

Centennial Anniversary Symposium of Filha
23 August 2007
Marina Congress Center

The clinical governance of asthma

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The clinical governance of asthma
or
how to improve the quality of care

The clinical governance of asthma

A system to improve the quality of clinical care.

Not by a new wonder treatment for asthma cure
but by giving the best care according to present
evidence

Governance

**the process of decision-making and
the process by which decisions
are implemented
(or not implemented)**

Governance

**Is a term for what leaders do -
or should do
politicians, administrators, leaders**

You are not alone or the only one

**Regulation and rules
have (fortunately/unfortunately) to be
inforced on society
also viewed from a health perspective**

Clinical governance

- A system for improving the standard of clinical practice.
- *‘a system to ensure that clinical standards are met, and that processes are in place to ensure continuous improvement, backed by a statutory duty for best quality’.*

Guidelines that describe the processes

When to diagnose – early intervention

How to diagnose – correct diagnoses incl. comorbidities

How to evaluate – basis for advice and treatments

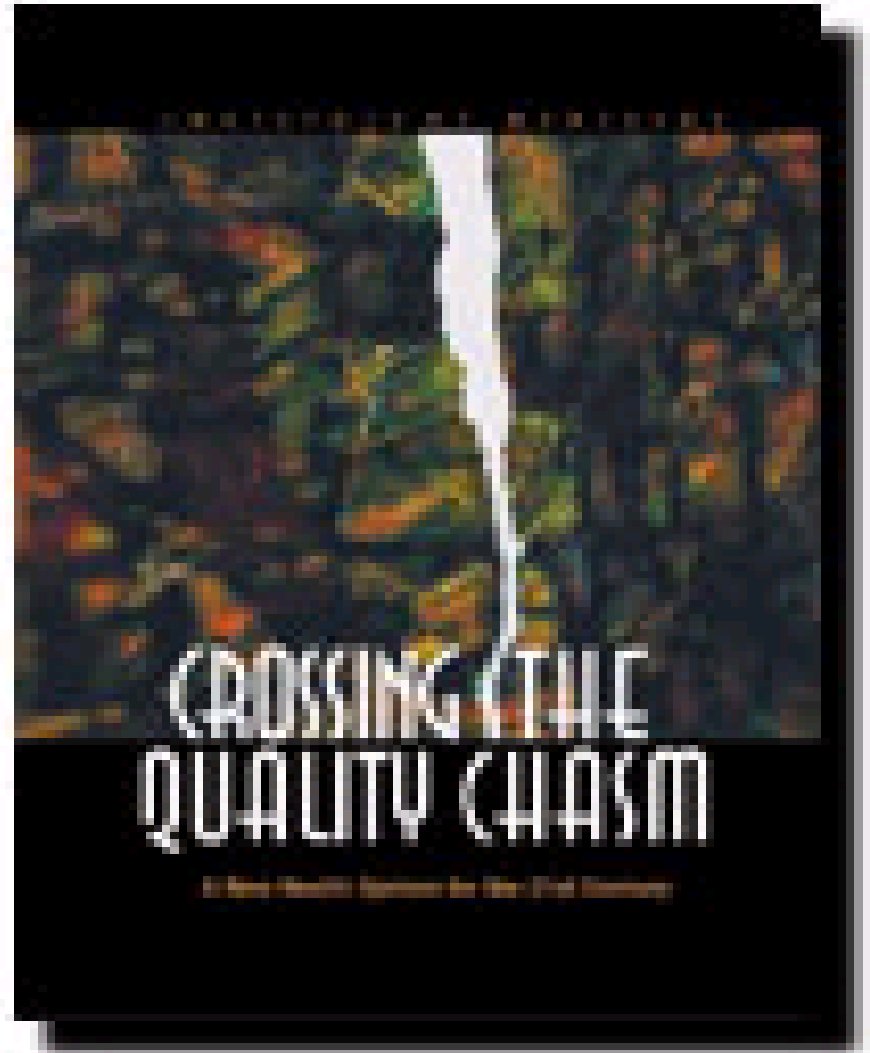
How to treat – choice of medications and interventions

How to follow up – frequency and content of consultations

The manual of governance

The Quality Chasm

- The chasm between what we do and what we ought to do
- Blaming physicians will not work.
- Changing organization and incentives will.



Ref.: Crossing the Quality Chasm. National Academy Press, Washington D.C. 2001

In medicine we tend to develop individual procedures and opinions on what is best practise – and it seems to get worse with age

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WIND YOU UP AND YOU JUST DON'T STOP!

Sometimes it is said that doctors are resistant to leadership

Clinical governance

- This framework challenges clinicians' traditional autonomy and will only succeed to the extent that they find it supportive and helpful.
- **clinical audit, education and training, research and development, and risk management** (including complaints) will become part of clinical governance.
- Funding of this continuing review of clinical practice must be present and visible in the budget.

For the benefit of all

- Rules/laws for handling waste product and sewers
- Rules for cars construction and traffic regulation, outdoor pollution
- Rules for tobacco smoking
- Work place exposures, ventilation , heavy loads, working hours
- Building constructions etc

We need governance

Although we hate to be governed we all call out for rules and regulations

The leaders have the difficult task to decide where the efforts and money should be directed

The Quality Chasm in Diabetes

<u>Event</u>	<u>conventional</u>	<u>Intensive</u>
Completed study	63	67
Cardiovasc.events	85 in 35 pats.	33 in 19 pats.
Cardiovascular deaths	7	7
Nonfatal MI	17	5
CABG	10	5
PTCA	5	0
Nonfatal stroke	20	3
Amputations	14	7
Periph.vasc.surgery	12	3

Ref. Gæde P et al. N.Engl.J.Med. 348: 383-393, 2003

What did the Steno group do?

- Multifactorial intervention and behavior modification
- Evidence based guidelines (Protocol).
- Clear aims and goals.
- Multidisciplinary team (Project team)
- Case management
- Patient education
- Continuity in care

