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Optimizing Biologic Strategies and Multidisciplinary Care in Severe Asthma

Dr. May:
This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Alexandria May. Joining me to explore how we can coordinate severe asthma care and optimize biologic strategies across multidisciplinary care are Drs. Flavia Hoyte and Brittany Duchene. Dr. Hoyte is a Professor in the Division of Allergy and Clinical Immunology at National Jewish Health and the University of Colorado in Denver. Dr. Hoyte, thanks for being here today.

Dr. Hoyte:
Thank you so much for having me. It's a real pleasure.

Dr. May:
And Dr. Duchene is a pulmonary and critical care physician and an Assistant Professor of Medicine at the University of Vermont in Burlington. Dr. Duchene, it's great to have you here as well.

Dr. Duchene:
Thanks for the invite. Happy to be here.

Dr. May:
Well, let's start by hearing your perspective, Dr. Duchene. Where do you see the most breakdowns when coordinating care for patients with severe asthma?

Dr. Duchene:
It's a really good question. When I think of the providers that are involved in the care of someone with severe asthma, I think of their primary care provider, ENT, pulmonology, allergy, and even our urgent care and emergency department providers. And not all of our great technology or systems talk to each other, so I think a lot of breakdown can happen when these patients are visiting different worlds. So I don't always know when patients have visited an ER or urgent care if it's outside of my system. That being said, there's private practices and academic institutions that also don't talk to each other automatically.

So I think there's a lot of area for delays in appropriate treatment, and that can also result in communication breakdown and not being able to fully discuss these patients in a very efficacious way.

Dr. May:
Turning to you now, Dr. Hoyte, what clinical signals or patterns prompt you to think that biologic therapy might be appropriate for a patient?

Dr. Hoyte:
Yeah, that's a great question. I think about my most severe asthmatics, but some of our moderate asthmatics may also benefit from early biologic introduction.

The first thing I want to do always is make sure that this is actually difficult-to-control asthma rather than poorly controlled asthma because there are issues with adherence or technique. Maybe we didn't do a good job of teaching them how to use the inhaler, so obviously it's not working. For comorbidities, I think about reflux—whether it's active reflux or silent reflux—vocal cord dysfunction, inducible laryngeal obstruction, allergies, and chronic rhinosinusitis with nasal polyps. All of these comorbidities can mimic asthma or complicate asthma, and if you ignore them, you keep stacking up those asthma medicines but you're not going to get where you need to go unless you're really targeting the underlying problem and its comorbidities. I also think about exposures. So similarly, if there's an

exposure that's really driving things, then without removing that exposure, you're not going to get all the way where you need to go.

Once I feel like the comorbidities have been addressed, exposures have been discussed, and all of that has been mitigated as much as possible, then we move on to understanding who the patient is in front of me. What exactly does their asthma look like? I think about the phenotype, but also the endotype. Is this adult-onset asthma? Is this an aspirin-exacerbated respiratory disease patient? Is this somebody who has allergic rhinitis that might be driving things? The biomarkers that are available are not perfect, but I try to get them in every patient that comes in with severe asthma or poorly controlled asthma. So I look for the exhaled nitric oxide. I look for eosinophil count. I look for atopic sensitization as well as an IgE level. And then I look at the data as well, so lung function and patient-reported outcomes. All of these things can be tracked over time.

It's important when thinking about a biologic to think about what the goal is for that particular patient and then target that goal once I understand, again, what kind of asthma they have and what's really driving their asthma.

Dr. May:
With that in mind, let's focus on the multidisciplinary team, which is often made up of pulmonologists, allergists, and primary care clinicians. Dr. Duchene, can you tell us who's accountable for what when it comes to identifying, referring, and managing patients with severe asthma?

Dr. Duchene:
So when I think about asthma and how we run our severe asthma clinic, it's truly multidisciplinary. From the very beginning, the primary care physician is the first-line provider who's going to think, "Hey, this seems like it's asthma." They're usually the ones who are initiating therapy, and then probably the ones thinking, "Hmm, their asthma is not well controlled despite my efforts in controlling it with inhalers." So those primary care doctors are the ones that are key in identifying and then thinking to refer for subspecialty care.

And typically, severe asthmatics will get referred to either pulmonology or allergy. Both specialties are equally equipped to manage severe asthma effectively. And really our role is to, as Dr. Hoyte mentioned, phenotype and endotype these patients and figure out, A, do they truly have asthma, B, what type of asthma do they have, and C, what's the best management for this patient? And oftentimes, that does involve other subspecialists, such as ENT. A lot of these patients have sinusitis or nasal polyposis that needs to be identified and treated aggressively if we want any success rate in treating their asthma.

Another provider that I frequently will loop in with my severe asthmatics would be GI. Acid reflux is very common in adults, and oftentimes, these people are getting a lot of prednisone and taking a lot of meds that could worsen acid reflux. So oftentimes, those providers are also involved in the loop.

