions about treatment, but dominate (Elwyn 2003)**
- Guidelines and evidence-based practice not always followed

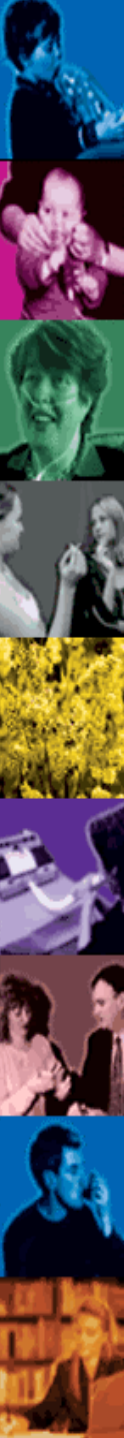




GUIDELINES

Bridging the gap between theory and practice





February 2003, Vol 58, Supplement 1

Thorax

AN INTERNATIONAL JOURNAL OF RESPIRATORY MEDICINE

British Guideline on the Management of Asthma

BMJ

National Asthma Education and Research Program

Asthma

Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma

Update on Selected Topics 2002

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NATIONAL ASTHMA EDUCATION AND RESEARCH PROGRAM

GLOBAL INITIATIVE FOR ASTHMA

LEADING SCIENTISTS FROM
NATIONAL MANAGEMENT AND PREVENTION
CONFERENCES
CONSIDER THE
CONSEQUENCES OF
ASTHMA

WORKING FOR HEALTHIER LIVES

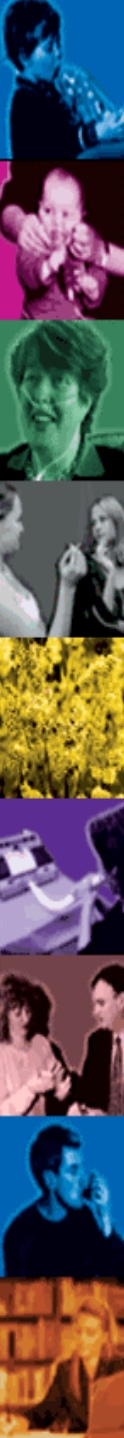
THE BURDEN OF LUNG DISEASE

A Statistics Report from the British Thoracic Society

STRICTLY EMBARRASSED FOR 00.01993
WEDNESDAY 21ST NOVEMBER 2001



