POLICY QUALITY STANDARDS TO IMPROVE ASTHMA CARE

WHY DO WE NEED QUALITY STANDARDS IN ASTHMA?

1

Lack of clarity / conflicting advice on how to implement clinical guidelines on Short-acting beta-agonist relievers (SABA) and Inhaled corticosteroid (ICS) controller medication[1,2,3,4]

2

Appetite among experts for clear, simple criteria to drive systematic improvement on SABA and ICS use[5,6]

3

Quality standards,[7,8] improve asthma care and encourage guideline implementation

OVERVIEW, AUDIENCE AND 'HOW TO USE GUIDE' FOR THE QUALITY STANDARDS

AIM AND PURPOSE:

This Quality Standard covers diagnosis, prescribing and dispensing, monitoring of asthma and post exacerbation care. It describes high-quality care in priority areas of improvement.

The main purpose of this document is to engage national elected policymakers and will offer a support guide for them on three key actions that they can take to improve asthma care: mandated actions for implementations, incentives to accelerate uptake, and measuring to continuously improve.

Audience	How to use the Quality Standards	How to implement the Quality Standards (policymakers)
GLOBAL BODIES	Endorse the Quality Standards and be a trusted partner for high level engagement to drive implementation	**Mandate** via national plans or quality standards **Incentivise**, via funding and contracting schemes **Measure**, via national audits or datasets
NATIONAL ELECTED POLICYMAKERS	To scrutinise the standard of asthma care in their country and hold their government to account for improving it in line with the quality standards	
PRIMARY CARE PHYSICIANS	To work with the government and health care system to improve care in line with the quality standards	

1 DIAGNOSIS

Quality Statement:

People suspected of having asthma are identified and receive an objective diagnosis specific to their individual symptoms.

Why an issue?

- Both under and over-diagnosis of asthma is common, but the issue is a concern in primary care, where most diagnoses are made[9,10]
- Overdiagnosis leads to unnecessary treatment and a delay in making an alternative diagnosis. Underdiagnosis risks daily symptoms, (potentially serious) exacerbations and long-term airway remodelling. It is also possible that patients may die of asthma prior to diagnosis.[11]
- The UK national review of asthma deaths found that 38% of these patients had four or fewer inhalers with a steroid component issued in the previous year, indicating that undertreatment was a probable important factor in their deaths[12]

What can policymakers do?

- Mandate that every GP / Hospital practice has a designated named clinical lead able to deliver an objective diagnosis of asthma, including provision of some functions virtually
- Incentivise by higher funding for digital-first primary care practices that provide an element of technology-enabled asthma management with evidence of local processes to ensure that the basis for a diagnosis of asthma is documented
- Measure by increased rates of objective diagnosis first time, and a reduction in patients presenting with undiagnosed asthma at A&E

TARGET:

All patients receive a timely, individual objective diagnosis results in a reduction in unscheduled care visits and healthcare savings

These non-promotional quality standards have been initiated, funded, and developed by AstraZeneca with input from Global Respiratory experts.
Veeva ID: Z4-25116 Date of prep: July 2020 Date of expiry: July 2022

2 PRESCRIBING AND DISPENSING

Quality Statement:

Newly diagnosed asthma patients are treated with pharmacological / non-pharmacological options that are appropriate to the long term management of asthma as an inflammatory disease, and all patients using ≥3 SABA canisters per year are flagged for treatment review

Why an issue?

- Historically, on initial diagnosis patients with asthma have been offered a short-acting beta-agonist or SABA which provides symptomatic relief. However, the SABA inhaler does not treat the underlying causes of asthma[1]
- Patients have a strong emotional attachment to their SABA and typically do not understand that frequent use of SABAs indicates poor asthma control[13]
- ≥3 SABA canisters per year associated with an increased risk of an A&E visit or hospitalisation and ≥12 canisters per year an increased risk of death[6]

What can policymakers do?

- Mandate that every newly diagnosed asthma patient should recieve anti-inflammatory treatment and that SABA should only be available to purchase with a valid prescription. In addition, no patient should be prescribed more than three inhalers per year without being flagged for an asthma review with their primary care physician or respiratory specialist
- Incentivise by rewarding creation of auto alerts at pharmacies for any patient collecting ≥3 SABA per year. This is an automatic trigger for treatment review, reducing the risk of uncontrolled asthma, reducing Health Care Resource Utilisation (HCRU) / improving patient self-management
- Measured by number of ICS prescriptions at first diagnosis and additional proactive treatment reviews in local area from flagging of ≥3 SABA patients

TARGET:

All newly diagnosed asthma patients receive an ICS prescription – changing the behaviour of starting patient with SABAs when asthma is an inflammatory disease.[14,15] Alerts flagging ≥3 SABA canisters per year as a trigger for a structured treatment review embedded across health system

3 REGULAR ASTHMA REVIEWS

Quality Statement:

Patients with asthma receive a regular review of their asthma every 3 – 12 months after starting treatment

Why an issue?

- Regular, structured asthma reviews improve health outcomes for people with asthma,[16] yet many people still don't receive this[17]
- COVID-19 represents an opportunity for virtual care to be a viable alternative in keeping patients out of hospital[18,19]

What can policymakers do?

