

Western Australian Chronic Respiratory Disease

Clinical Service Improvement Framework



November 2005

Developed by the Western Australian Health Respiratory Reference Group

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Foreword



Chronic diseases are major causes of disability, hospital admission and premature death throughout the world. In Australia, chronic diseases are responsible for 70 percent of the total burden of disease. Diseases of the respiratory system such as asthma, Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure make a substantial contribution to the burden of chronic disease within Western Australia.

Historically chronic disease management has been episodic, with an emphasis on crisis care. However, evidence suggests that optimal care requires greater integration to provide an effective, patient focused approach across all sectors of the health care system. This Framework is a tool for driving improvement in health services for Chronic Respiratory Disease. The Framework establishes clear standards encompassing prevention, detection, screening, management, treatment, and rehabilitation for Chronic Respiratory Disease that will lead to major improvements in quality and access to services. The Framework will provide a high level guide for service planners, designers, funders and providers in helping to deliver the most appropriate evidenced-based care for Chronic Respiratory Disease.

The Chronic Respiratory Disease Clinical Service Improvement Framework is the first in a series of frameworks that will be developed to address the urgent need for a more coordinated and integrated approach to the management and control of chronic diseases and prevent further exacerbations and unnecessary presentation for acute care.

I would like to commend the excellent work of the Western Australian Respiratory Reference Group, formed as part of the WA Strategy for Chronic Disease Management, which convened in March 2004 and was chaired by Dr Martin Phillips to examine respiratory health and subsequently undertook the task of developing this Framework for improving services over the next five years.

Thank you also, to all those who participated in the consultation process in developing this Framework. The depth and breadth of input received has been, and will continue to be, an extremely valuable resource to guide us in the establishment of a Respiratory Health Network and the implementation of the key milestones and targets outlined within this Chronic Respiratory Disease Clinical Service improvement Framework.

We now need to build on what has been achieved previously across Western Australia and develop services that can respond better to the needs of this group of people. The WA Chronic Respiratory Disease Clinical Service Improvement Framework compliments the Western Australian Ambulatory Care Framework and reaffirms the importance of focusing upon the management of long-term conditions through self-care, disease management and case management. The standards identified are designed to put the individual at the heart of care and to provide services that are efficient, supportive and appropriate at every stage from diagnosis to end of life.

I am confident this Framework, and the work to be carried out through the Respiratory Health Network, will significantly enhance respiratory services in this State through improved communication, referral pathways and service provision that all patients deserve to experience.

Dr Neale Fong
Director General of Health,
Executive Chairman, Health Reform Implementation Taskforce.

Overview

The Western Australian Chronic Respiratory Disease Clinical Service Improvement Framework is a tool to bring about more person centred, equitable, timely, effective and affordable care for all Western Australians affected by chronic respiratory disease.

This document provides a summary of the WA Chronic Respiratory Disease Clinical Service Improvement Framework, which reaffirms the importance of focusing upon the management of long-term conditions through self-care, disease management and case management.

A full version of the WA Chronic Respiratory Disease Clinical Service Improvement Framework is available on the CD (attached to this document).

This Clinical Service Improvement Framework is a high level guide for health services to inform:

- Consumers
- Clinicians
- Planners and designers
- Policy makers, funders and providers, and
- Professionals and managers.

It is designed to support and compliment National Clinical Frameworks and State and Territory plans, aimed at reducing the burden of chronic disease.

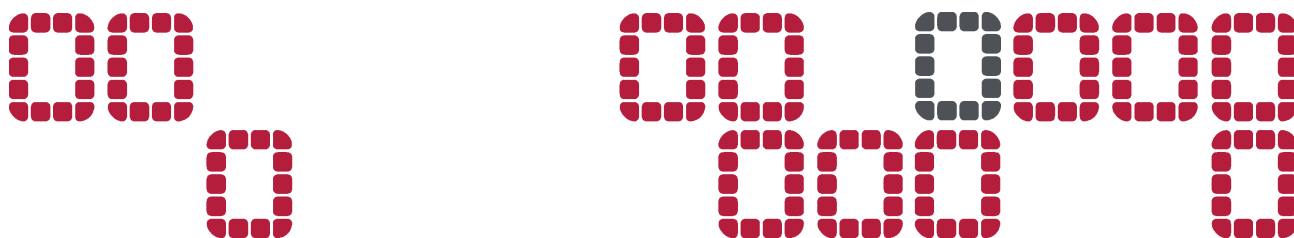
This Clinical Service Improvement Framework adopts a practical, evidence-based and flexible approach to tackling disease by:

- Setting standards of care, both clinical and organisational, for treatment and prevention
- Establishing initial milestones, goals and performance indicators against which progress within agreed timeframes can be measured, and
- Identifying practical tools to support implementation and monitor progress.