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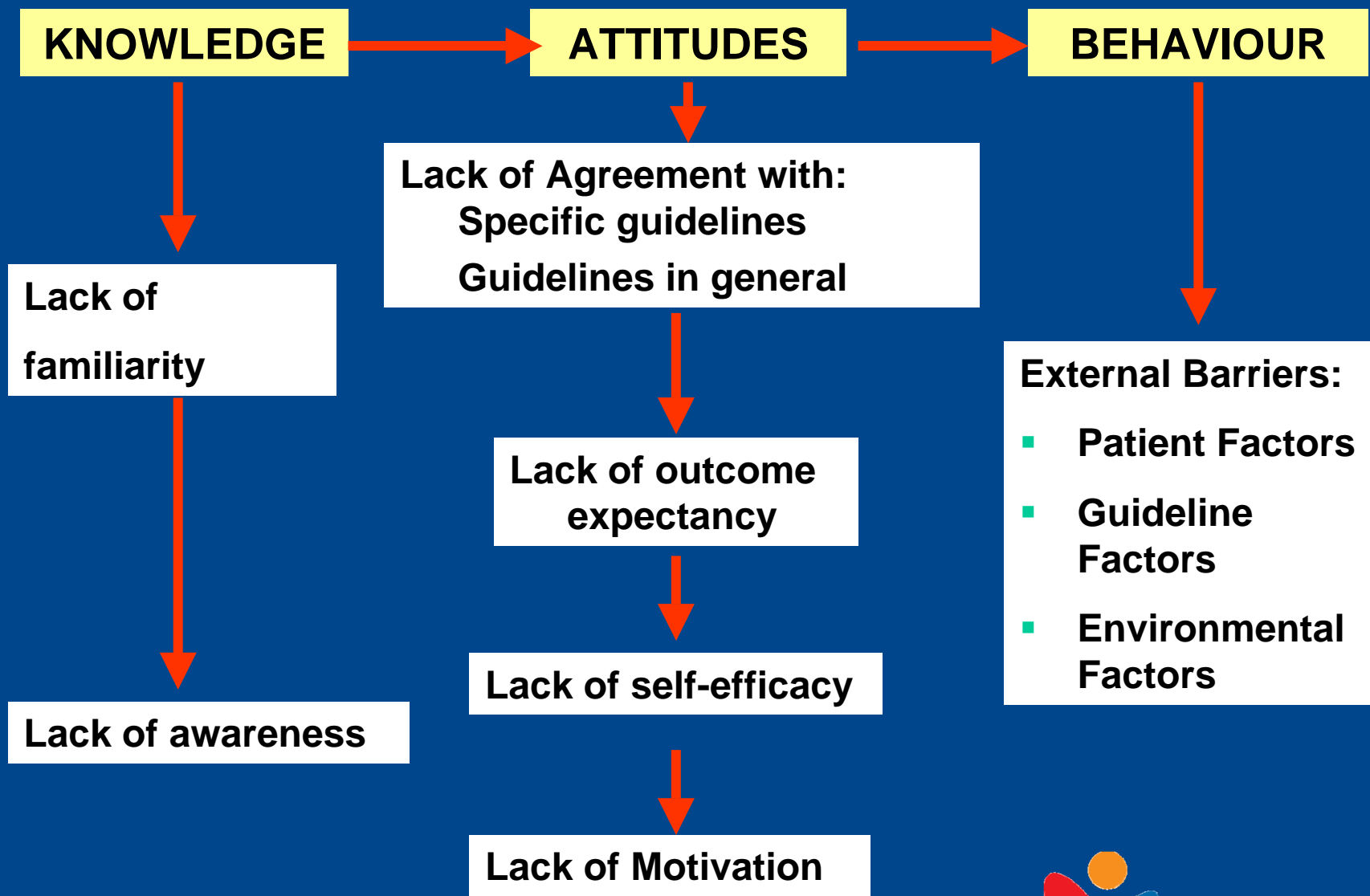
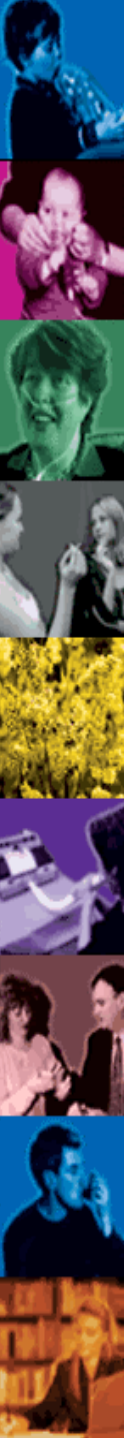


Despite their widespread promulgation, there is unequivocal evidence that guidelines have: limited effect on changing physician behaviour, marginal improvement in patient outcomes and their cost effectiveness is called into question!

Lomas et al(1989), Woolfe et al(1993), Grimshaw et al 2004, Thomas et al (2005)

How are they communicated to Health professionals? Are there lessons to be learnt?





Cabana 1999

Possible Reasons

Health Systems

- Enormous burden of disease
- Fragmented health systems
- Financial pressures
- Acute care model not optimal for chronic illness
- Research needed on organisation for best care

Patient factors

- Tolerance of poor asthma control
- Lack of access
- Lack of effective patient education
- Minimal self management skills
- Failure to follow treatment regimens
- Communication issues