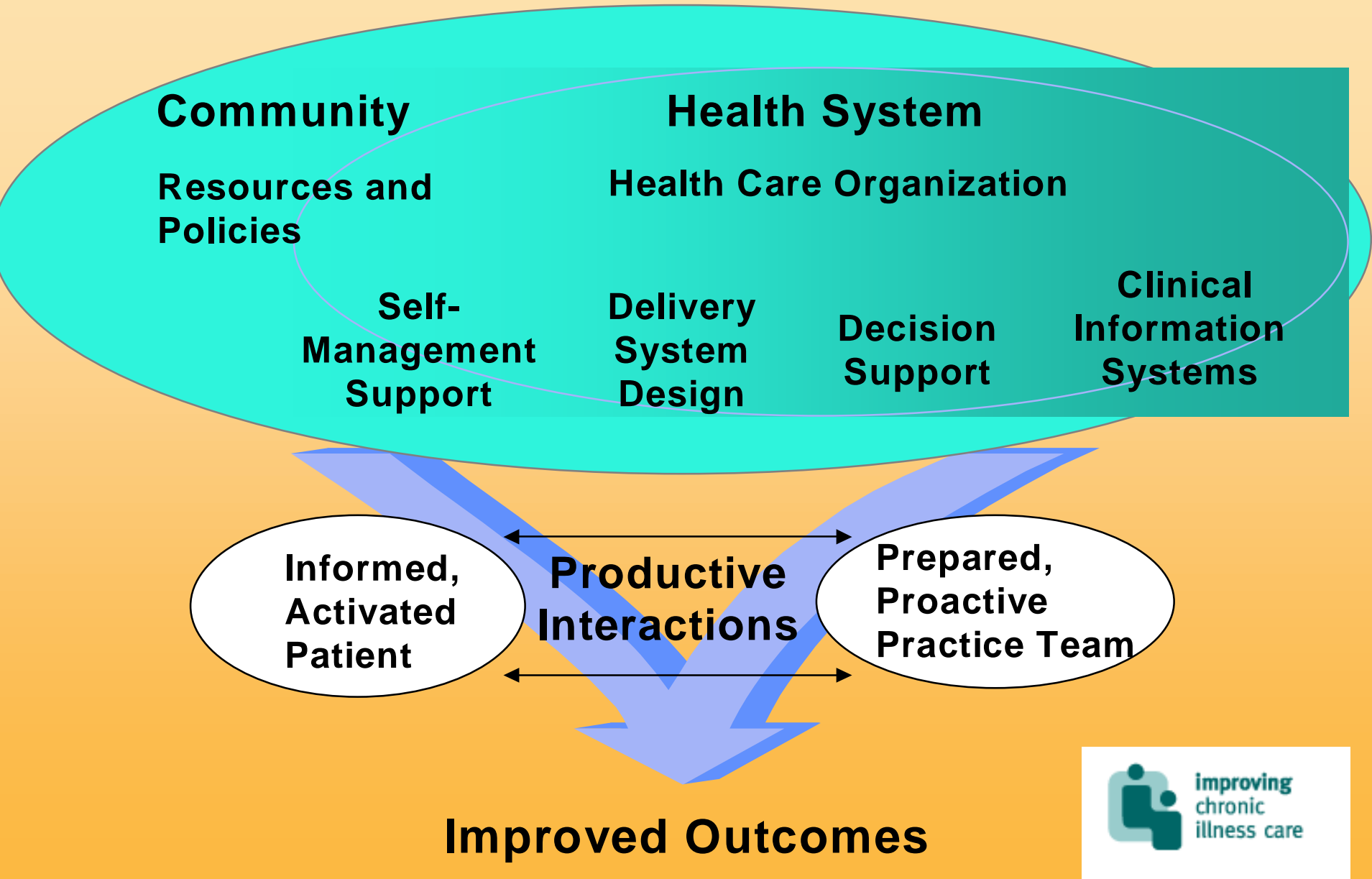
We can do better

All activities in society rest on theories and philosophies often based on experience or gathered evidence.

We need a mechanism, a story, an explanation - to support our behaviour

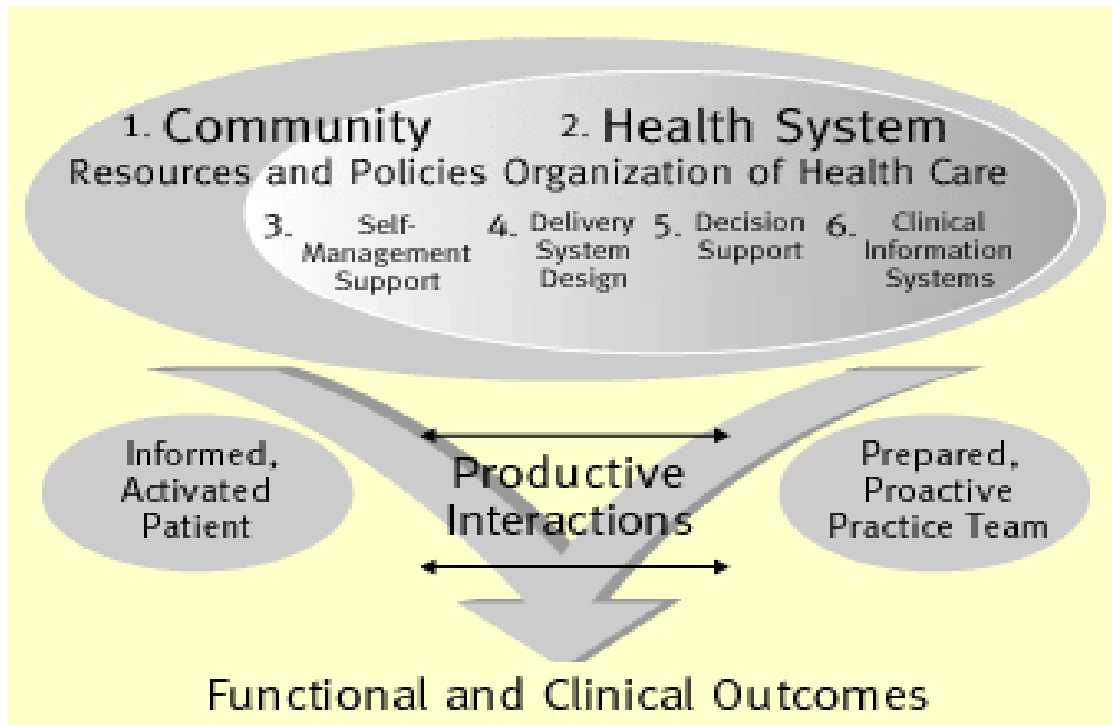
The Chronic Care Model

Chronic Care Model



Survey of operational practices was built on the Chronic Care Model

- Which is the *most* important practice?