Dr. May:
For those just tuning in, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Drs. Flavia Hoyte and Brittany Duchene about coordinating severe asthma care and optimizing biologic strategies across multidisciplinary teams.

So, Dr. Hoyte, in order to operationalize collaboration across the care team, what workflow models help ensure timely referral and biologic initiation?

Dr. Hoyte:
As Dr. Duchene mentioned, there is definitely a delay in starting these biologics, and that oftentimes comes from not recognizing that somebody is getting more and more severe. Or oftentimes, if they're going to urgent care or emergency rooms, then as she mentioned, primary care may not even be aware that their asthma's out of control.

We're definitely in a better place now with many systems being on Epic or other electronic medical records that can talk to each other. And so now you can actually get a sense of, "Oh, you went to the emergency room a couple of times. Tell me about those visits." Whereas historically, we just relied on the patient to tell us. So I think we should be capitalizing on the electronic medical record and then using it, if possible, to provide prompts. So if a primary care provider had prompts that said, 'more than two exacerbations in a year or one hospitalization for asthma,' any of these things that are systematic as triggers for a referral would really cut down on that time because the patient would get to the specialist earlier.

And then once they're in the center, have that multidisciplinary review. We have a severe asthma conference that we have once a month with pulmonary, ENT, and allergy. And we bring cases and journal articles, and we have that touch point, even if it's once a month or once a week if you have the luxury of doing that, to get everybody together, communicate, and hear how the other thinks. And so we're much more likely to think about referring the next patient that comes or picking up the phone and talking through the patient. And I think with the more severe patients and these newer agents such as biologics, that communication is really key.

Dr. May:

Now, even when referrals happen, information doesn't always follow, as we've mentioned. That being said, Dr. Duchene, what strategies have you found effective for closing those communication gaps and making sure everyone is aligned on treatment decisions?

Dr. Duchene:
Certainly, our electronic health records have improved some of the communication barriers that we previously saw, so we're able to forward our notes to each other, keep each other in the loop, and send messages.

There are other asthma-specific tools that we can use that are very effective, such as the asthma action plan. So having that filled out with your patient, going through it at least once a year or when there are big changes to their medication regimen, giving the patient a copy, and then distributing the copy of your asthma action plan to other vested parties—so their primary care and ENT doctor—will allow them to really see on paper what your treatment plan is so that if this patient exacerbates, we are all on the same page of what the treatment regimen would be for that. And we're all on the same page as to what their medication regimen is. As we know, patients are not the best always at remembering their medication regimen. They'll say, "I'm on the purple inhaler," or "I'm on this red one," which isn't always super helpful. So this way, everything's written in a documented way, and that's really standard practice for most severe asthma clinics.

Dr. May:
Another core part of the team is the patient themselves. So before we close, Dr. Hoyte, how do you engage patients as active participants, especially when initiating biologic therapy across multiple specialties?

Dr. Hoyte:
Yeah, I think that's a great point. The patient needs to be invested. They need to want to go to that next step. I think that we have a lot more buy-in now than when the first biologics came out, and I think that's in part because a lot of people are injecting weight loss medications and other biologics, and so it's becoming a little bit more accepted, normalized, and maybe not as scary for the patient. So I think we're helped a little bit by that.

But I really start off by getting a sense for their goals. If I'm starting a biologic so that I can increase their FEV1 but they don't care about their FEV1—they care about going out for a jog with their wife, sleeping through the night, staying out of the hospital, or getting down on their oral steroids—then me talking about FEV1 is not going to land.

Once we establish those goals, then I explain how the biologic may be able to get them to those goals. I set realistic expectations, making sure that they realize that this is not an injection that's like, 'If I'm having symptoms, I'm going to inject it like my Albuterol.' This is going to be more of a controller medication that's in the background that takes a little time to act usually, so if they don't have that immediate benefit within the first two weeks, they don't give up on it. The patients who have that expectation earlier do better in terms of being okay with it not being an immediate fix, and then we can reevaluate.

And then with the biologics, it's really hard sometimes to know which is the perfect one for that patient. And I think in some ways, that's empowering. Now we have many options, and I use it as a positive with the patient. We discuss what the different options are and the logistics behind them, so that's a big thing. But then I let them know that we're going to make this choice based on our decision together, and if it's not the right one, we have other options. So in four, six, or 12 months, we may be switching to a different one if this is not the perfect one for you. And I think that also gives them hope that we're going to try this, but it's not the end-all be-all.

Dr. May:
As those final strategies bring us to the end of today's program, I want to thank my guests, Drs. Flavia Hoyte and Brittany Duchene, for joining me to share their perspectives on how multidisciplinary care teams can work together to optimize the identification, referral, and management of patients with severe asthma. Dr. Hoyte, Dr. Duchene, it was great speaking with you today.

Dr. Hoyte:
Thank you.

Dr. Duchene:
Thank you so much.

Dr. May:
For ReachMD, I'm Dr. Alexandria May. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!