

Final report for CRC for Asthma 2006

Patient Priorities

Introduction and aims

Despite the existence of effective medical therapies for asthma and well-publicised treatment algorithms, an enduring theme of both asthma morbidity and mortality studies is the poor application of these “effective” treatments in an individual context. Strategies to reduce asthma morbidity rely on asthma self-management plans, regular medical review and education. Such strategies have been derived historically from a perceived medical need and assume the capacity and desire of people with asthma to effectively implement self-management strategies.

Consistent with the “Public Benefit” aims of the CRC, our ‘Patient Priorities’ Project 8 aimed to develop strategies to address the priorities of consumers in asthma care and thereby improve patient outcomes using currently available treatments.

As qualitative research methodology aims to generate an understanding of attitudes, beliefs and preferences, the study used a predominantly qualitative research design which informed the approaches to improving the delivery of medical therapy from the perspective of both patients and health professionals.

Recruitment

Sixty-two adult patients who utilised hospital emergency departments for asthma care were interviewed in-depth, to determine what barriers to optimum asthma management existed in this group. Results from this study also identified issues which could be addressed in future interventions, facilitating more effective medical care.

The first component of our study was an analysis of an existing qualitative dataset of individuals who presented to hospital accident and emergency departments with asthma. All consenting individuals with asthma who presented to a central city, a metropolitan and a rural hospital in a two month period were recruited.

Major outcomes

1. Asthma action plans.

Contrary to previous reports, most individuals with asthma action plans found these useful. The most common reason for not having an action plan was that participants had not been prescribed one by the doctor. The application of asthma action plans was dependent on an individual’s past experience of asthma and these were then modified. This work has implications for the production of international asthma guidelines and has been published accordingly [1].

2. Costs of asthma.

The wide-reaching impact of asthma on individuals was studied. It emerged that the costs of treatment were a significant impediment to use of optimal medication in Australia. In addition concerns about drug side effects were very significant and people with asthma performed their own “risk benefit” analysis in order to decide whether to take medications or not [2].

3. Inhaled corticosteroid use.

Letter to MJA regarding inhaled corticosteroid use using data from the CRC study, suggesting people with severe asthma were often using significantly more asthma medication than recommended prescribed doses [3].

4. Asthma self-management.

The paper examines the literature in regard to ‘self management’ and concludes that it implies a shift to acceptance of the doctor/patient partnership based on acceptance of patient knowledge and expertise [4].

5. What makes a good asthma doctor?

This draws on the qualitative interviews to describe the qualities of a “good” asthma doctor. Patients chose where to seek medical care based on several issues including convenience, cost, time taken as well as the quality of the doctor-patient relationship. Many patients attended emergency departments after a perceived failure of their asthma to respond to care from their GP [5].

6. What is an asthma attack?

Participants were asked “what is an asthma attack?” in both the qualitative and quantitative components of the study. Individuals had widely differing responses to this question, which underpins several prominent surveys in asthma care. Our study identified that individuals categorised “major” and “minor” attacks. The words “out of control” were important in identifying a severe attack [6].

Thirty-two of the original Emergency Department participant group had re-presented to an Emergency department on more than one occasion in the past 12 months: designated “reattendees”. Nearly 2/3 of this group had chronic severe asthma. All of these presentations were assessed and factors sought which may have prevented re-presentation.

Approximately 2/3 were deemed to have presented appropriately to a hospital emergency department with acute severe asthma or due to previous risk of life-threatening asthma. Nearly half of hospital emergency department re-attendees (15) had seen a GP within one week of their presentation to emergency. The most common reason for asthma exacerbation in 59% of recurrent attendees being attributed to a respiratory tract infection. Issues identified which might be addressed in those patients who likely have preventable elements of their presentation include:

- a) the cost of asthma medications and treatment
- b) the availability of asthma education and an asthma management plan
- c) the use of rescue doses of high-dose oral prednisolone by general practitioners in treating asthma exacerbations

Major outcomes

1. Recurrent Accident and Emergency Attenders.

This dataset provides evidence regarding the reasons for re-attendance for emergency care and challenges the received wisdom that most re-attendance is preventable. In our in-depth study of emergency department re-attendees, only one-third participants had easily reversible features to their presentation, mostly asthma education and access to appropriate medication [7].

2. Emergency treatment of asthma: how are we doing?

Review article on emergency asthma treatment [8].

Health professionals' priorities in asthma care

Introduction and aims

In our recent studies of patients' for asthma care, one of the recurrent themes was the importance of the doctor-patient relationship. General practitioners deliver the bulk of asthma care, yet their priorities in order to deliver best care are uncommonly publicised and often not incorporated into international guidelines. In order to understand why asthma guidelines are not always implemented we undertook a study to ascertain what health professionals thought were the priorities required for delivering optimal asthma care.

Recruitment

Forty nine General Practitioners, 24 consultants, 13 pharmacists and 13 asthma educators from both metropolitan and country areas took part in a nominal group consensus technique.

Major outcomes

The priorities for asthma care between the differing groups of health professionals was surprisingly consistent.

1. Health professionals priorities for delivering asthma care

Specialists, General practitioners, Pharmacists and Asthma Educators participated in a series of nominal group discussions which asked 'what do you think are the priorities for the optimal care of asthma?' Prominent themes were: asthma education, not only for patients but also for health professionals; a need for consistency in asthma education and treatments; collaboration between health professionals; and a need to raise public awareness about asthma and emergency asthma treatment in schools, workplaces and the community in general [Paper comparing health professionals priorities for asthma care in progress].

2. Barriers to General Practitioners delivering optimal asthma care

The General practitioners in our study were remarkably consistent in their priorities for delivering asthma care. Our study identified barriers to asthma guideline adherence, including accessible, relevant education for GPs, and structural, time and cost barriers GPs must overcome in providing asthma treatment and patient education [9].

A study of individuals who purchase over the counter beta 2-agonists

Introduction and aims

A study on the nature of over the counter beta 2-agonist purchase was undertaken in order to gain knowledge of the asthma severity of individuals who purchase beta 2 agonists, who are not taking preventer medication and also further understand their priorities.

Recruitment

Participants were recruited from randomly selected metropolitan and country pharmacies throughout Victoria. One participant, not using preventer medication and/or had the poorest symptom control or lung function from each pharmacy was also invited to take part in a qualitative interview.

Major outcomes:

Quantitative paper reporting results is in progress.

Qualitative paper reporting reasons for OTC purchase, asthma medication adherence etc currently in progress, Qualitative paper reporting on smoking and asthma medication use in progress

Overall study outcomes

Currently there are nine papers published in peer-reviewed journals and another four are in progress. There have also been at least 28 conference presentations between 2000-2006.

Other outcomes

- The findings of our study related to the costs of asthma have been used to help design the questionnaires for CRC Project 9: “The economic burden of asthma”.
- Industry partners have expressed significant interest in this work and have used information so far in designing marketing strategies. They particularly wish to use the outcomes of this work in the studying those who use β -2 agonists for asthma treatment.
- Sessions at the CRC Asthma Education symposium.
- The findings from our study have been presented to NACA and Asthma Australia, being used to support further guideline development.
- Media reports: The Burden of Asthma: ABC News, 6PR, Gold FM, Radio Nova, Channel 9, 15/09/02, Medical Observer 27/9/02.
- Media Reports: Asthma Action Plans: The Age, The Sun Herald, Channel 9, Channel 7, April 02.

Publications

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3. Goemans D, Sawyer SM, Abramson M, Stewart K, Thien F, Aroni R, Douglass J. Inhaled steroids – too much of a good thing? *MJA* 2003; 178: 247
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