- Leadership
- Accountability
- Champions
- Resources
- Financial Incentives
- Provider Feedback
- Program Evaluation
- Patient Action Plans
- Patient Education
- Guideline Training
- Provider Alerts
- AMR
- Defined Care Path
- Risk Stratification
- Registry
- Outreach and Follow-up
- Inreach
- Care Coordination
- Team-Based Care
- Cultural Competence

From Improving Chronic Illness Care
Ed Wagner, MD, Group Health Cooperative of Puget Sound

Kilde: Guy Chicoine, Kaiser Permanente – og baseret på Ed. Wagner

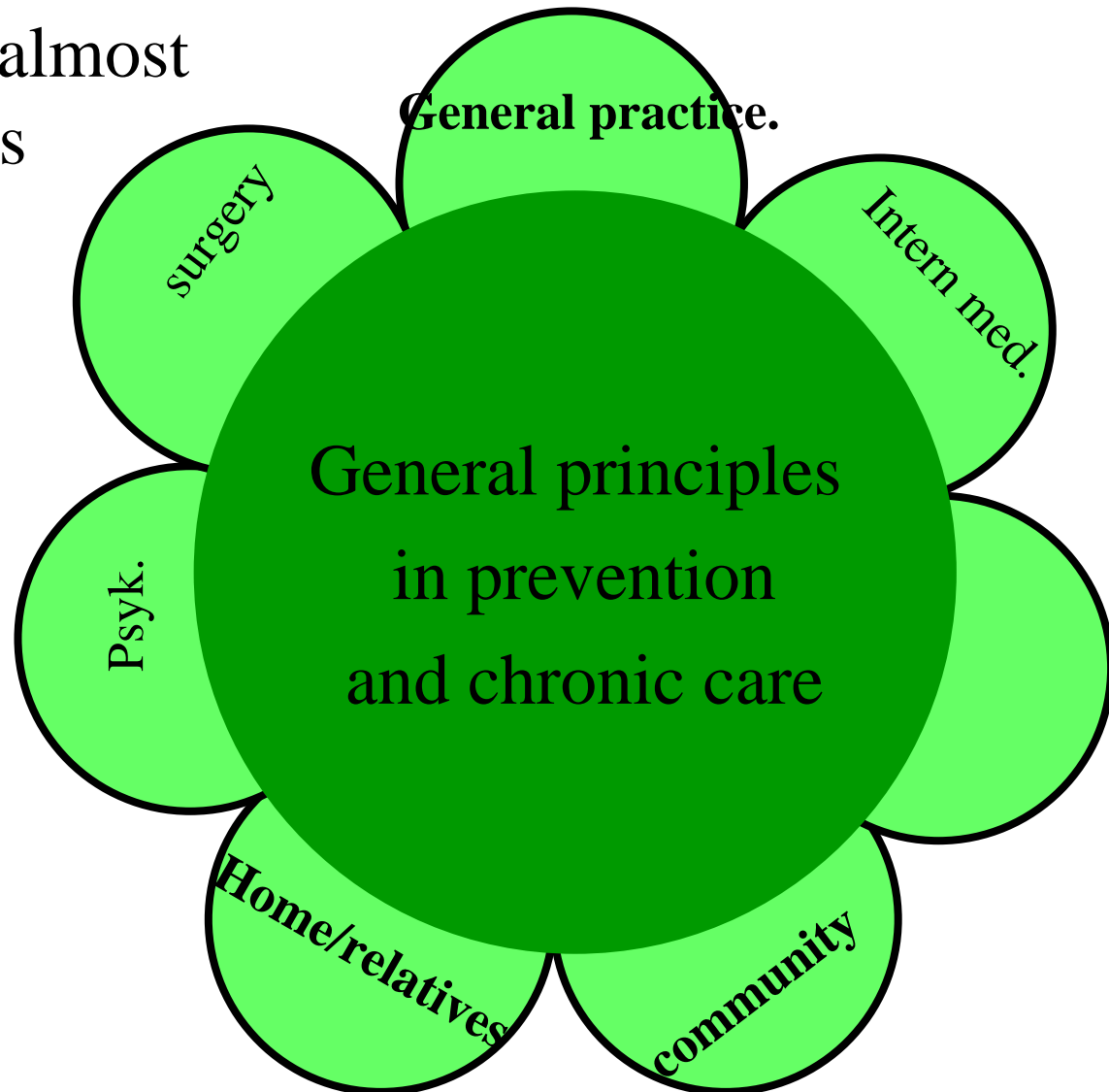
- General standards of patient management - Referral, Visitation, receipt, Evaluation and planning, coordination and continuity, diagnostics, observation, Patient involvement, Patient information and communication, Intensive care, Invasive treatment, Rehabilitation, Medication, prevention and health promotion and nutrition
- Organisational standards - supplies, Patient transport, equipment and technology, Quality assurance, Risk assessment, Hygiene, Recruitment education and CME, Documentation, audit and data management Leadership and politics, standards and guidelines
- Disease specific standards - stroke, COPD, asthma lung cancer etc.

Chronic disease management is based on general principles

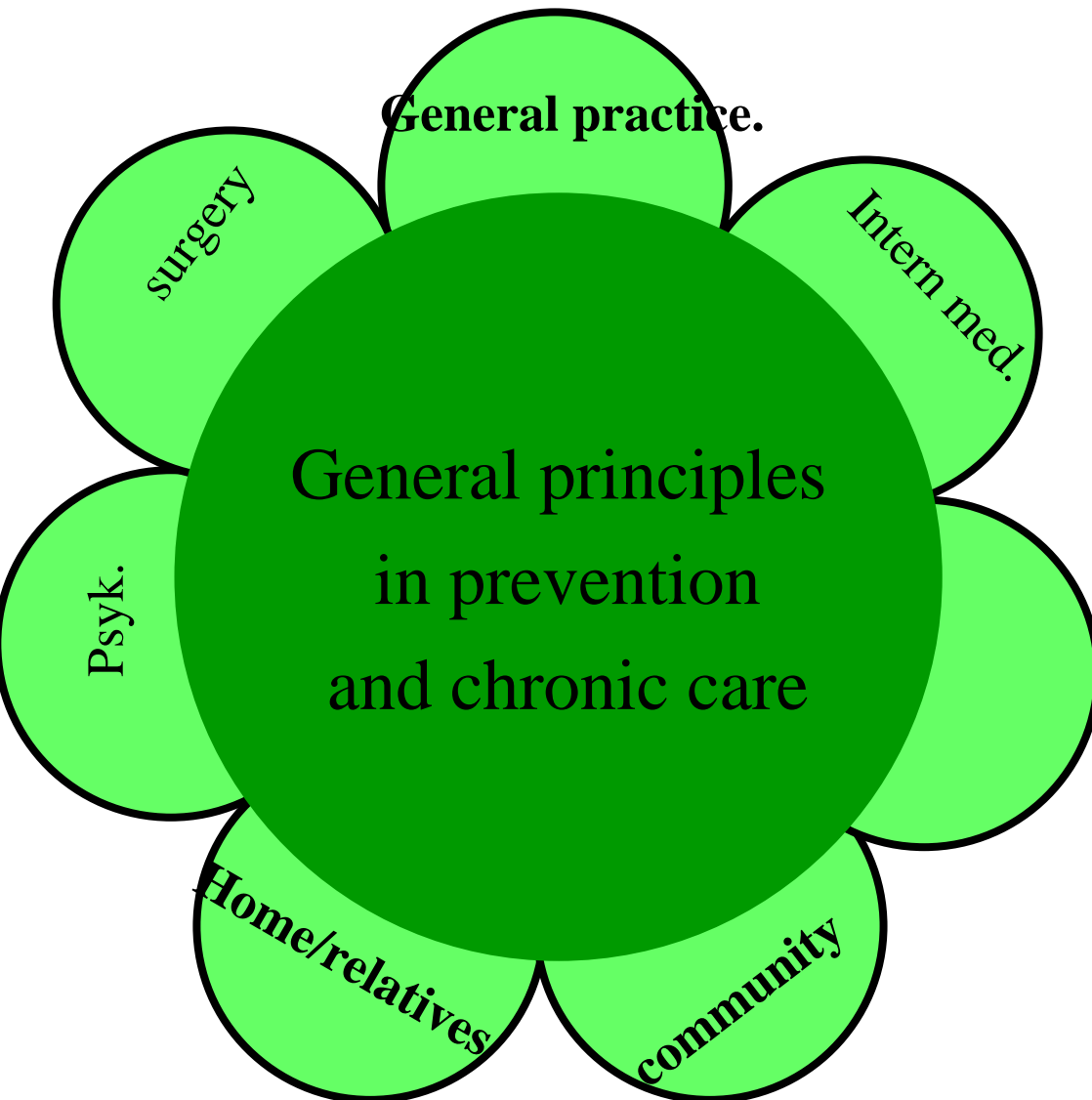
Same basic principle almost independent of diagnosis

