ABS14: The organised care of asthma in primary care: the '3+ visit plan'. A report on progress

H. John Fardy

University of New South Wales, PO Box 82, Shellharbour Square, 2529, Australia

Introduction: At the Amsterdam IPCRG conference in 2002, information was presented on the ''3+ visit plan''. It has now been in the community for more than 3 years and has been evaluated. This information will be presented. The ''3+ visit plan'' was an initiative of the General Practitioners Asthma Group, a committee of the National Asthma Council Australia. In summary, it organises all the required elements of recommended asthma care into a series of visits. Since the introduction in November 2001, there have been 85,000 ''3+ visit plan'' completions. In addition to the plan itself, there have been a number of educational initiatives relating to the plan but are really an educational program about asthma management in primary care. *Conclusions:* There have been 4 papers published in peer-reviewed journals relating to the ''3+ visit plan'' [1—4]. Barriers; There is a consistent theme in the published papers that any new program is difficult to implement in a primary health care system that is under stress. Benefits; Where Primary Health care teams have chosen to implement the ''3+ visit plan'' it has made a measurable difference to patient care.

Conflict of interest and funding
Nil.

References

[1] Glasgow NJ, Ponsonby A, Yates R, et al. Proactive asthma care in childhood: general practice based randomised trial. BMJ 2003;327:659.
[2] Zwar NA, Comino E, Hasan I, et al. General Practitioner views on barriers and facilitators to implementation of the Asthma 3+ Visit Plan. Med J Aust 2005;183(9):64—7.
[3] Goeman DP, Hogan CD, Aroni RA, et al. Barriers to delivering asthma care: a qualitative study of general practitioners. Med J Aust 2005;183(9):457—60.
[4] Couzos S, Davis S. Inequities in Aboriginal Health - Access to the Asthma 3+ Visit Plan. Aust Fam Physician 2005;34(10):837—40.

doi:10.1016/j.pcrj.2006.04.116

ABS15: International Perspectives on National Asthma Programs

Justin Beilby, Teresa Burgess

University of Adelaide, North Terrace, Adelaide, 5005, Australia

Introduction: There is agreement from the World Health Organisation down, that the most effective way to reduce the morbidity and mortality burden of asthma is to address it at a national level. However, by 2004, few countries had developed national asthma strategies or plans and these included Finland, France, the USA and Australia.

Objectives:

- To examine international initiatives in the development and implementation of national asthma programs and policy and identify the key elements required for an effective national asthma program
- To review Australia's First National Asthma Program and identify similarities and differences with other international asthma programs

Methods: A review of peer reviewed asthma literature and published policy and program documents available on the world wide web, as well as asthma specific Australian policy documents. *Results:* Few countries have developed national asthma programs, and those that have used varying models. However all programs contain the following key elements:

- Primary prevention (including smoking, occupational exposure, exposure to allergens, breastfeeding etc)
- Improved management (medication, spirometry, asthma education, written plans etc)
- Systems support (guidelines, detailed monitoring, ongoing epidemiological research, advocacy and planning, policy)

In Australia, asthma was made a National Health Priority in 2001 and the First National Asthma Management Program was initiated. Core strategies were:

- The Asthma 3+ Visit Plan
- Establishment of the Australian Centre for Asthma Monitoring (ACAM)
- The Asthma Community Support and Grants Program
- The Asthma Innovative Management Initiative
- The Asthma Friendly Schools Program
- A range of professional education activities

Conclusion: Primary care as the most appropriate context for systematic asthma care and the importance of community education about asthma are constantly emphasised as core policy elements. A key aspect is the importance of the maintenance of effective and efficient data collection and monitoring systems. Areas of increasing concern include occupational asthma, and the evaluation of national asthma programs.

Conflict of interest and funding
No conflict of Interest declared.

doi:10.1016/j.pcrj.2006.04.117

Copyright General Practice Airways Group
Reproduction prohibited

ABS16: Implementing national programs for asthma care in Australia - a review of the first four years of the National Asthma Reference Group

Ron Tomlins[a], Michael Fisher[b]

[a] *University of Sydney, PO Box 436, Cherrybrook, NSW 2126, Australia* [b] *Australian Department of Health and Ageing, Australia*

Introduction: This review is part of a series of presentations describing aspects of Australian National Asthma programs implemented in the period 2001 to 2005. Following endorsement of asthma as a National Health Priority [1], the National Asthma Reference Group was established in 2000 to provide advice to the Minister for Health in relation to implementation of the National Asthma Action Plan 1999—2002 (NAAP) [2]. The NAAP built on strategic documents developed by the National Asthma Council Australia (NACA) [3] since 1989. About AUD 60 million (€37 million) was allocated over a four year period in 1999/2000. In 2005, funding for a further four years was provided. Key elements of the NAAP were the establishment of the Australian Centre for Asthma Monitoring [4], the Asthma Friendly Schools program [1], and the Asthma GP Initiative [1], based on the 3+ Visit Plan developed by the NACA GP Asthma Group. The Asthma GP Initiative included a public awareness campaign, information resources for patients and their carers and a patient helpline. In addition, educational resources for primary care providers were developed and 160 seminars were conducted in 2003 and 2005, reaching an estimated 4,000 GPs, nurses and community pharmacists. The activities of the National Asthma Reference Group and the processes underpinning its operation will be discussed.

Conflict of interest and funding
None.