This Framework (which is aligned with the National Chronic Disease Strategy), adopts a whole of system approach and aims to improve health services for Western Australians experiencing ill health arising from Chronic Obstructive Pulmonary Disease (COPD) and Asthma. In driving improvements in health services for people with chronic respiratory conditions, this Framework therefore aims to:

- Enhance primary prevention initiatives to reduce the incidence of chronic conditions
- Improve the quality of life of people with chronic conditions
- Improve the quality of life of their carers and families
- Reduce the number of unnecessary and inappropriate hospital admissions and readmissions, and
- Reduce variations in the standards of care.

The approach outlined in the WA Chronic Respiratory Disease Clinical Service Improvement Framework requires a fundamental shift away from an acute focus towards a coordinated approach across the continuum of care. For many people living with conditions such as COPD and Asthma, the main issue, until science can find a cure, is improving the quality of their lives, supporting them to manage their symptoms and live as independently as possible.



We now need to build on what has been achieved previously across Western Australia and develop services that can respond better to the needs of this group of people.

This framework outlines initial milestones, targets and demonstrations of compliance within agreed timeframes for achievement over a three-year period until 2007 for both Chronic Obstructive Pulmonary Disease (COPD) and asthma. As COPD and asthma services are organised differently across the State, this Framework does not attempt to prescribe what services will look like at the jurisdictional local level. It focuses instead on what should be expected to happen for all patients, based on optimal pathways of care.

The standards identified are designed to put the individual at the heart of care and to provide services that are efficient, supportive and appropriate at every stage from diagnosis to end of life.

This Framework should be viewed as a 'living' document, which will evolve over time to include new scientific research findings for improving the health care along with responses from the consultation process.


Approach to the Chronic Respiratory Disease Clinical Service Improvement Framework

The framework and structure used in this paper are based on the National Service Improvement Framework for Cancer developed by the National Health Priority Action Council¹ (2004) and work undertaken by Dr Sharon Kletcho, as well as the New South Wales Clinical Service Framework for Chronic Respiratory Disease (New South Wales Department of Health, 2003). As with these papers, best evidence forms the basis of recommendations (see Table 1 for a summary of the categorisation of levels of evidence).

Table 1 Categorisation of L evels of Evidence

Evidence category	Sources of evidence	Definition
A	Randomised controlled trials (RCT's). Rich body of data.	Evidence is from endpoints of well-designed RCT's that provide a consistent pattern of findings in the population for which the recommendation is made. Category A requires substantial numbers of studies involving substantial numbers of participants.
B	Randomised controlled trials (RCT's). Limited body of data.	Evidence is from endpoints of intervention studies that include only a limited number of patients post-hoc or subgroup analysis of RCT's, or meta-analysis of RCT's. In general, Category B pertains when few randomised trials exist, they are small in size, they were undertaken in a population that differs from the target population of the recommendation, or the results are somewhat inconsistent.
C	Non-randomised trials. Observational studies.	Evidence is from outcomes of uncontrolled or non-randomised trials or from observational studies.
D	Panel Consensus Judgement	This category is used only in cases where the provision of some guidance was deemed valuable but the clinical literature addressing the subject was deemed insufficient to justify placement in one of the other categories. The Panel Consensus is based on clinical experience or knowledge that does not meet the above-listed criteria.

¹ A full list of all references is available on the attached cd.



The framework indicates that people and services range across a continuum from well people in their communities, through detection and diagnosis to people living with diseases (National Health Priority Action Council 2004). The focus of the framework is on:

- Risk reduction
- Early identification of disease
- Availability of best treatment and support during and after acute episodes, and
- Provision of optimal care at the end of life.

Standards, Milestones and Targets

Standards, milestones and targets proposed within this framework are based upon work undertaken by a Respiratory Reference Group (see Appendix 1 for membership). This group reviewed and benchmarked a number of appropriate initiatives, data and literature pertinent to Chronic Respiratory Disease. The Group has also identified opportunities of improvement for management, systems and function, and proposed solutions targeting issues related to chronic respiratory disease within Western Australia. These opportunities for change are outlined throughout this document.

This framework outlines initial milestones, targets and demonstrations of compliance within agreed timeframes for achievement over a three-year period until 2007 for both Chronic Obstructive Pulmonary Disease (COPD) and asthma. As COPD and asthma services are organised differently across the State, this Framework does not attempt to prescribe what services will look like at the jurisdictional local level. It focuses instead on what should be expected to happen for all patients, based on optimal pathways of care.