80 % general

20 % disease specific



Chronic disease management is based on general principles



- self management
- mastery
- family/network
- exercise
- nutrition/diet
- physiotherapi
- social circumstances
- maintain motivation
- smoking cessation
- etc

Chronic disease management is based on general principles

But the disease specific knowledge and clinical problems are not contained in the general philosophy.

There are similarities (chronicity) but huge differences between chronic diseases i.e. asthma, ulcerative colitis, rheumatoid arthritis etc

General knowledge of the principles of chronic disease management is mandatory for all and disease specific knowledge essential for the specific disease management

Preparing a health care workforce for the 21st century

THE CHALLENGE OF CHRONIC CONDITIONS

World Health Organization 2004

AND

European Respiratory Society

Changes are needed

- In organisation of care (acute vs chronic)
- In cooperation between sectors
- In content emphasis in all health educations
- Health promotion and prevention

We need governance not chaos

Asthma Programme in Finland 1994-2004

A community problem needs
community solutions

T.Haahtela

L.Tuomisto

A.Pietinalho

T.Klaukka

M.Kaila

M.Erhola

M.A.Nieminen

E.Kontula

L.A.Laitinen

Focus on inflammation,
early treatment and
networking

Ministry of Health and Social Welfare
Filha ry.

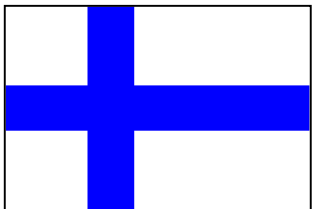
Finnish Asthma Programme 1994-2004

TRADITIONAL

- Money
- Personnel
- Facilities
- Time

NEW

- Innovation and **new knowledge**
- Attitude and motivation
- Unused know-how
- Resources not organised for common goals
- Interest group participation



Measures to achieve the goals were :

- early diagnosis and active treatment;
- guided self-management as the primary form of treatment;
- reduction in respiratory irritants such as smoking and environmental tobacco smoke;
- implementation of patient education and rehabilitation combined with normal treatment, planned individually and timed appropriately;

Measures to achieve the goals were:

- increase in knowledge about asthma in key groups; and promotion of scientific research.
- Appointment of one doctor, one nurse and one pharmacist responsible for asthma care in each clinic/ region

Education during the whole programme period from 1994 to 2004.

Step	No of sessions	No of participants
(1) Pulmonary and paediatric hospital units	100	5300
(2) Primary and secondary care professionals	237	3700
(3) All healthcare professionals	450	25500
(4) Regional paediatricians and primary care professionals (mini-programme)	25	1300

Stepwise educational sessions and target groups during the 10 year programme organized by Finnish Lung Health Association (Filha) and other professional bodies

Facilities and knowledge of asthma care in Finnish health centres in 2000

Facility/knowledge

Proportion of health centres (%)

Peak flow meters available	.....	100
Guided self-management used	.....	98
Inhaled corticosteroid as first line medication	.....	97
Spirometry available	.....	95
Local asthma-responsible person designated		
Nurse	.....	94
General practitioner	.....	83
Regional asthma programme available	.....	79
Diagnosis of adult asthma in health centre.	.....	77
At least annual follow up visit recommended	.....	75
Asthma education arranged for professionals (mean 3.2 sessions/centre in 2 years)	.....	71

