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

The level of care Māori and Pacific peoples with asthma in New Zealand receive does not match their burden of disease. He Māramatanga Huangō: asthma health literacy for Māori children in New Zealand, is a report that found that caregivers of Māori and Pacific children are less likely to receive information that allows them to make appropriate health decisions to manage asthma than caregivers of non-Māori and non-Pacific children.

Asthma education involves increasing the patient's knowledge in a stepwise approach at every point of contact. To do this effectively health professionals need to base the progression of learning on existing knowledge. This can be assessed by open-ended questions that allow for existing information to be acknowledged and reinforced as well as uncovering any misconceptions.

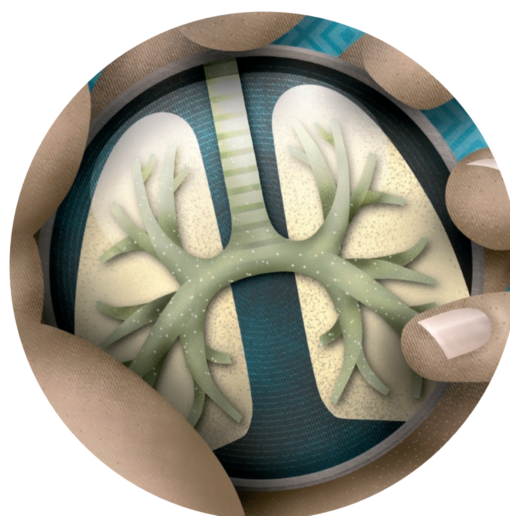
During the diagnostic process clear communication prevents families from falling into a "diagnostic limbo" because they have not been categorically told that their child has asthma. Avoid the use of jargon and use terms that the patient or whānau have used themselves to demonstrate attentiveness and build a common language. Asthma education should always be supportive and should never be interpreted by the patient or whānau as being a test. Once one aspect of asthma education has been covered explain to the patient what will happen next. This avoids confusion and allows patients to plan for and participate in the next stage of asthma management. It is a good idea to document in the patient's notes what has and has not been discussed.

Consider nominating a member of the practice as "asthma champion" to take responsibility for the uptake and implementation of asthma best practice. Ideally patients should be followed-up one to three months after starting treatment for asthma and every three to 12 months thereafter. Asthma reviews should be scheduled during periods when the patient's symptoms are well controlled. A follow-up should be arranged within one week of a patient experiencing an exacerbation.

Many people do not realise that asthma is a long-term condition, requiring preventative treatments even when well. If patients acknowledge that they do not take preventative medicines regularly, describing the benefits that the daily use of preventer medicines provide may improve adherence. If forgetfulness is a reason for treatment non-adherence this may be overcome by linking administration of asthma preventer medicines with other daily activities. Incorrect inhaler technique can contribute to poor asthma control and should be assessed regularly. Concern about possible adverse effects associated with the daily use of inhaled corticosteroids may be a reason for non-adherence with asthma preventer treatment. If a patient is experiencing less than optimal symptom control, revisit their action plan and ensure that it is appropriate.

Peer group discussion points:

1. Do you think that your practice is proactive in asthma education? If so what are the key processes that have been implemented, and if not, what things do you think could be done better?
2. Would you consider creating a role in your practice for an "asthma champion"? What tasks would this person be responsible for? Do you think it is feasible for neighbouring practices to "join forces" and share an "asthma champion"?
3. What communication techniques do you use to assess a patient/family's stage of asthma literacy?
4. What are some of the common barriers to the regular use of asthma preventer medicines that you encounter?
5. Do you have any strategies for improving asthma treatment adherence?



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