- Mandate that all GP practices are able to provide regular asthma reviews and, where appropriate, these are offered digitally, along with the provision of a personalised digital asthma action plan that is reviewed at least twice a year
- Incentivise clinicians to provide digital asthma reviews as a solution to increase health system capacity for 3 month follow up, to flag those who have been prescribed ≥3 SABA canisters per year for an immediate treatment review
- Measured by an increase in the number of at-risk patients who have been flagged and have an urgent, structured asthma review

TARGET:

Increased structured asthma reviews and improved digital documentation of these, including detailed assessment of asthma control

4 POST-EXACERBATION (ATTACK) CARE

Quality Statement:

Patients who have received treatment for an acute asthma exacerbation are provided a dedicated follow up within 7 working days of discharge by a trained primary care professional

Why an issue?

- The National Review of asthma deaths found that at least 21% of those who died had attended an Emergency Department (ED) within the previous year[12]
- Need to identify if exacerbations are resolving and manage modifiable risk factors to mitigate the likelihood of future exacerbations

What can policymakers do?

- Mandate that all patients who are treated for an asthma exacerbation receive a dedicated follow up by a trained asthma clinician to explore the reasons for the attack and to give advice about reducing future risk (to include detailed review of SABA and preventer prescriptions and collections)
- Incentivised to develop automated communication referral from hospitals back to clinicians ; ensuring hospitals have to collect relevant primary care physician data from patients so they can ensure an exacerbation is a 'never event'
- Measured by a reduction in the number of ED admissions for asthma

TARGET:

Updated emergency discharge protocols, with simple text reminders for a dedicated follow up and anti-inflammatory treatment given to all patients upon discharge

Veeva ID: Z4-25116 Date of prep: July 2020 Date of expiry: July 2022

REFERENCES

[1] O'Byrne PM, Jenkins C, Bateman ED. The paradoxes of asthma management: time for a new approach?. Eur Respir J. 2017;50(3):1701103. Published 2017 Sep 9. doi:10.1183/13993003.01103-2017

[2] Beasley R, Bird G, Harper J, Weatherall M. The further paradoxes of asthma management: time for a new approach across the spectrum of asthma severity. Eur Respir J. 2018;52(5):1800694. Published 2018 Nov 1. doi:10.1183/13993003.00694-2018

[3] Keeley D, Baxter N. Conflicting asthma guidelines cause confusion in primary care. BMJ. 2018;360:k29. Published 2018 Jan 9. doi:10.1136/bmj.k29

[4] Gupta S, Paolucci E, Kaplan A, Boulet LP. Contemporaneous International Asthma Guidelines Present Differing Recommendations: An Analysis. Can Respir J. 2016;2016:3085065. doi:10.1155/2016/3085065

[5] Pavord ID, Beasley R, Agusti A et al. After asthma: redefining airways diseases. Lancet. 2017; 391: 350-400

[6] Global Initiative for Asthma. Global strategy for asthma management and prevention. 2020. Available at: https://ginasthma.org/wp-content/uploads/2020/04/GINA-2020-full-report_-final-_wms.pdf

[7] National Institute for Health and Care Excellence. 2018. Asthma Quality Standard [QS25]. www.nice.org.uk/guidance/qs25

[8] Health Quality Ontario. 2020. Asthma in Children and Adolescents. www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/asthma-in-children-and-adolescents

[9] Aaron SD, Boulet LP, Reddel HK, Gershon AS. Underdiagnosis and Overdiagnosis of Asthma. Am J Respir Crit Care Med. 2018;198(8):1012-1020

[10] Schneider, A., Gindner, L., Tilemann, L. et al. Diagnostic accuracy of spirometry in primary care. BMC Pulm Med 9, 31 (2009). https://doi.org/10.1186/1471-2466-9-31

[11] Kavanagh J, Jackson DJ, Kent BD. Over- and under-diagnosis in asthma. Breathe (Sheff). 2019;15(1):e20-e27. doi:10.1183/20734735.0362-2018

[12] Levy M, Andrews R, Buckingham R, et al. Why asthma still kills: the National Review of Asthma Deaths (NRAD) Confidential Enquiry report. London, Royal College of Physcians, 2014.

[13] Blakeston S, Harper G, Zabala Mancebo J. Identifying the drivers of patients' reliance on short-acting β2-agonists in asthma [published online ahead of print, 2020 May 29]

[14] Beasley R, Burgess C, Crane J, et al. Pathology of asthma and its clinical implications. Journal of Allergy and Clinical Immunology. 1993; 92 (1): 148-154 4

[15] Busse WW, Lemanske RF Jr. Jr. Asthma. NEJM. 2001; 344 (5): 350-362

[16] Gibson PG, Powell H, Coughlan J, et al. Self-management education and regular practitioner review for adults with asthma. Cochrane Database Syst Rev. 2002;(1):CD001117. doi:10.1002/14651858.CD001117

[17] Asthma UK. 2017. Falling through the gaps, why more people need basic asthma care. Available at: https://www.asthma.org.uk/globalassets/get-involved/external-affairs-campaigns/publications/annual-asthma-care-survey/annual-asthma-survey-2017/asthmauk-annual-survey-2017.pdf Accessed June 2020

[18] Beaney T, Salman D, Samee T, Mak V. Assessment and management of adults with asthma during the covid-19 pandemic. BMJ. 2020;369:m2092

[19] Chongmelaxme B, Lee S, Dhippayom T et al The effects of telemedicine on asthma control and patients' quality of life in adults: A systematic review and meta-analysis J Allergy Clin Immunol Pract 2018;7:199-216

Veeva ID: Z4-25116 Date of prep: July 2020 Date of expiry: July 2022