Primary care

Changes in asthma management during the programme

1993

2004

General practitioner

Asthma suspicion referred to specialist without lung function tests

Infrequent follow up visits

Prescriptions renewed without check up

Nurse

Rarely spirometry measurements made or peak flow values followed

Diagnosis of asthma by GP

Short specialist consultation as needed

Anti-inflammatory treatment started without delay

Easy access to evidence based guidelines and local treatment chains

Annual follow up visits

Daily spirometry measurements

Routine guidance in peak flow measurement and use of inhalers

Patient centred asthma education with written action plan

Annual follow up visits

Specialist care

Changes in asthma management during the programme

1993

2004

Adults

Diagnosis of asthma - Most follow up visits - Emergency care

Children

Diagnosis, treatment, follow up of all childhood asthma

Inpatient treatment of acute asthma

Pharmacies, Asthma coordinators

No actively organised role in asthma care

Only a portion of new diagnoses

Follow up of severe cases only

Part of emergency care

Diagnosis of childhood asthma

Treatment, follow up of preschool asthma

Inpatient treatment of acute asthma

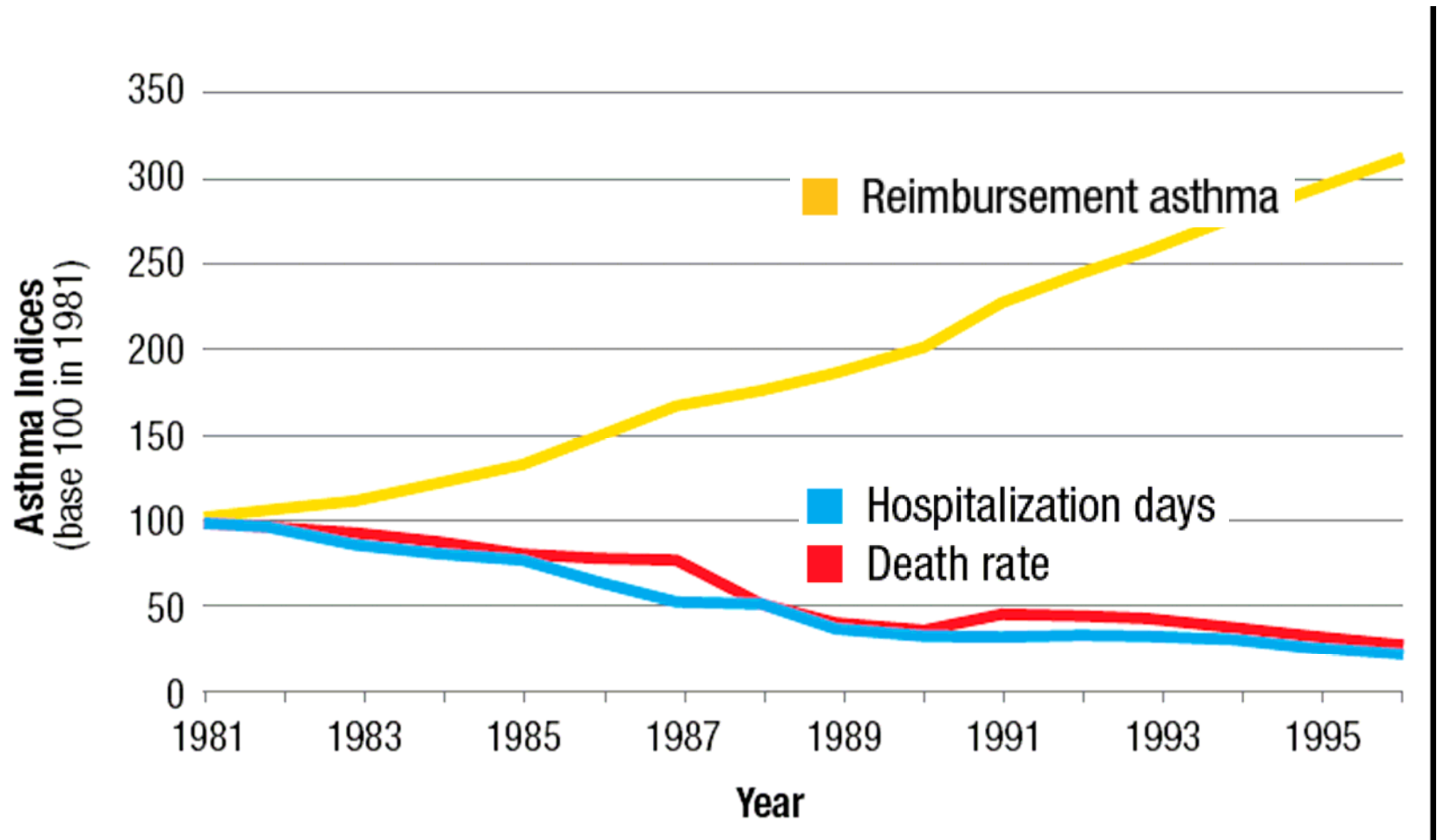
Active guidance in use of preventers and relievers;

guidance in inhalation technique

Networking with local health care

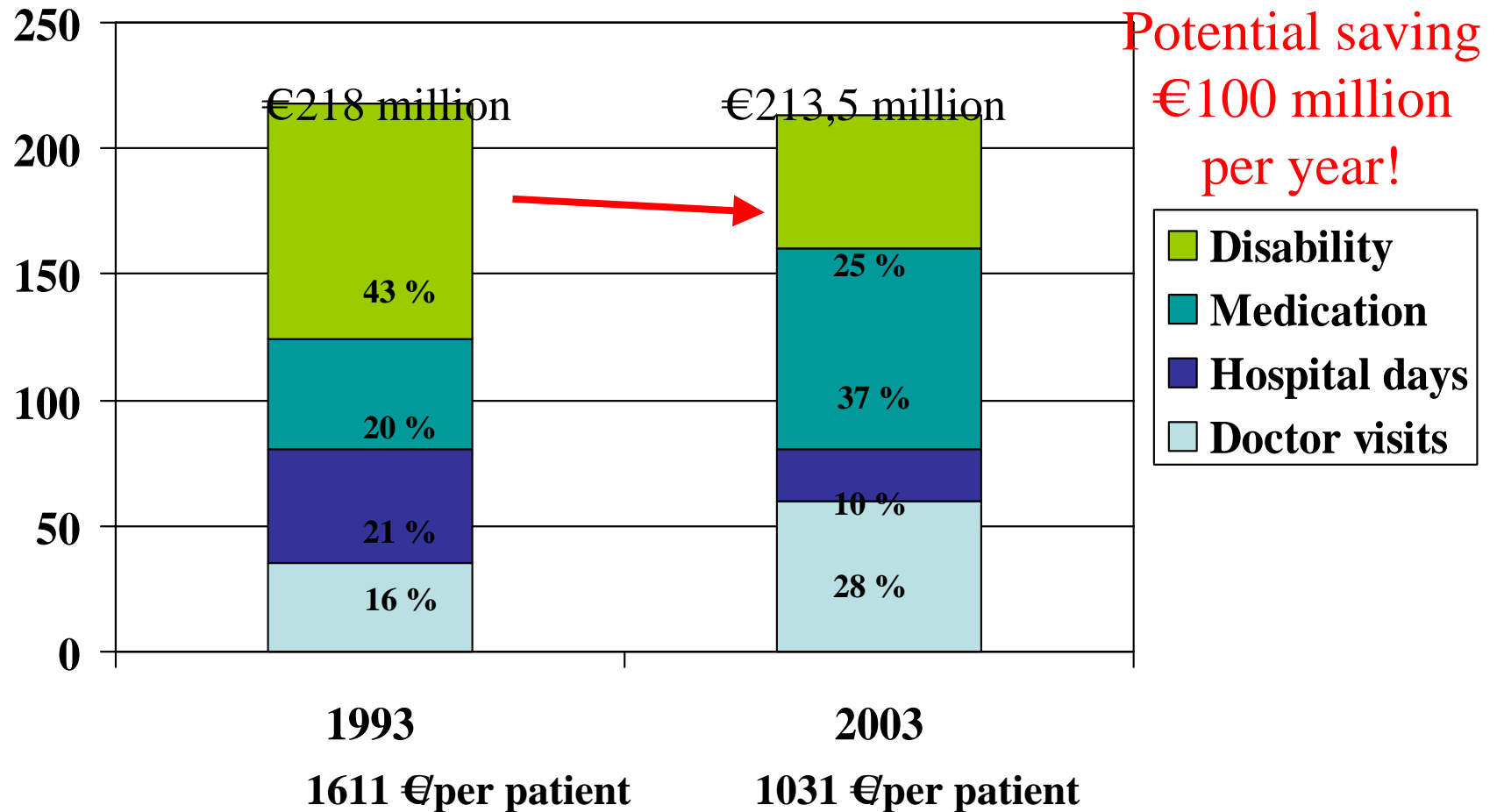
Finnish Asthma Programme

New patients, death rate and hospital days



Asthma costs 1993 and 2003

Hospital care, outpatient care, medication and disability (pensions, days off work, rehabilitation)



Asthma is well taken care of in the Nordic countries especially in Finland-
maintenance of asthma governance

Allergy need focus and active investment

Evidence based medicine in allergy and asthma

- We know much about use and outcome of pharmacotherapy.
- We know little/nothing about why allergy, asthma, allergy in hay fever, food allergy, allergies in asthma and eczema is increasing.