Patients under estimate the severity of their disease

Asthma in Real Life Study
(AIR Study) **Price et al 1999**

Asthma insights & reality in Europe (AIRE) study
Rabe K. et al 2000

Asthma Control and Expectations Survey (ACE)
Griffith Jones K. et al 2002

Living & Breathing Study
Haughney et al 2004

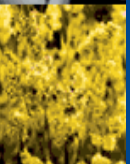
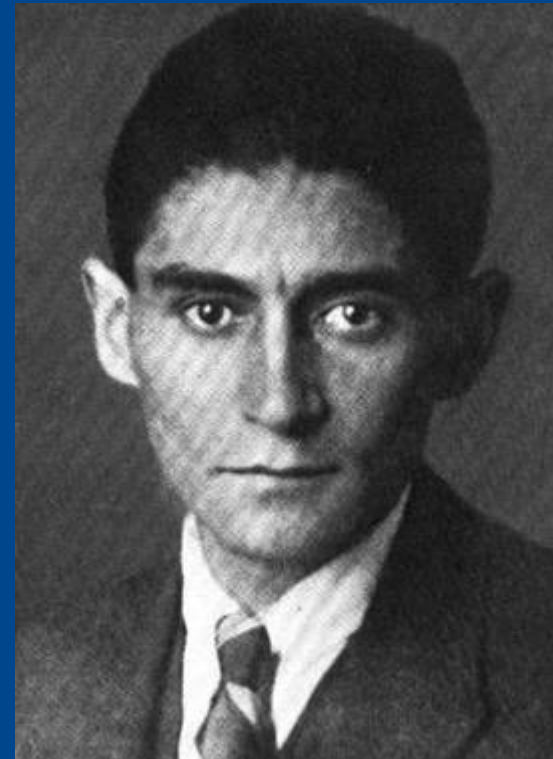


The art of medicine....

"To write prescriptions is easy,
but to come to an
understanding with people is
hard"

Franz Kafka

A country doctor



“When I want your opinion, I’ll give it to you”



It is the patient’s agenda and not the healthcare professionals that determine whether patients take medications

Marrinker & Shaw 2003



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Medicines are a key therapeutic tool in Primary Care

- In UK 686m prescriptions dispensed in 2005
- Cost of over £8bn
- Average of 14 items per head of population
- 45% medicines not taken as prescribed
- 20% not taken at all
- WHO: Non-adherence a worldwide problem of striking magnitude (2004)





UK Government drive Medicines partnership UK initiative established in 2002

“Medicines Partnership exists to enable people to get the most out of their medicines by involving them as partners in treatment decisions, to the extent that they want it, and supporting them in medicine taking. Its task is to work with others to integrate this model throughout the healthcare sector.”



What happens.....

- 1/3 medical advice ignored
- 1/3 adopted incorrectly
- 1/3 followed correctly

Podell (1975)



We need to shift our efforts to improve concordance

- **Compliance:** Whether patients take medicines according to the prescriber – give in to a demand! (Implies passivity)
 - Measures patient behaviour
- **Adherence:** Patients choice to behave (More active) But intentional or unintentional
 - Measures patient behaviour
- **Concordance:** Shared decision making about medicines between a healthcare professional and a patient, based on partnership, where the patient's expertise and beliefs are fully valued
 - Measures a process

Source: Weiss M and Britten N, Pharmaceutical Journal vol 271 (493)



Reasons for non compliance with treatment

- Lack of understanding of the disease/ treatments
- Denial/apathy/complacency
- Fear of side effects
- Complex medication regimens
- Need for control by not adhering to medical advice



Patients attitudes to inhalers

- Nearly half of patients (47%) prefer not to use their inhaler devices in front of other people
- Just over a fifth of patients (22%) like to keep their inhalers hidden
- Nearly a fifth of patients (19%) prefer others not to know they take inhalers
- Three-quarters (75%) of patients felt it was important for devices to be small
- Three-quarters (77%) expressed a preference for minimising the number of daily doses
- Nearly three-fifths (59%) would prefer to use a single inhaler

Fletcher M. et al Patients' perceptions of asthma inhalers: a national (UK) survey.

