AIM AND PURPOSE:

Diagnosis

Audience

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

To work with the government and health care system to improve care in line with the quality standards

PRIMARY CARE PHYSICIANS

Quality Statement:

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.  
- 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.  
- 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.

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

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

Why do we need quality standards in asthma?

These non-promotional quality standards have been initiated, funded, and developed by AstraZeneca with input from Global Respiratory experts.

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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.

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.

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.

Need to identify if exacerbations are resolving and manage modifiable risk factors to mitigate the likelihood of future exacerbations.

Mandate that all newly diagnosed asthma patients receive 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.

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Mandate that all newly diagnosed asthma patients receive an ICS prescription – changing the behaviour of starting patient with SABAs when asthma is an inflammatory disease.

Alerts flagging ≥3 SABA canisters per year as a trigger for a structured treatment review embedded across health system.

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.

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.

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

Regular, structured asthma reviews improve health outcomes for people with asthma, yet many people still don’t receive this.

COVID-19 represents an opportunity for virtual care to be a viable alternative in keeping patients out of hospital.

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

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


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


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


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