Chronic Respiratory Disease

Respiratory disease is a term that is used to describe a number of problems that affect the organs of the respiratory system. Diseases of the respiratory system such as asthma, Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure make a substantial contribution to the global burden of chronic disease. The WHO describes the five main respiratory diseases as representing 17.4 percent of all global deaths, with COPD related deaths and burden of disease increasing, and 150 million people affected globally with Asthma (WHO 2003).

Chronic respiratory disease is cited by elderly people in western society as being the second most common cause of self-perceived disability; four times more common, for example, than stroke (Connolly 2004).

Caring for patients with chronic respiratory disease, particularly patients with COPD will present a major challenge over the next decade. The direct and indirect exposure to tobacco smoke is the principal risk factor for its development. Rising rates of smoking in developing countries and the impact of women 'catching up' with men's smoking habits will further affect the development of COPD, as well as lung cancer.

Other less frequent factors include:

- Heavy exposure to air pollution derived from indoor and outdoor sources
- Occupational related disorders
- Malnutrition and low birth weight, and
- Multiple early lung infections.



A Focus on Chronic Obstructive Pulmonary Disease (COPD) and Asthma within Western Australia

This framework focuses on the priority areas of COPD and Asthma. In 2002, COPD accounted for 4 percent of all male deaths and 3 percent of female deaths in Western Australia (Katzenellenbogen et al. 2003). Asthma has long been recognised as a major problem in Australia (AIHW 2004). In 1999 Asthma was made a national health priority area.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is a progressive respiratory disease characterised by airflow limitation and airway inflammation of varying severity. COPD has considerable impact on the quality of life of the patient, involving long term medical care, frequent hospital admissions for treatment of exacerbation of symptoms and often results in premature death (McKenzie et al. 2003).

Chronic Obstructive Pulmonary Disease (COPD) is a leading cause of death and disability worldwide. It is largely preventable and expensive to treat. COPD is a major reason for hospitalisation in Australia. Within Australia, COPD is the largest contributor to the burden of disease associated with all lung diseases and conditions (including asthma), three times the burden of acute respiratory infections and more than four times the burden of other chronic respiratory diseases (AIHW 2004). Patients need frequent primary and secondary care input and up to one in eight emergency hospital admissions may be due to COPD.

There is current consensus of scientific opinion in COPD management regarding the importance of spirometry, smoking cessation, oxygen therapy, pulmonary rehabilitation and influenza vaccination for improving outcomes. These and other evidence-based recommendations are incorporated in the form of five standards for COPD which relate to:

- Chronic Obstructive Pulmonary Disease (COPD) Prevention
- Early diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
- Management of Stable COPD
- Treatment and support during acute exacerbations, and
- Supporting end stage COPD.

Unless otherwise stated, the treatment measures incorporated in the COPD standards are generally based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD).

Standards, Milestones and Targets for Chronic Obstructive Pulmonary Disease

Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard One</p> <p>Chronic Obstructive Pulmonary Disease (COPD) Prevention</p>	<p>WA Health and Area Health Services should:</p> <p>a) Develop, implement and monitor programs that reduce the prevalence of COPD in the population.</p> <p>b) Contribute to a reduction in the prevalence of smoking.</p> <p>All health care providers should:</p> <ul style="list-style-type: none"> ■ At every contact, where appropriate, educate smokers on the dangers of smoking and offer practical advice on how to stop. 	<ul style="list-style-type: none"> ■ By August 2006, to continue and expand population based efforts targeting delaying the uptake of smoking (children and young people), encouraging and supporting quitting smoking (adults) and reducing exposure to environmental tobacco smoke through regulation and legislation. ■ By December 2005, 100 percent of Area health Services will have Smoking Cessation programs in place. ■ By December 2005, 100 percent of patients admitted to WA hospitals will have a smoking history taken, be advised to stop smoking, offered referral to a smoking cessation program or the Quitline and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction. ■ By December 2005, 100 percent of patients with COPD who smoke will be advised to stop smoking, offered referral to a smoking cessation program and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Two</p> <p>Early Diagnosis of COPD</p>	<p>General practitioners, primary care teams and specialists should:</p> <p>a) Use spirometry to confirm a diagnosis of COPD.</p> <p>b) Identify people with established COPD.</p> <p>c) Identify people at significant risk of COPD (ie. smokers).</p>	<ul style="list-style-type: none"> ■ By August 2006, 100 percent of people attending a health care facility (primary, secondary or tertiary) with: <ul style="list-style-type: none"> ■ Unexplained breathlessness ■ Chronic or intermittent, unusual cough ■ Frequent or unusual sputum production ■ Relapsing acute infective bronchitis, and ■ Risk factors such as exposure to tobacco smoke, occupational dusts and chemicals, and a strong family history of COPD should receive spirometry (performed by appropriately trained staff). ■ By August 2006, 100 percent of patients admitted to hospital with a smoking history of 15 pack-years* will be assessed by spirometry. ■ By August 2006, 100 percent of patients diagnosed with COPD should have access to spirometry (performed by appropriately trained staff) and an assessment by a specialist consultant.

Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Three Management of Stable COPD</p>	<p>General practitioners, specialists and other health care professionals should:</p> <p>a) Provide optimal, evidence-based management including prevention of complications (e.g. Influenza vaccination and appropriate pneumococcal) and non-pharmacological treatment</p> <p>b) Educate stable COPD patients on strategies to optimise functional status and reduce risk factors in the ongoing management of the disease</p> <p>c) General Practitioners in conjunction with their patient develop an individualised care plan for the most effective management of people with COPD.</p> <p>Designated Area Health Services with appropriate facilities should have protocols for surgical management of selected COPD patients.</p> <p>Other Area Health Services should develop protocols to assess the suitability of selected COPD patients for specialist assessment for surgical treatment.</p>	<ul style="list-style-type: none"> ■ By December 2005, 100 percent of patients admitted with COPD will be given written information about their disease and the of importance regular exercise ■ By March 2006, 100 percent of patients diagnosed with COPD will be offered vaccination and informed of the benefits of regular exercise. ■ By August 2006, all Area Health Services will have multi-disciplinary pulmonary rehabilitation programs in place that include options for maintenance programs both within the community and, for some patients in hospitals. ■ By August 2006, all Area Health Services will develop linkages with General Practice to promote access to multi-disciplinary pulmonary rehabilitation programs. ■ By August 2006, 100 percent of patients with moderate to severe COPD, will be offered the opportunity to participate in a pulmonary rehabilitation program. ■ By August 2007, a minimum of 50 percent of appropriate patients with moderate to severe COPD will have completed a pulmonary rehabilitation program.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Three (Cont.)</p> <p>Management of Stable COPD</p>	<p>Area Health Services should:</p> <p>Put in place agreed protocols/ systems of care so that patients with moderate and severe COPD have access to supervised exercise and in higher level organisations, multi-disciplinary rehabilitation programs including exercise and education/ self-management.</p> <p>The aim of this comprehensive program will be to enhance health related quality of life and self-efficacy, promote and improve exercise performance, and reduce symptoms of dyspnoea and fatigue and decrease hospital admissions for COPD.</p> <p>Health Care Providers should:</p> <p>Identify patients with COPD who are eligible for oxygen therapy and refer them for specialist assessment.</p> <p>Area Health Services should:</p> <p>Put in place agreed protocols and systems of care so that, prior to leaving hospital, all patients admitted for COPD have been assessed for suitability to receive oxygen therapy.</p>	<ul style="list-style-type: none"> ■ By August 2006, 100 percent of patients with COPD who are graded as moderate and severe will be given education about the disease and its treatment and supported in the development of a self- management plan (and if appropriate a care plan) that should include an action plan for exacerbations. Such action plans should state when to start antibiotics, oral corticosteroids, commence or increase bronchodilators, and when to seek appropriate medical attention. ■ By March 2005, all Area Health Services will have protocols/systems of care defined to ensure that all patients admitted with moderate to severe COPD, attending pulmonary rehabilitation clinics, or attending specialist medical services, will be assessed for suitability to receive oxygen therapy. ■ By December 2005, 100 percent of COPD patients prescribed oxygen therapy will have received written and oral instructions on how to operate the equipment and maximise benefits and be reviewed to determine ongoing need. ■ By August 2007, 100 percent of patients with COPD who are graded as moderate to severe will receive timely and equitable access to services which include: <ul style="list-style-type: none"> ■ Assessment of and treatment for Sleep Disorders (Nocturnal ventilatory support) ■ Non-Invasive (positive pressure) Ventilation (NIV) ■ Surgical management/Intervention (lung volume reduction techniques and transplantation) where appropriate.

Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Four</p> <p>Treatment and Support during Acute Exacerbations</p>	<p>People with symptoms of a possible acute exacerbation of COPD should:</p> <p>Receive appropriate investigations and treatment to relieve their symptoms. Be assessed for admission to hospital. Have a management plan indicating steps to take and changes to medications, if appropriate. Be treated at home when possible.</p> <p>Area Health Services should:</p> <p>a) Put in place agreed protocols and systems of care so that people presenting to hospital with acute exacerbations of COPD are appropriately assessed and offered treatments of proven clinical and cost effectiveness to reduce their risk of disability and death.</p> <p>b) Develop, implement and monitor a program to provide multi-disciplinary coordinated and comprehensive care, including supportive and, when appropriate palliative services for patients with COPD.</p> <p>c) Put agreed protocols and systems of care in place so that if people known to the service are unwell in the community, ambulatory assessment and treatment would be available.</p>	<ul style="list-style-type: none"> ■ By March 2006, all Area Health Services will have developed protocols and systems of care to assess and manage COPD exacerbations ■ By August 2006, all Area Health Services will have plans or protocols for the multi-disciplinary coordinated care for patients with COPD ■ By August 2006, all Area Health Services will have developed or enhanced ambulatory (clinic, home and community based) services for people with COPD.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Five</p> <p>Care and Support at End of Life</p>	<p>Palliative care services are less well developed for patients with chronic disorders compared to those with malignant disease.</p> <p>Area Health Services should:</p> <ul style="list-style-type: none"> ■ Develop, implement and monitor a program to provide multi-disciplinary coordinated and comprehensive care, including supportive and, when appropriate, palliative services for patients with end stage COPD. 	<ul style="list-style-type: none"> ■ By August 2006, 100 percent of end stage COPD patients and their carers will be provided with information about their illness to facilitate participation in decision making that includes information on: <ul style="list-style-type: none"> ■ Course of their disease ■ Treatment options ■ How treatments work and their limitations ■ How that individual will be supported both physically and emotionally throughout the course of their illness. ■ By August 2007, all Area Health Services will have developed protocols and multi-disciplinary systems of care to support end of life management in the community for patients with COPD.

Asthma

Asthma is a chronic condition with attacks occurring at varying intervals and with varying degrees of severity. International comparisons of asthma in adults (Burney et al. 1996) and in children (Asher et al. 1995) indicate that Australia has one of the highest asthma prevalence rates in the world. The 2001 National Health Survey found that 11.6 percent of Australians had asthma as a current condition including 13.9 percent of children aged 0 to 17 years (Australian Bureau of Statistics 2002).

Best practice strategies identified in the area of asthma management include reduction of exposure to tobacco smoke, allergens and pollutants, the importance of monitoring and self management strategies, the use of written asthma action plans, and the development of collaborative partnerships between patients and their general practitioners. These and other strategies are detailed in the ten standards for asthma, which relate to:

- Reducing the risk of asthma
- Early diagnosis of asthma
- Asthma self-management
- Assessing asthma severity
- Preventing acute exacerbation of asthma
- Stabilising chronic asthma
- Management of the acute episode in the Emergency Department
- Management of the transition of care
- Paediatric asthma management, and
- Asthma education.



Standards, Milestones and Targets for Asthma

Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard One</p> <p>Reducing the Risk of Asthma</p>	<p>Exposure to tobacco smoke is an important risk factor in the development of asthma.</p> <p>Area Health Services, General Practitioners and specialist should:</p> <p>Provide support to patients who wish to stop smoking and provide education about the harmful effects of passive and prenatal smoking.</p>	<ul style="list-style-type: none"> ■ By December 2005, all Area Health Services will have Smoking Cessation programs in place. ■ By December 2005, 100 percent of asthma patients who smoke and are admitted to hospital, will be advised to stop smoking, offered referral to a smoking cessation program or the Quitline and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction. ■ By December 2005, all women who are pregnant and smoke will be advised in antenatal classes will be advised to stop smoking, offered referral to a stop smoking cessation program or the Quitline. ■ By March 2006, 100 percent of admitted patients will be screened for smoking, offered referral to smoking cessation services or the Quitline and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction. ■ By August 2006, 100 percent of smokers who have children with asthma, will be advised of the effects their smoking has on their child as passive smoking is a major cause of asthma. The parents will be advised to stop smoking, offered referral to a smoking cessation program or the Quitline and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction ■ By December 2005, all patients with asthma or assessed in primary care with asthma will be advised to stop smoking offered referral to smoking cessation services or the Quitline and advised on nicotine replacement therapy or other pharmacotherapy for nicotine addiction. ■ By December 2005, all women who smoke, attending pre-natal General Practitioner clinics will be advised to stop smoking.

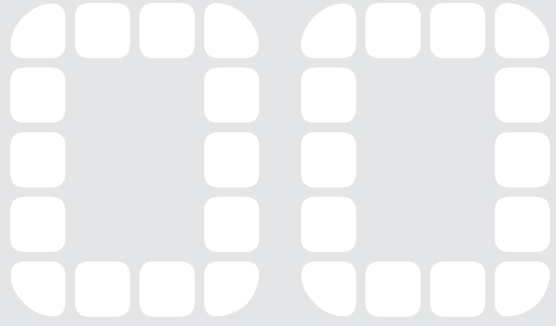
Standard	Evidence-Based Recommendations	Milestones and Targets
Standard Two Early Diagnosis of Asthma	<p>General practitioners, specialists and other health care professionals involved in the management and treatment of asthma should:</p> <p>Have access to a spirometer to assist in the diagnosis and assessment of the severity of asthma.</p>	<ul style="list-style-type: none"> ■ By December 2005, all patients aged over eight years and admitted to hospital with asthma or assessed in Emergency Departments with suspected asthma will have spirometry to assist in the diagnosis and assessment of the severity of asthma. ■ By December 2006, all patients aged over eight years with asthma or assessed in primary and community care with suspected asthma will have spirometry to assist in the diagnosis and assessment of the severity of asthma.