Eur Resp J; 2005 26 256



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Patients attitudes to inhalers - conclusions

- Patients hold many attitudes regarding their inhalers that are related to adherence
- Clinicians should explore patients' attitudes as they may impact on adherence
- Health professionals should be aware that a substantial number of patients are sensitive about using inhaler devices in public
- Patients' negative attitudes towards their inhaler devices may affect adherence to asthma therapy
- Encouraging patient choice and taking more notice of preferences may improve adherence to therapy

Fletcher M. et al Patients' perceptions of asthma inhalers: a national (UK) survey.
Eur Resp J; 2005 26 256



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Necessity-concerns framework and adherence



Doubts about
NECESSITY

+

CONCERNS
about potential
adverse effects



Low adherence

Horne & Weinman, 1999, 2002



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Four most important factors Influencing compliance

- Clinician/patient relationship
- Patients understanding of disease
- Current beliefs and perception of illness
- Active role in illness management

Mork, Van Ganse, Osman, 2003 Primary Care Respiratory Journal



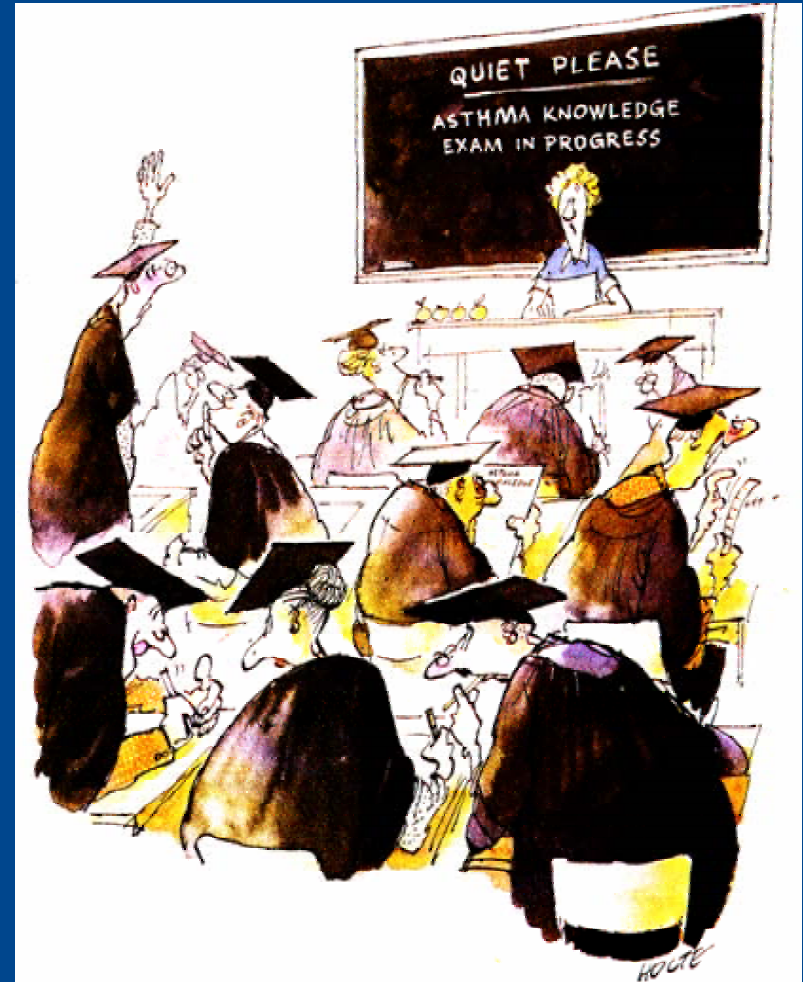
Evidence of improved QOL from asthma education

Cochrane reviews by Gibson et al

Limited education only
patient education
programmes (2002)

Self management & regular
patient reviews
(2002)

Poor correlation between
asthma knowledge alone



Meet Joyce (Monica's mother)



The majority of patients report that they want shared decision making

- For the doctor to decide what is best for me: 32%
- For the doctor and I to decide what is best for me: 40%
- Doctor explains decision choices then I decide which I prefer: 24%

Mori Research : Medicines and the British 2003

50% of people with asthma feel they have a full discussion with their doctor or nurse about the best medication for them



Take the escalator?