Prevention of allergy, atopic dermatitis, asthma, rhino-conjunctivitis, food allergy

- Probiotics – atopic dermatitis
- Omega-3 fatty acids in pregnancy – asthma
- Sterile environment and low allergen exposure – or the opposite
- Farming, cats, LPS and similar
- Infections and infestations
- Diet incl cow milk avoidance
- Airborne allergen avoidance incl at work place
- Avoidance of damp homes
- Avoidance of passive/active smoking

There is a global agreement on adequate practice in asthma, COPD, and other major respiratory diseases

Current practice lags behind these recommendations

Challenges for organisation of CRD management

Major problem of affordability for both drugs and equipment in poor populations

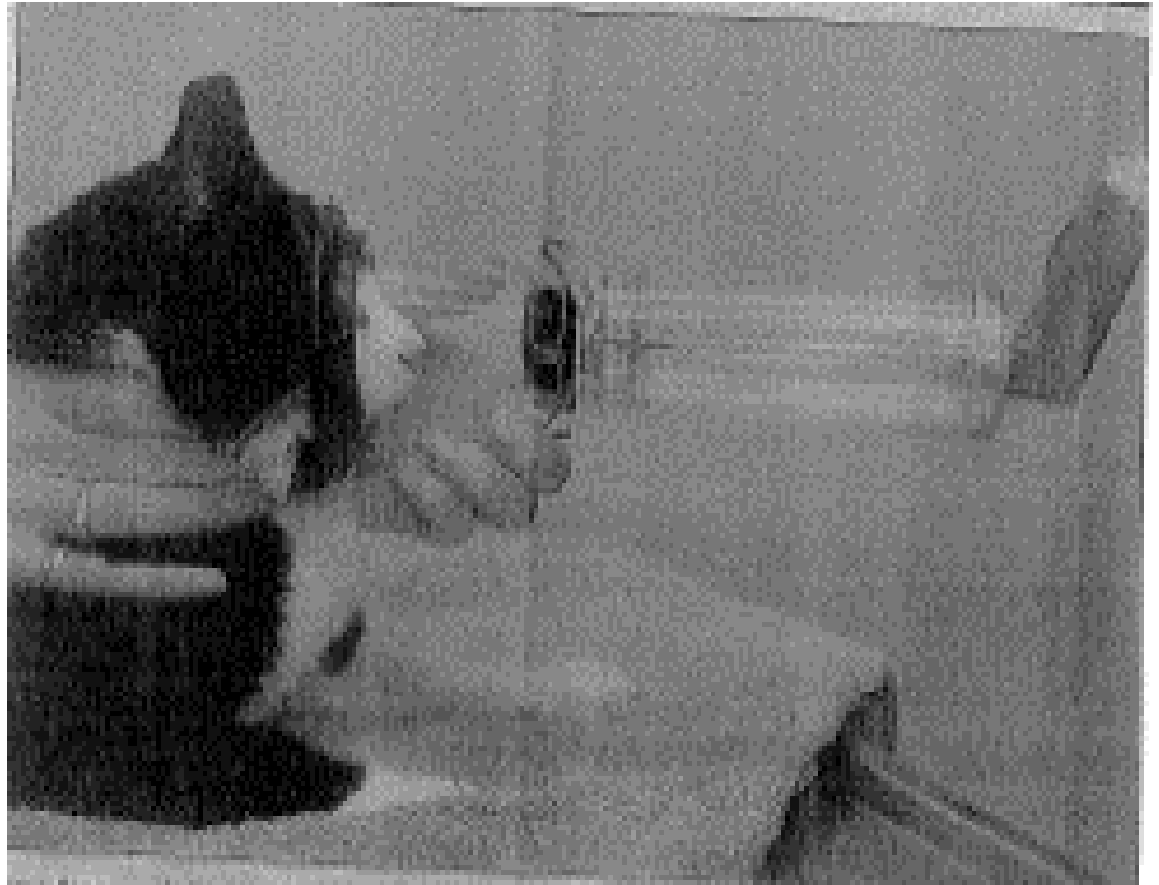
Estimates of the prevalence of preventable chronic respiratory diseases

Chronic respiratory disease	Year of estimation	Prevalence
Asthma	2004	300 million
Chronic obstructive pulmonary disease	2000	210 million
Allergic rhinitis	1996–2006	400 million
Other respiratory diseases	2006	>50 million
Sleep apnea syndrome	1986–2002	>100 million

We must avoid that
treatment of major diseases like
tuberculosis, pneumonia, asthma, COPD etc.
will be limited to the rich patients

We must avoid that
the number of patients with poor access to adequate
care increase in the coming years

And for animals
in rich countries!



New Zealand. Sunday Star. Times January 4th.2004 Photo: Kevin Stent

The mission and responsibility of the health ministry is to improve the health of the country's population

The mission and responsibility of the WHO is to improve the health of the worlds population

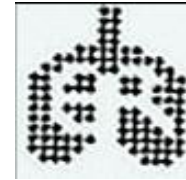
The WHO council is constituted by the health ministers of member states

The Global Alliance against Chronic Respiratory Diseases (GARD)

- **GARD brings together national and international organizations, institutions and agencies to combat chronic respiratory diseases.**
- **GARD's goal is to reduce the global burden of chronic respiratory diseases.**
- **GARD's emphasis is on the needs of low- and middle-income countries.**



ACAAI



AAA



CNR



KTL

International Union Against Tuberculosis and Lung Disease



IPCRG

RSP

FIRS



Wonca World family doctors. Caring for people.



DANMARKS LUNGEFORENING



Dokkyo University



SFAIC



Turkish Thoracic Society

IRCCS



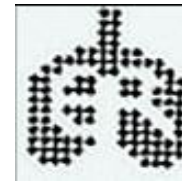
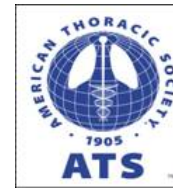
KAAF

IPRAIS





ACAAI



AAA



CNR



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World family doctors. Caring for people.