References

[1] Asthma — the Australian Government perspective. Accessed on 15 January 2006 at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pq-asthma-index.htm.
[2] National Asthma Action Plan 1999—2002 Australian Government 2001. Accessed on 15 January 2006 at www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pq-asthma-pubs-naap.htm/$FILE/naap.pdf.
[3] The National Asthma Council Australia. See strategic documents and other resources at www.nationalasthma.org.au/html/strategy/home/index.asp accessed on 15 January 2006.
[4] The Australian Asthma Monitoring Centre. See the latest report Asthma in Australia 2005 accessed on 15 January 2006 at www.asthmamonitoring.org/.

doi:10.1016/j.pcrj.2006.04.118

ABS17: Linking evidence to policy — lessons from the national evaluation of the Asthma 3+ Visit Plan in Australia

Justin Beilby[a], Nicholas Zwar[b], Teresa Burgess[a], Iqbal Hasan[b], Gawaine Powell Davies[b], Sophie Couzos[c], Scott Davis[c]

[a] *University of Adelaide, North Terrace, Adelaide, 5005 Australia* [b] *University of NSW, Australia* [c] *NACCHO, Australia*

Introduction: The Asthma 3+ Visit Plan (rewarding systematic asthma care in primary care) is unique to Australia. Based on the Six Step Asthma Plan, it comprises three GP visits over four months for patients with moderate to severe asthma. GPs receive an incentive payment on completion of the three visits. *Objectives:* The **Aim** was to establish the degree of uptake of the Plan. **Objectives** included identifying barriers and enhancers to uptake for consumers and GPs. *Subjects:* GPs, GP organisations and consumers (including non English speaking and Aboriginal and Torres Strait Islander peoples).

Methods:

- Statistical analysis of Medicare GP Payment data
- A semi structured phone interview of all 120 National GP Organisations
- A GP Survey (of a stratified sample of GPs)
- Consumer interviews
- Focus groups with non English speaking Australians
- Aboriginal and Torres Strait Islanders uptake analysis

Data from all these elements were analysed and triangulated and this paper reports on this extensive analysis. *Results:* Uptake remains low and has not increased notably since a peak six months after introduction in 2001. Key barriers identified were:

- Structure of the incentive
- Lack of consumer education
- General Practice systems

The current Plan is not appropriate for Aboriginal and Torres Strait Islander or CALD populations. *Conclusion:* A ''one size fits all'' policy does not meet the range of needs across the Australian community. The value of rewarding systematic asthma care in primary care was however demonstrated. Flexibility, multi-disciplinary participation and a recognition of differing practice circumstances is required and efficient general practice systems are demonstrated as the key to systematic chronic disease interventions. Consumer education is needed around preventive health care.

Conflict of interest and funding

Funding: Australian Government Department of Health and Ageing. No conflict of interest declared.

doi:10.1016/j.pcrj.2006.04.119

ABS18: Role of hypertonic saline in bronchoprovocation for the diagnosis of bronchial asthma

S.M. Abdullah, Al Manun, Mahiuddin Ahmed, Mustafizur Rahman

NIDCH, Mokhali, Dhaka, 1216, Bangladesh

Introduction: Bronchoprovocation is performed to evaluate bronchial hyper-responsiveness. Almost all asthma patients demonstrate bronchial hyper-responsiveness. *Materials and method:* 50 non-smoking adults with complaints of breathlessness, cough,chest tightness & positive family history of bronchial asthma, baseline FEV1 > 70% of predicted (mean FEV1 = 84, median value = 81.7) were included in this study. Patients underwent bronchoprovocation using methacholine followed by hypertonic saline, 7 days apart or vice versa. *Results:* Of 50 patients, 34 were male,16 were female with a mean age of 26.44 years. With 1 mg/ml of methacholine fall of FEV1 > 20%, 10—20%, <10% was observed in 36 (72%), 8 (16%) & 6 (12%) patients respectively. With 14% hypertonic saline >20% fall was observed in 32 (64%), >10—20% in 4 (8%), 5—10% in 2 (4%) & <5% in 2 (4%) patients. No response was observed in 10 patients. *Conclusion:* This study shows that hypertonic saline is an equally effective but more specific bronchoprovocative agent than methacholine in bronchial asthma. Since hypertonic saline is very cheap and easily available, we propose that it should be considered as a reliable bronchoprovocative agent for the diagnosis of bronchial asthma in poor countries.

Conflict of interest and funding

None declared.

doi:10.1016/j.pcrj.2006.04.120

ABS19: Parents perceptions of asthma in children aged 2—5 years

Margaret Cuffwright

Salford Primary Care Trust, Sandringham House-Salford Primary Care Trust, Windsor Street, Salford, Manchester, M5 4DG, United Kingdom

Introduction: There is reluctance on the part of clinicians to diagnosis asthma in young children consequently parents of children with asthma express anxieties about how to manage their child's symptoms. *Objective:* To explore the significance of a diagnosis on parents. *Methods:* The purposive sample consisted of parents of 28 children with newly diagnosed asthma aged 2—5 years. Data were analysed using the principles of grounded theory. *Results:* During the pre-diagnosis phase parents learned that asthma is variable. Conflicting advice from professionals influencing their view about preventative treatment. Parents had few concerns about steroids although this view changed by the 2nd interview. *Conclusion:* Parents views of asthma were shaped by the events leading up to the diagnosis and these influenced how they managed the condition now and in the future.

Conflict of interest and funding

Funded by North West Office of the Department of Health.

doi:10.1016/j.pcrj.2006.04.121

ABS20: Developing a community based spirometry service for east London

Jill Goddard

Tower Hamlets PCT, City University, Bancroft Road, London, E1 4DG, United Kingdom

Introduction: Spirometry is the gold standard for the diagnosis and classification of severity in chronic obstructive pulmonary disease (COPD). It also provides a valuable tool

Copyright General Practice Airways Group Reproduction prohibited