- Do we really address patient choice in our consultations?
 - Choice as which treatments we prescribe
 - Which inhalers to use
 - Choice as to whether or not to use an inhaler
 - How symptomatic they wish to be



Fly or not to fly ?

WE all make hundreds CHOICES every day!!

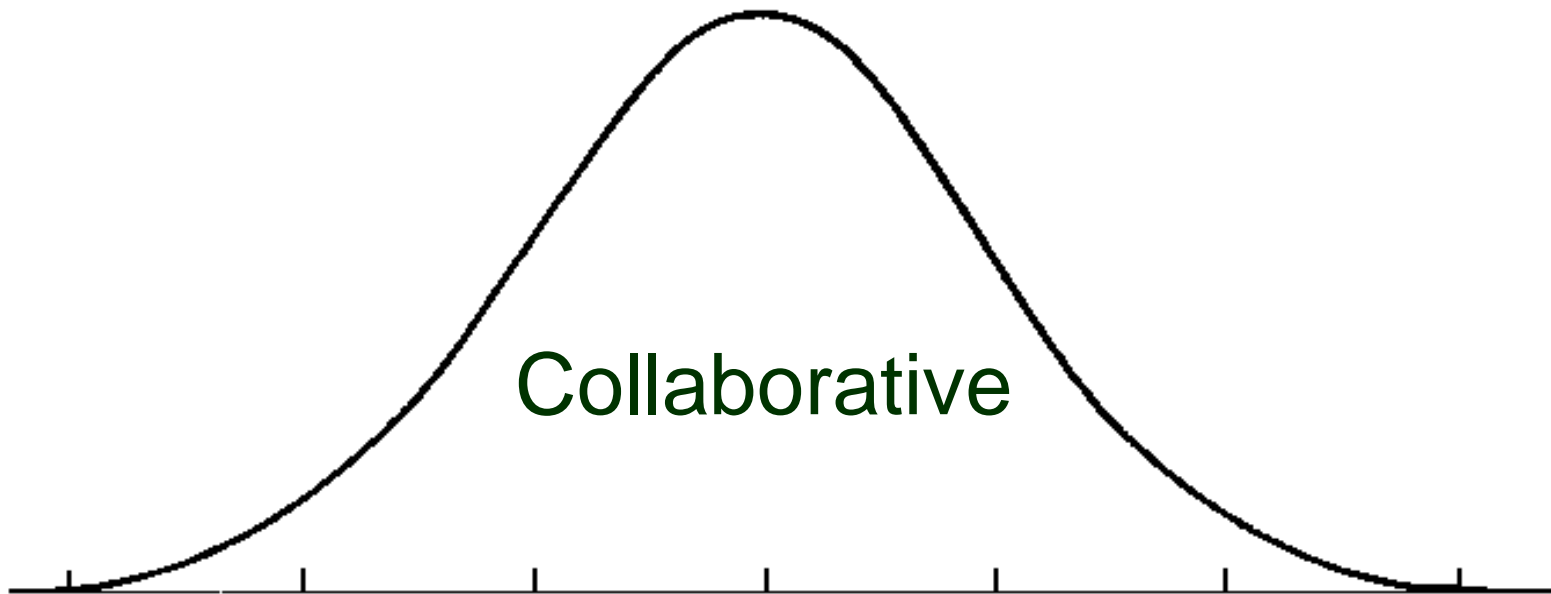
Why shouldn't people have more choice in treatments