DANMARKS LUNGEFORENING



Dokkyo University



SFAIC



Turkish Thoracic Society

IRCCS

KAAF



International Association of Asthmology

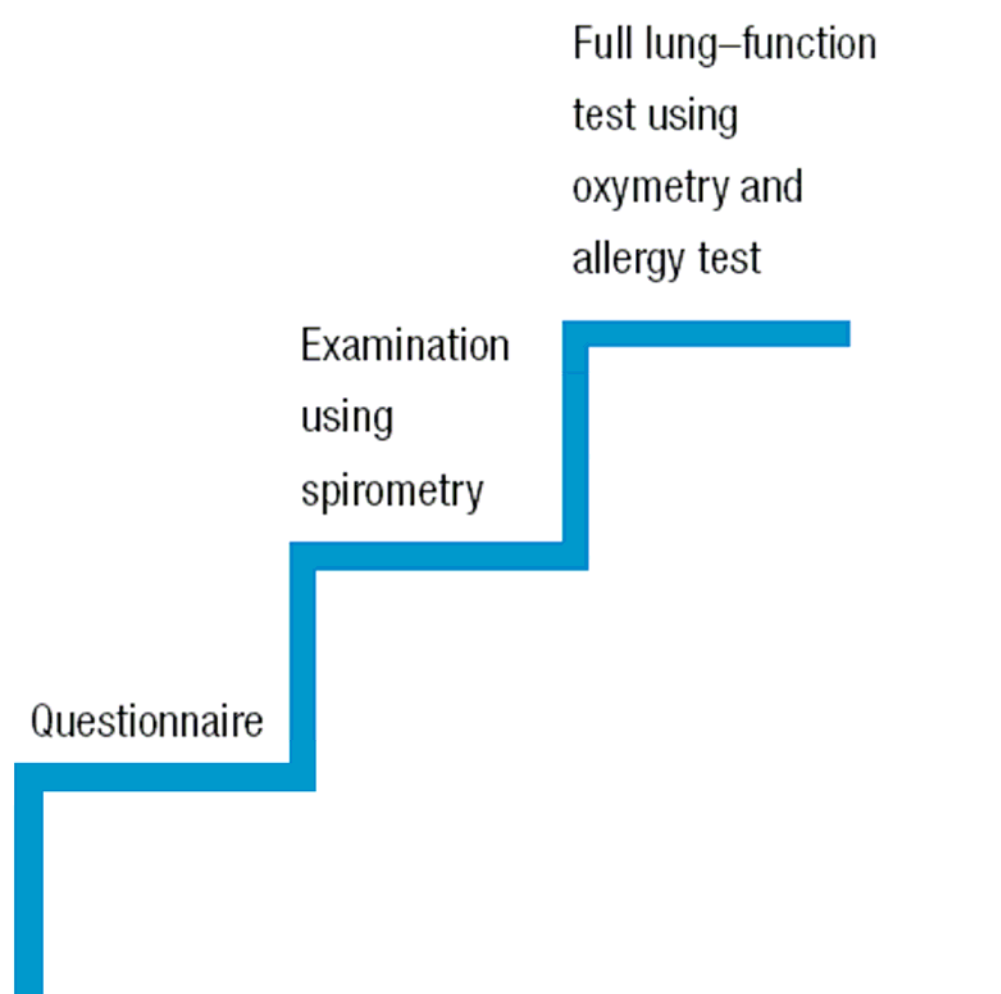


IPRAIS

GARD Approach

- **GARD will work at international and national level.**
- **GARD's planning steps correspond to WHO's strategic objectives and action plans.**
- **GARD will exploit synergies, building on and complementing existing programmes and projects.**

Diagnosis of chronic respiratory diseases based on a stepwise investigation



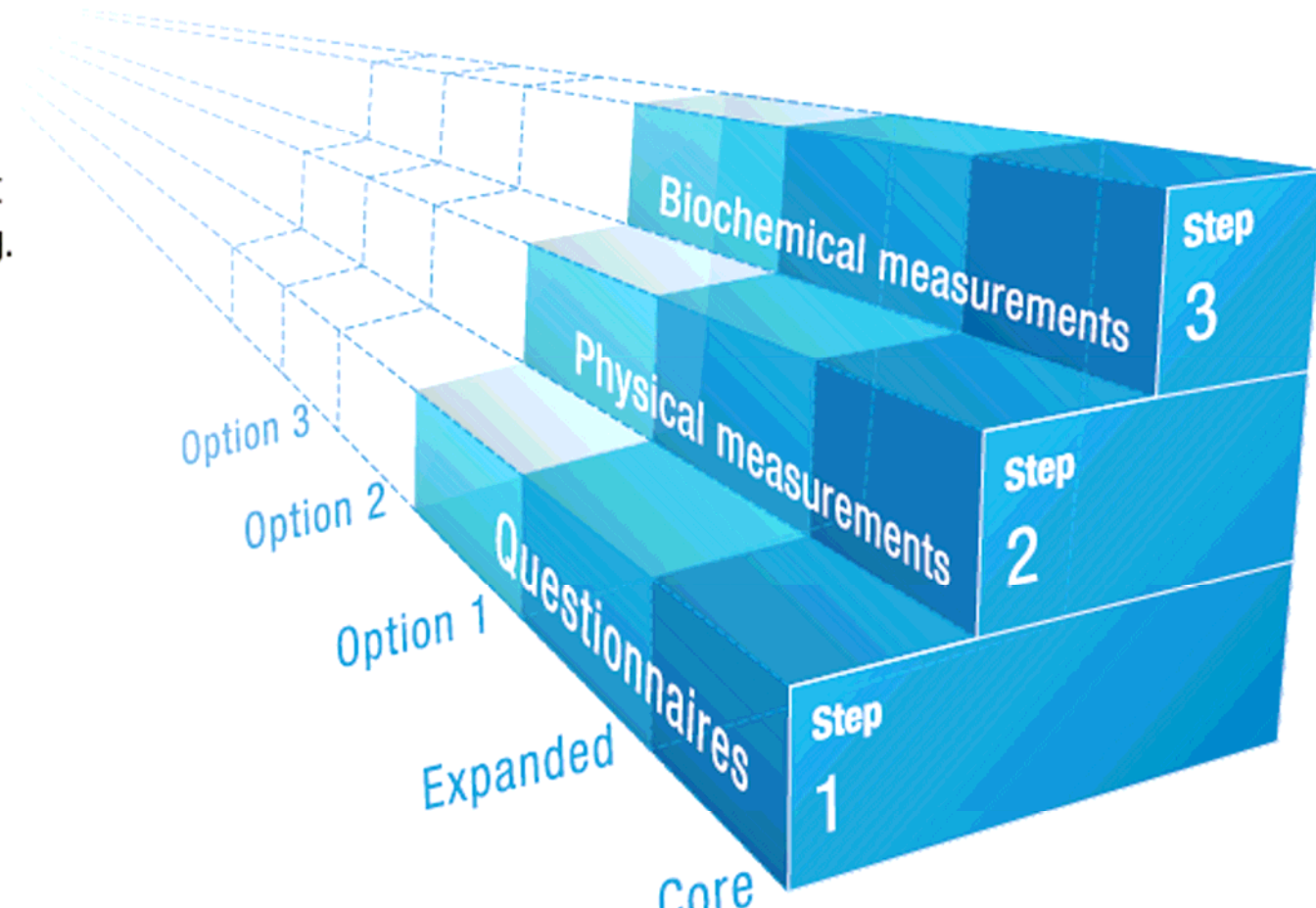
GARD proposal for the stepwise approach to surveillance of chronic respiratory diseases