Standard	Evidence-Based Recommendations	Milestones and Targets
Standard Three Asthma Self-Management	<p>Area Health Services should develop education programs for:</p> <p>a) health care professionals b) patients c) carers</p> <p>that seek to promote patient self-management techniques and highlight the importance of regular review by general practitioners.</p>	<ul style="list-style-type: none"> ■ By August 2006, all admitted patients will receive asthma education regarding device use, medication, the need for regular medical review, and will be offered a referral to an educator on discharge. ■ By December 2005, all admitted patients will receive a written asthma action plan (or equivalent) at discharge or on first review, will have its use explained to them and be reviewed by the GP within four weeks. ■ By August 2006, all Area Health Services will have developed plans which foster the participation of patients and their carers in patient self-management education programs. ■ By August 2006, all health care professionals will have access to up skilling courses on a regular basis and remain updated on best practice.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Four</p> <p>Assessing asthma severity</p>	<p>General practitioners, specialists and other health care professionals should:</p> <p>a) Base the assessment of asthma severity on overall asthma severity, and not the severity of an acute attack.</p> <p>b) Assess asthma severity when the patient is stable, not during an attack.</p> <p>c) Reassess on a regular basis.</p>	<ul style="list-style-type: none"> By August 2006 - 100 percent of patients will have asthma severity assessed based on National Asthma Council Guidelines.

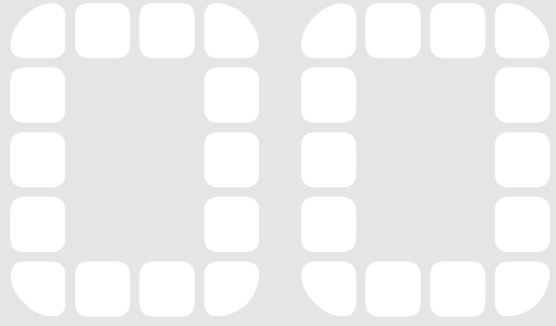
Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Five</p> <p>Preventing acute exacerbations of asthma</p>	<p>Area Health Services should:</p> <p>Ensure that all health care professionals and asthma educators involved in the management and/or treatment of asthma:</p> <p>a) Receive ongoing education and up-skilling in the optimal management and treatment of asthma, including information on how to identify the high-risk patient.</p> <p>b) Assist people with asthma to avoid acute exacerbations of the disease by regular review and working in partnership with General Practitioners, specialists and hospital and community based pharmacists to monitor and control the disease.</p>	<ul style="list-style-type: none"> By August 2006, all Area Health Services will ensure that all health care professionals involved in the management and/or treatment of asthma have access to ongoing education and up-skilling in the optimal management and treatment of asthma. By August 2006, a General Practitioner will be contacted for all admitted patients at discharge to arrange first review. By March 2006, all patients who attend hospital with moderate to severe asthma will be provided with a discharge management plan pending the development of a written asthma management plan in consultation with their General Practitioner.



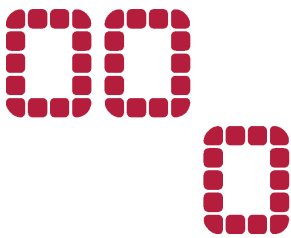
Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Five (Cont.)</p> <p>Preventing acute exacerbations of asthma</p>	<p>c) Develop collaborative partnerships with General Practitioners, and hospital and community based pharmacists and asthma educators to promote the Six-Step Asthma Management Plan (or equivalent) and inform people with asthma of the improvements in health status and quality of life they and their families can expect from contracting with their general practitioner to undertake the plan.</p> <p>d) Provide educational material and information on self-management techniques, including an explanation of, and the need for adherence to written asthma action plans (or equivalent), to enable patients to monitor and manage their own self-care.</p>	