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Locus of control

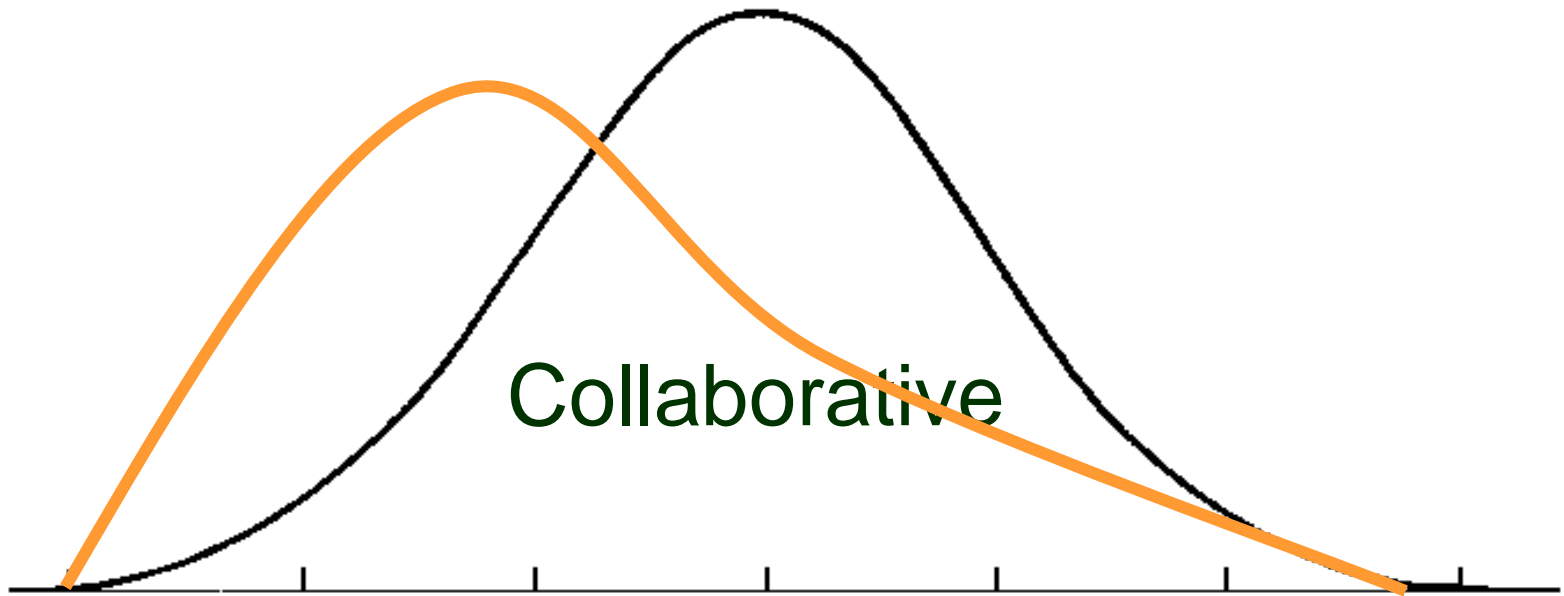


Patient active
Clinician passive

Clinician active
Patient passive



Locus of control



Patient active
Clinician passive

Clinician active
Patient passive



Locus of control

“I prefer to leave all my decisions to my doctor”



“I prefer to make the final decision”



