Global Quality Standards on the use of reliever treatment in asthma

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Global Quality Standards on the use of reliever treatment in asthma

Background on the AstraZeneca Global Steering Group on Improving Asthma Outcomes

In 2017, a number of leading respiratory experts were brought together by AstraZeneca to form a Global Steering Group on Improving Asthma Outcomes as part of its Asthma Zero initiative which seeks to address and act to overcome SABA overreliance and ICS underuse. The meetings of the Group and its outputs are funded by AstraZeneca. The Quality Standards and associated timescales outlined in this document are a consensus of the Group based on extensive respiratory clinical expertise.

Why are Quality Standards needed in asthma?

The latest global data shows that there are 339 million people living with symptoms of asthma¹ and preventable deaths continue to occur.² Experts have therefore called for a fundamental shift in how asthma is treated.³ Recent academic debate has highlighted a ‘paradox’ in asthma treatment whereby most patients, when symptoms worsen, increase short-acting beta₂ agonists (SABA) use instead of using controller medication, namely inhaled corticosteroids (ICS).⁴ ICS are designed to address the underlying inflammation of the condition, the cornerstone of asthma treatment.¹ Important new Global Initiative for Asthma (GINA) recommendations on a global strategy for asthma management and prevention have been considered as the most fundamental change in asthma management in 30 years and follow a decade-long programme of work which focused on the risks and consequences of the long-standing approach of commencing asthma treatment with short-acting β₂-agonists (SABA) alone.⁵

Scope and purpose of the Quality Standards

The following Quality Standards developed by an AstraZeneca funded expert Global Steering Group help support the need for a new approach in asthma to act on recent recommendations and address the current ‘paradox’ in care and treatment. Substantial gaps in the quality of asthma care exist and the following standards are intended to provide clarity on a minimum standard of good quality clinical care for patients with asthma for use by national and local clinical groups. The standards draw on the latest evidence based guidelines including the recent update to the Global Initiative on Asthma (GINA) strategic recommendations for asthma care⁶ and are intended to drive up the quality of asthma care for patients across the spectrum of asthma severity. Each standard consists of a prioritised set of specific, concise and measurable statements.

The AstraZeneca Global Steering Group consensus is that people with asthma should receive care through an integrated approach that facilitates access to interprofessional services from primary care providers right through to referral to a specialist. Interprofessional collaboration, shared decision making, coordination and continuity of care (including follow-up care) are hallmarks of this patient-centred approach. Many of the timescales outlined are a consensus agreed by the Group based on clinical expertise.

Principles underpinning this Quality Standard

The AstraZeneca Global Steering Group on improving asthma outcomes propose that standards should be sensible, practical and of use to the user. They should be stretching but achievable and are not a “wish list”. For success, they must also be tailored to the local circumstances and “owned” by national and local clinical groups. Healthcare systems around the world face different issues with regards to asthma management depending on local context, access to resources and their local health system. The Global Steering Group are currently exploring how best to support local implementation of these standards and are aiming to publish on this separately.

The following Quality Standards are expected to contribute to improvements in the following four outcomes:

• Diagnosis of asthma
• Prescribing and dispensing
• Regular asthma reviews
• Post-exacerbation care
Quality Standards

Statement 1:
People suspected of having asthma are identified and receive an objective diagnosis specific to their individual symptoms.

Statement 2:
Newly diagnosed asthma patients receive an ICS-containing regimen, either symptom-driven or on a daily regular basis.

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

Statement 4:
Patients who have received treatment for an acute asthma exacerbation, including hospitalisation or an emergency department (ED) visit, are provided a dedicated follow up within 7 working days of discharge by a trained primary care professional.
Quality statements to drive improvements in asthma care:

Diagnosis of asthma

Statement 1:
People suspected of having asthma are identified and receive an objective diagnosis specific to their individual symptoms.

Rationale

Asthma can be commonly misdiagnosed, or over diagnosed which means that people can have untreated asthma. People who display symptoms potentially indicative of asthma may not get an accurate or objective diagnosis, putting them at risk of asthma exacerbations. Despite there being no definitive gold standard test on what constitutes a formal diagnosis of asthma, a diagnostic pathway that includes objective testing can help healthcare professionals to clinically diagnose asthma in people presenting with indicative symptoms.

Essential criteria

1ai) Although there is a lack of consensus in the respiratory community about diagnosing asthma, the clinical assessment and investigation of people with indicative symptoms of asthma should focus on making a differential diagnosis of asthma. The AstraZeneca Global Steering Group believe this should be done by a healthcare professional or respiratory specialist trained in asthma management and include at a minimum:

- Recording of clinical history of a pattern of common symptoms (shortness of breath, cough, wheezing and chest tightness)
- History of hospitalisation or unscheduled primary/secondary care visits regarding acute symptoms
- A family history of asthma, atopy or allergy alongside medication history
- Smoking status and exposure to environmental triggers
- Performance of lung function tests such as spirometry and peak expiratory flow variability
- Further testing as needed such as bronchial challenge testing to help work out what type of asthma a patient may have
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Quality statements to drive improvements in asthma care:

Prescribing and dispensing

Statement 2a:
Newly diagnosed asthma patients receive an ICS-containing treatment regimen, either symptom-driven or on a daily regular basis.