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Six</p> <p>Stabilising chronic asthma</p>	<p>General practitioners, specialists and other health care professionals should:</p> <p>a) Explain the benefits of the National Asthma Council’s Six-Step Asthma Management Plan to all patients with asthma.</p> <p>b) Provide optimal management based on evidence as outlined in the Six-Step Asthma Management Plan.</p>	<ul style="list-style-type: none"> ■ By March 2006, all patients with moderate to severe asthma who attend an Emergency Department or are admitted for asthma will be provided with information about the Six-Step Asthma Management Plan. ■ By December 2005, all patients who attend hospital with moderate to severe asthma will be prescribed appropriate medication such as inhaled corticosteroids, and educated on the use. ■ By March 2006, all patients with moderate to severe asthma who attend an Emergency Department or are admitted for asthma will be advised on the benefits of the Six-Step Asthma Management Plan and will receive an appointment to visit their General Practitioner for follow-up care (see Standard No.7). ■ By August 2006, all asthma patients who attend primary care will be advised on the benefits of the ‘Six-Step Asthma Management Plan or an equivalent plan.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Seven</p> <p>Management of the acute episode in the Emergency Department</p>	<p>Area Health Services should:</p> <p>a) Ensure that appropriate treatment protocols are in place at every hospital Emergency Department for management of acute episodes of asthma.</p> <p>b) Ensure that these treatment protocols include the need to effect rapid symptom relief by:</p> <ul style="list-style-type: none">■ administering a short-acting beta₂agonist■ determining asthma severity by spirometry and/or peak flow measurements to gain an objective measure of airflow obstruction, and■ considering the need for oral corticosteroids and oxygen.	<ul style="list-style-type: none">■ By March 2006, all patients managed in the Emergency Department with an acute episode will have an assessment of the acute attack documented.■ By March 2006, all patients managed in the Emergency Department with an acute asthma episode will have oxygen saturation assessed.■ By August 2006, all patients managed in the Emergency Department with an acute episode will have spirometry.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Eight</p> <p>Management of the transition of care</p>	<p>Area Health Services should:</p> <p>Ensure that the transition of care for patients discharged to community-based care from the acute health sector includes a written asthma action plan and an effective follow-up care developed in collaboration with relevant health care professional including hospital and community based staff, general and specialist staff such as Aboriginal health workers and multicultural health workers</p>	<ul style="list-style-type: none"> ■ By March 2006, all patients managed in the Emergency Department with an acute episode will have an assessment of the acute attack documented. ■ By March 2006, all patients managed in the Emergency Department with an acute asthma episode will have oxygen saturation assessed. ■ By August 2006, all patients managed in the Emergency Department with an acute episode will have spirometry.

Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Nine</p> <p>Paediatric asthma management</p>	<p>Area Health Services should:</p> <ul style="list-style-type: none"> ■ Ensure that information concerning the most effective management and treatment of acute exacerbations of asthma in children is readily available in all hospital Emergency Departments and other health care facilities, including community health centres and pharmacies. ■ Ensure that hospital discharge planning processes include the provision of a discharge management plan and personal health record containing relevant information concerning diagnostic test results, medication regimens, known allergic reactions, emergency contact details and other essential information. ■ Ensure that effective protocols are in place for appropriate follow-up care of children discharged from hospital following an acute exacerbation of the disease. 	<ul style="list-style-type: none"> ■ By March 2006, information concerning the most effective management and treatment of acute exacerbations of asthma in children will be readily available in all hospital Emergency Departments and other health care facilities including community health centres and pharmacies, as well as within local schools. ■ By March 2006, hospital discharge planning processes will include the provision of a written asthma action plan (or equivalent). ■ By March 2006, 100 percent of parents of school-aged patients admitted to hospital with asthma will be offered information regarding the Asthma Friendly Schools Program on discharge. ■ By August 2006, effective protocols will be in all Area Health Services for appropriate follow-up care of children discharged from hospital following an acute exacerbation of asthma.



Standard	Evidence-Based Recommendations	Milestones and Targets
<p>Standard Ten</p> <p>Asthma education</p>	<p>All health care professionals involved in the management/ treatment of patients with asthma, particularly General Practitioners, specialists, pharmacists (hospital and community-based) and asthma educators, should:</p> <p>Collaborate in educating and reinforcing the key concepts of asthma management.</p> <p>Area Health Services should:</p> <p>Ensure that all patients with asthma are provided with a personal health record incorporating an individualised written asthma action plan and information concerning medication, diagnostic test results, allergies, emergency contact details and any other essential information.</p>	<ul style="list-style-type: none"> By March 2006, all patients with moderate to severe asthma will receive asthma self-management education, and a written asthma action plan.

Framework Implementation Strategy

Effective implementation of this framework will require the active engagement of all stakeholders. This includes Area Health Service executives, clinicians, managers and service planners working in close liaison with the primary care sector as well as community health and allied health sectors in order to establish effective discharge planning processes which ensure seamless transitional care for people with chronic disease and ongoing health needs.