Rethinking Healthcare

Patient
as Consumer

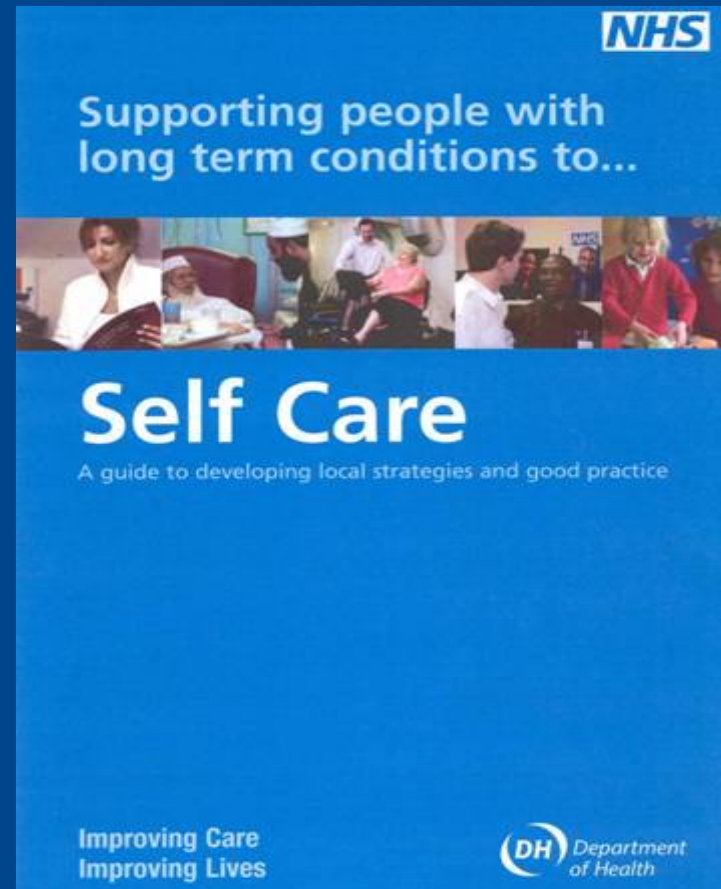


Patient
as Provider



Moving from a medical model to a Partnership Paradigm

- Self care in UK – a new way of thinking.....
- People with chronic disease are their own principal caregiver and make life decisions
- Expert patients
- Care management
- Health professionals should support patients in their decision making



Power Sharing Consultations

- Be restrained listen to patients
- Convey conviction that solution lies with the patient
- Hand over final responsibility about decision
- Find common ground re management decisions
- Cope with conflict if patient chooses a management plan which may give sub optimal health outcomes



Dissonance: What is important?

Patients

- No bad asthma days
- Free from restrictions on their life
- PEF not important to patients

Health Professionals

- No chronic symptoms
- No asthma attacks or emergency visits
- Minimal use PRN relievers
- Normal physical activity including exercise
- Normal lung function

Needs of patients with asthma (National Asthma Campaign 2000)



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Expert patients

Patient

Experience of illness

Social circumstances

Attitude to risk

Values

Preferences

Need for greater understanding that improvements in health can be achieved by people themselves

Clinician

Diagnosis

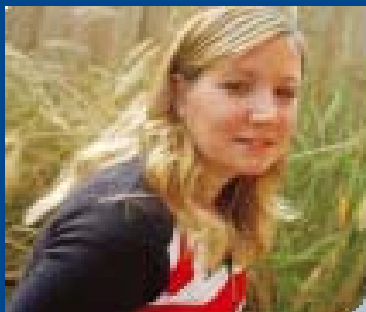
Disease aetiology

Prognosis

Treatment options

Outcome probabilities

Need for greater recognition of health care professionals' important role in supporting people in taking responsibility for their own care



'I lived for so long with poorly controlled asthma that it ruled my life. However, now that I have good care and a personal asthma action plan, I know how to control my asthma and recognise when my symptoms are worsening. Now I control my asthma and I feel much healthier and happier as a result.' **CHARLOTTE PALMER**

Personalised asthma action plans

A	All patients (particularly those admitted to hospital) should be offered self-management education, including written individualised asthma action plans
B	Introduce asthma action plans as part of a structured educational discussion

Reasons non usage: Cost, lack of understanding, time

Diminishing doctor authority (Jones et al 2000)

Materials unavailable, plans too complex

Not all patients want it

Patient education and self-management. Thorax 2003; 58 (Suppl 1): i1-i92



Evidence base for asthma action plans

- Part of structured asthma education
- Appropriate treatment must be given
- Greatest benefits in most severe disease
- Milder patients also benefit
- Cost-savings



Conclusions

- Despite all the improvements in science and technology ... 'we ain't cracked it yet!'
- Evidence to suggest patients under estimate the severity of their disease
- Health professional need to engage patients opinions, choices & preferences in consultations: Power share
- 'Purely' seeing patients in our clinics will not in itself improve patient outcomes!



The key to good, long lasting partnerships



Is to establish early on who's the boss!