SURVEILLANCE OF MAJOR CHRONIC RESPIRATORY DISEASES ACCORDING TO WHO-STEPS (1)

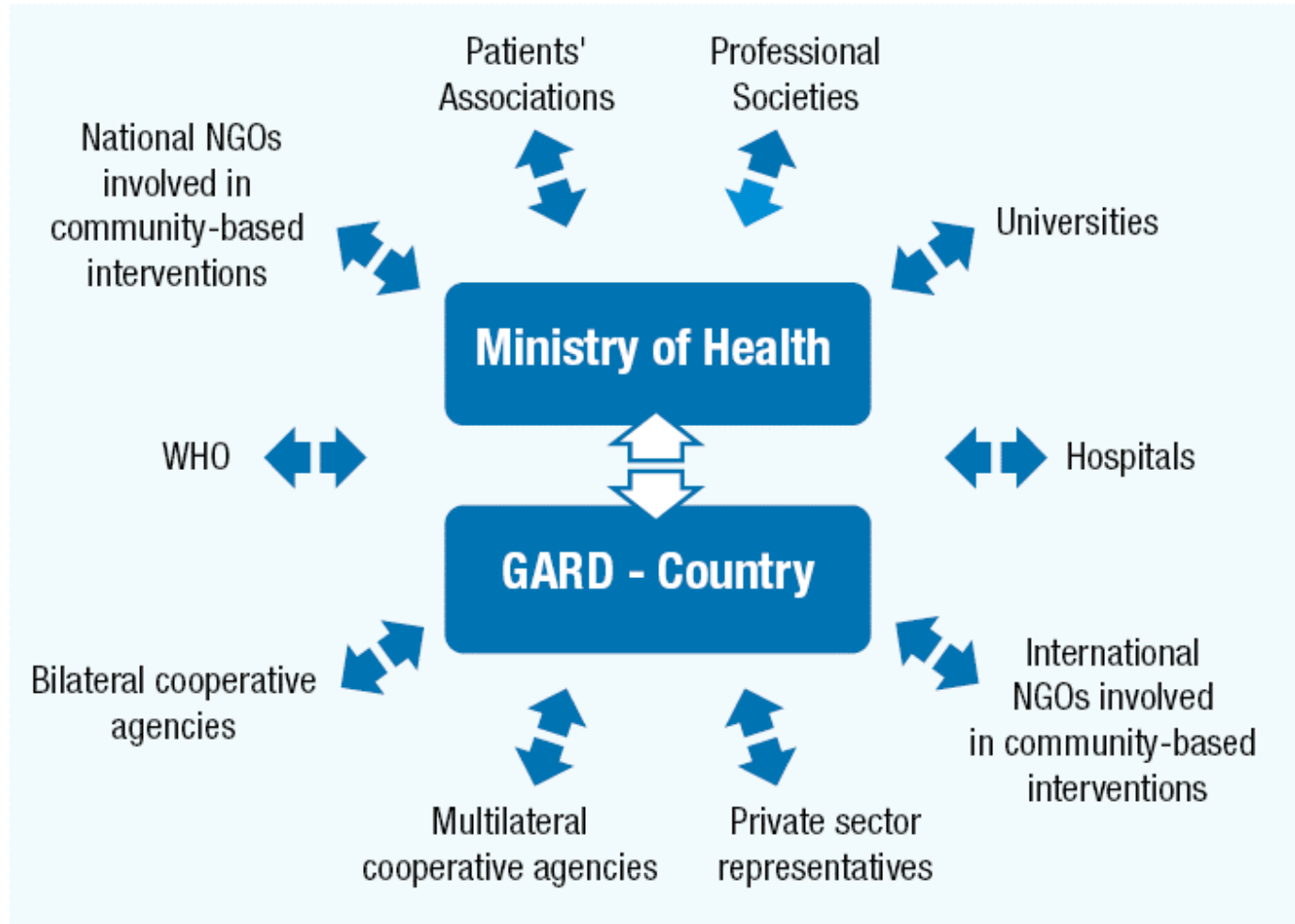
Step 1: Questionnaire-based assessment

Step 2: + Physical assessment
Simple objective measures (e.g. peak flow meter)

Step 3: + more expensive or time consuming tests (e.g. methacholine challenge, skin prick test, IgE testing, reversibility test, blood gas measurement, alpha-1-antitrypsin)



GARD at country level



GARD at country level

National GARD organisations has been established in China, Korea, Russia, Turkey, Tunesia, Algeria, Brazil, Argentina a.o.

Denmark will establish a GARD organisation 2.11.2007

Szech republik 14.11.2007

Norway 15.11.2007



GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASE
A world where all people breathe freely

- WHO sites
- GARD**
- About
- Collaborating parties
- Countries
- Publications
- News and events
- Links

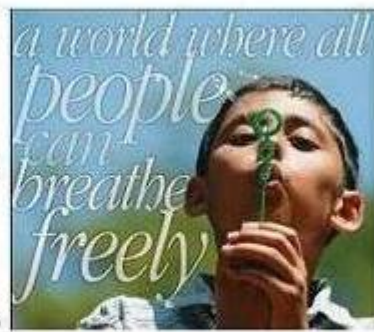
Global Alliance against Chronic Respiratory Diseases

STOP THE GLOBAL EPIDEMIC OF CHRONIC DISEASE

What is the Global Alliance against Chronic Respiratory Diseases (GARD)?

GARD is a voluntary alliance of national and international organizations, institutions, and agencies committed towards the common goal to improve global lung health.

The Global Alliance is part of the World Health Organization's (WHO) global work to prevent and control chronic diseases. Because most of the *chronic respiratory diseases* are under-diagnosed, under-treated and the access to essential medications in many countries is poor, a global effort to improve the diagnosis and the medical care is needed.



The Global Alliance was officially launched on 28 March 2006 in Beijing, People's Republic of China.

Do you share GARD vision?

As an interested individual you can show your support by signing up on the "[A world where all people breathe freely](#)" page on this website.

NEW IN GARD



WHO GARD meets with WHO Traditional Medicine team
[More information](#)

NEW PUBLICATIONS



2006 Beijing General Meeting Report
[More information](#)



First issue of the newsletter
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Poor quality is a threat to any doctor and health care organisation

- Continuous medical education – CME demanded of all doctors for their entire carrier because knowledge and best practice get outdated

The continuing professional development of clinicians

- How is the health system developed and kept to highest standard – to match the education standard of the CME doctor ?

The continuing professional development of the organisation

Clinical governance is a powerful, new and comprehensive mechanism for ensuring that high standards of clinical care are maintained throughout each individual clinic, organisation and the entire health care system and the quality of services are continuously improved.

Thank you for your attention