Implementation of this framework will also require effective clinical governance

Assessing Progress: Statewide Performance Indicators

At a Statewide level the following indicators have been selected for analysis of progress:

- Rates of admissions to hospital of patients who have a diagnosed respiratory disease
- Rates of un-planned re-admissions to hospital of patients who have a diagnosed respiratory disease
- Percentage of patients who have been diagnosed with COPD who are enrolled in a pulmonary rehabilitation program
- Percentage of patients enrolled in a pulmonary rehabilitation program who complete the program, and
- Rates of patients who are diagnosed with asthma who present to an Emergency Department with an acute exacerbation of the disease and who leave the Emergency Department with evidence-based information.



Conclusion

The new approach outlined in this framework requires a fundamental shift in the way that health services are currently delivered in Western Australia.

There are many other initiatives being undertaken within Western Australia at the time of developing this Service Improvement Framework. The WA Health Clinical Services Framework (CSF) is a strategic planning framework for the development and provision of health care services throughout Western Australia over the next ten to fifteen years and beyond. Informed by the final recommendations of the Health Reform Committee in 2004 (the 'Reid report'), the Clinical Services Framework provides a guide for the Department of Health and Area Health Services for the development of a health care system. The Strategic Directions 2005 focuses on the major goals for the public health system, and identifies the objectives and actions that will be pursued, and set the basis for the development of WA Health's Strategic Intent 2005 - 2010.

The involvement of clinicians in decision-making in strategies to improve service provision for people with chronic illness is paramount to future system reform and Western Australia is committed to the establishment of health networks to ensure this level of involvement. This Chronic Respiratory Disease Clinical Services Improvement Framework is testament to the positive outcomes that can be achieved by such multi agency ways of working. The implementation of this Framework will be dependent upon the adoption of a similar approach.

Appendix 1

WA RESPIRATORY REFERENCE GROUP MEMBERSHIP

Membership of the Respiratory Reference Group comprises:

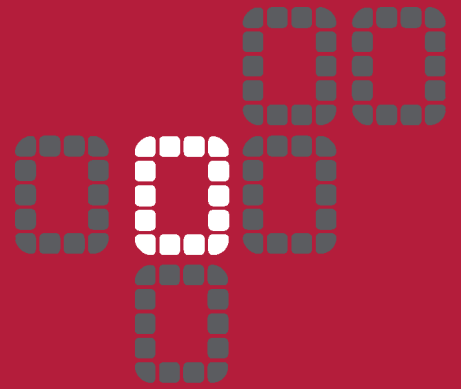
- The Chair (appointed by the Deputy Director General, Health Care)
- Senior Clinicians from East, North and South Metropolitan Area Health Services
- President of the Thoracic Society of Australia and New Zealand (Senior Clinician)
- Key expert clinicians as appointed by the Chair
- Senior Paediatric Respiratory Clinician
- Clinical Nurse Specialist for Respiratory Medicine East Metropolitan Area Health Service
- GP Practice nurse
- General Practitioner representative
- Asthma Educator
- Home Link Respiratory nurse
- Allied Health representative
- Community representative

Chairperson

Dr Martin Phillips, Consultant Respiratory Physician, Sir Charles Gairdner Hospital

Members

Dr Weng Chin	President	Thoracic Society of Australia and New Zealand (WA)
Ms Piper Collis	Education and Training Manager	Asthma Foundation of WA
Ms Shauna Gaebler	Deputy CEO	Perth and Hills Division of General Practice.
Dr David Hillman	Head of Department	Pulmonary Physiology, Sir Charles Gairdner Hospital
Assoc.Prof. Susan Jenkins	Physiotherapy Department	Sir Charles Gairdner Hospital
Dr Peter Kendall	Chest Physician	Department of Respiratory Medicine, Fremantle Hospital
Assoc. Prof Fiona Lake	Head of Department	Department of Respiratory Medicine, Royal Perth Hospital
Ms Sue Morey	Clinical Nurse Consultant	Respiratory Medicine, Sir Charles Gairdner Hospital
Dr Sutapa Mukherjee	Respiratory Physician	WA Respiratory Sleep Disorders Institute, Queen Elizabeth II Medical Centre
Assoc. Prof. Stephen Stick	Head of Department	Respiratory Medicine, Princess Margaret Hospital
Ms Barbara Stubber	Home Link Respiratory Nurse	Respiratory Medicine, Sir Charles Gairdner Hospital
Dr Alan Wright	GP Liaison	Medical/Surgical Directorate, Fremantle Hospital
Assoc. Prof. John Upham	Institute of Child Health Research	University of Western Australia
Executive Officers	Clinical Development Branch	Health Policy & Clinical Reform Division, Department of Health WA



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