Asthma education in primary care: **A focus on improving outcomes for Māori and Pacific peoples**

Key practice points

- Improving asthma education for Māori and Pacific families helps to reduce health care disparities in New Zealand
- Asthma education should acknowledge and be tailored to existing patient/family knowledge
- Ideally patients with asthma should be followed-up one to three months after starting treatment and every three to 12 months thereafter
- Make sure every patient with asthma has an action plan and that their family knows how to follow it
- Consider nominating an "asthma champion" in your practice to take responsibility for and optimise the care of patients with asthma

There is a gap in asthma care

Asthma is more prevalent and more severe in Māori and Pacific peoples. Māori are almost three times, and Pacific peoples over 3.5 times, more likely to be hospitalised due to asthma than people of other ethnicities in New Zealand.[1]

Part of the reason why Māori and Pacific peoples have a higher asthma burden is under-treatment. Despite having more severe asthma, Māori and Pacific children are less likely to have their treatment escalated.[2] Poor health literacy also contributes to asthma disparities as it is associated with reduced self-efficacy and under utilisation of medicines.[3] The report "He Māramatanga Huangō: asthma health literacy for Māori children in New Zealand" found that caregivers of Māori and Pacific children are often not provided with the information they need to manage asthma effectively.[3] Practices in primary care therefore need to make asthma education a priority.

Making asthma education a priority at your practice

When people with asthma or their families do not understand what good asthma management is they are more likely to accept poor asthma control as normal; health professionals in primary care can change this.

"Hardwire" asthma education into your practice. This involves increasing the patient's or family's knowledge of asthma in a stepwise approach at every point of contact.[3]

Nominate a staff member as "asthma champion" to take responsibility for optimising asthma care in the practice. An asthma champion may be responsible for checking that each patient is receiving regular follow-up as well as identifying those with the greatest need who will benefit the most from more intensive support.

Document asthma education at every stage, including what has not been discussed. This enhances continuity of care and allows other practice staff to easily identify gaps in education that need to be addressed.

Asthma education begins at diagnosis

Avoid "diagnostic limbo" by ensuring clear communication about the patient's symptoms and treatment approach, particularly in young children when a formal diagnosis may not be made for several years.

Assess the patient's/family's knowledge about asthma before providing management advice. This allows for existing information to be acknowledged and reinforced, and gaps in understanding or misconceptions corrected. During discussions health professionals should:

- Use language that is appropriate; adopting terms that the patient or their family has used displays attentiveness and builds a common language
- Explain what will happen next; this avoids confusion and allows patients to plan for and participate in the next stage of asthma management

Discussing asthma treatment

The clinical goals of asthma management are to provide all patients with:[4]

1. Good symptom control without adverse effects
2. Minimal exacerbations and airway limitations

Asthma management is a cycle of ongoing assessment, treatment and review.[4] The patient's personal goals should be addressed whenever asthma management is discussed and included as shared goals of care.[4]

Ideally patients should be followed-up one to three months after starting treatment for asthma and every three to 12 months thereafter.[4] Asthma reviews should be scheduled during periods when the patient's symptoms are well controlled. As part of this process the patient's likelihood of experiencing an exacerbation should be regularly assessed as well as any asthma trigger avoidance strategies that have been put in place. A follow-up should be arranged within one week of a patient experiencing an exacerbation.[4]

Incorrect inhaler technique can contribute to poor asthma control and should be assessed regularly.[4] Spacers are recommended for all patients using pressurised asthma inhalers as they make it easier to use the inhaler and improve medicine delivery.[4]

Explain the "why" as well as the "how". Carers of children with asthma often have a good understanding about how to perform tasks but this does not necessarily equate to an understanding as to why a task is performed.[3] Many families affected by asthma do not realise that people with the condition require preventative treatments even when well.[3]

If forgetfulness is a reason for treatment non-adherence this may be overcome by suggesting patients link administration of preventer medicines with other daily activities or use an electronic reminder.

Provide an action plan for every patient with asthma and ensure the family is able to follow it. Asthma actions plans contain instructions on when and how to make short-term adjustments in treatment in response to worsening symptoms and when to access additional medical care. Action plans are available online that can be customised for individual patients.

A Pictorial Asthma Medication Plan (PAMP) for children translated into Te Reo Māori, Samoan, Tongan and Tuvaluan is available from: **www.pamp.co.nz**

Bestpractice offers a free "Childhood Asthma module" which includes an action plan automatically populated with the patient's details. For further information, see**: www.bestpractice.net.nz**

Asthma action plans for adults are available from: **www.asthmafoundation.org.nz/wp-content/uploads/2012/03/AsthmaSelfManagementPlan08_final.pdf**

For further information, see: "Asthma education in primary care", BPJ 70 (Sep, 2015).

References

1. Barnard L, Baker M, Pierse N, et al. The impact of respiratory disease in New Zealand: 2014 update. 2015. Available from: http://asthmafoundation.org.nz/wp-content/uploads/2012/08/2015-Respiratory-Impact-Report.pdf (Accessed Dec, 2015).
2. Gillies TD, Tomlin AM, Dovey SM, et al. Ethnic disparities in asthma treatment and outcomes in children aged under 15 years in New Zealand: analysis of national databases. Prim Care Respir J 2013;22:312–8. doi:10.4104/pcrj.2013.00068
3. Jones B, Ingham T, Reid S, et al. He Māramatanga Huangō: Asthma Health Literacy for Māori Children in New Zealand. 2015. Available from: http://asthmafoundation.org.nz/wp-content/uploads/2015/07/Asthma-Health-Literacy-Report.pdf (Accessed Dec, 2015).
4. Global Initiative for Asthma (GINA) and Global Initiative for Asthma (GINA). Global strategy for asthma management and prevention. 2015. Available from: www.ginaasthma.org (Accessed Dec, 2015).
5. Gibson PG, Powell H, Coughlan J, et al. Self-management education and regular practitioner review for adults with asthma. Cochrane Database Syst Rev 2003;1:CD001117. doi:10.1002/14651858.CD001117