Rationale

The Global Initiative for Asthma (GINA), led by a group of international respiratory experts published new strategic recommendations in 2019, based on patient safety concerns which aim to reduce exacerbations though evidence-based treatment options for patients across the whole spectrum of asthma severity. GINA no longer recommends treatment with SABA alone in adolescents or adults defined as step 1 as there is strong evidence that SABA-only treatment does not protect patients from severe exacerbations. The use of three or more SABA canisters per year is associated with an increased risk of severe exacerbations and using more than 12 canisters in a year is associated with increased risk of asthma-related death.

Essential criteria

2ai) Treatment decisions for patients should be based on the latest evidence
2aii) No patients should be prescribed more than three SABA inhalers per year without being flagged for an asthma review with their primary care physician or respiratory specialist

Statement 2b:
SABA canisters are only be dispensed to patients under controlled settings to mitigate against over-reliance

Rationale

A significant number of patients with asthma still rely on their SABA inhaler as their sole asthma treatment. One factor that could possibly contribute to over-reliance on SABA is the ease of which it can be globally obtained. While SABA could still continue to be an add on treatment option, its dispensing should be controlled and closely monitored

Essential criteria

2bi) SABA should only be available to purchase when a patient has a valid prescription or is in a clinical emergency such as an asthma exacerbation, and should not be prescribed alone
2bii) Any patient collecting three or more SABA inhalers per year should should receive a referral for an asthma consultation to assess their treatment, followed by their pharmacist being informed
Quality statements to drive improvements in asthma care:

## Regular asthma review

### Statement 3:

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

### Rationale

Asthma is an inflammatory disease with recurring flare-ups of inflammation and symptoms. Regular monitoring of symptoms will help identify those at risk of poor outcomes. In addition to a routine planned review, the AstraZeneca Global Steering Group believes it is sensible to perform a review after a change in treatment or an exacerbation, which is tailored to offer ongoing education, training and support.

### Essential criteria

3ai) An asthma review should be triggered by the following, and should occur ideally within 48 hours:

- If a patient's asthma symptoms worsen beyond the normal pattern of day-to-day variation, and in spite of an appropriate use of controller medication
- If a patient experiences an asthma exacerbation
- If a patient hasn't had a periodic review in the last 12 months
- If a patient has been prescribed more than one SABA inhaler in the last 4 months
- If a patient has been prescribed a new course of oral corticosteroids

3aii) The AstraZeneca Global Steering Group believes a periodic review should include, as a minimum:

- Recording of significant medical events and risk factors including asthma exacerbations
- Assessing use of medications for asthma (e.g. number of SABA and ICS prescriptions and medication collections), including existing barriers and facilitators to appropriate use of ICS
- Assessment and personal review of a patient's inhaler technique against a device-specific checklist
- Confirmation of the patient's smoking habits and an offer to support smoking cessation when relevant
- Review of symptoms and comorbidities that may jeopardize a patient's asthma control
- Assessment of potential allergens, occupational agents, and environmental or occupational factors triggering asthma symptoms/exacerbations
- Provision of an agreed personal asthma action plan to help patients recognise when their asthma is poorly controlled and what to do if their medication is not working
- Measurement of lung function before a change in treatment, 3-6 months later then periodically

3aiii) All decisions related to ongoing management of patients with asthma should be integrated within a personal asthma action plan. This plan should be reviewed regularly and tailored according to a patient's personal thoughts and goals. It could detail patients' triggers and current treatment regime. It should also be available to all healthcare professionals involved in the care of the individual from initial presentation of symptoms right through to referral to a specialist, if needed.
Quality statements to drive improvements in asthma care:

Post-attack care

Statement 4:

Patients who have received treatment for an acute asthma exacerbation, including hospitalisation or an emergency department (ED) visit, are provided a dedicated follow up within 2-7 working days of discharge by a trained primary care professional.

Rationale

An exacerbation (asthma attack) signifies a sudden worsening of asthma symptoms; therefore, a follow up appointment, ideally before prescribed oral corticosteroids run out, should be conducted as a priority after every episode or visit to an ED/hospitalisation to: i) determine whether the exacerbation is resolving and to optimise care accordingly; and ii) to identify and manage modifiable risk factors (e.g. adherence, smoking or persistent allergen exposure) to mitigate the likelihood of future exacerbations.

Essential criteria

4ai) Post-exacerbation, all patients should be provided with a review appointment taking place within 2-7 working days. In addition, a letter informing their primary care professional or respiratory specialist that an asthma exacerbation has taken place, and what treatment has been given. If oral corticosteroids are prescribed, clear written instructions should be made on the dosage and duration of treatment.

4aii) Patients should also be checked by a trained primary care professional or respiratory specialist to ensure that their treatment is working and to understand why their asthma got worse. This can also include a review of current medications, comorbidities and a review of previous exacerbations. Information should be provided in a simple and clear format or added into the patient’s existing asthma action plan to help the individual understand the available treatment options and the implications of different management approaches following an exacerbation.

4aiii) Post-exacerbation, patients should receive, as a minimum, a review of their inhaler technique, their current controller and reliever usage as well as a consideration of a step-up of treatment to help manage their symptoms. A patient’s asthma action plan should also be revised, and clear controller and reliever guidance should be included. Patients are to be defined as continued ‘at-risk’ if they have any of the risk factors detailed in the latest GINA strategy or the latest BTS/SIGN guidelines or if they have another asthma exacerbation.

4aiiv) Each asthma exacerbation should be entered into the primary care record so that those with recurrent exacerbations are readily identifiable for specialist referral.
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