Practical Strategies to Improve Asthma Management and Health Outcomes in Rural Australia

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BACKGROUND

Over the last 12 months, there have been significant developments in asthma care that will impact on general practitioners and other rural health professionals:

♦ confirmation of asthma as the sixth National Health Priority area;

♦ development and implementation of GP-designed programs (Asthma Partnerships and the 3+ Visit Plan) to assist GPs to enlist patients to behaviour change and education to improve asthma outcomes;

♦ the formation of the International Primary Care Respiratory Group (incorporating the National Asthma Campaign’s GPs’ Asthma Group);

♦ publication of Asthma Adherence: A Guide for Health Professionals (National Asthma Campaign, Melbourne, 1999); and


EVIDENCE-BASED INTERVENTIONS IN PRIMARY CARE

The Australian government allocated $8.2 million over three years as an investment in the infrastructure supporting better health outcomes for people with asthma, and the Department of Health and Aged Care (DHAC) is encouraging programs with a rural focus. Commencing early next year, programs designed to enhance the management of asthma in general practice will be implemented through the National Asthma Campaign and Australian Divisions of General Practice in rural and urban areas. The evidence-based principles behind Asthma Partnerships and the 3+ Visit Plan will be described and their evaluation outlined. These programs will also facilitate the use of the MBS multi-disciplinary care planning items.

The 3+ Visit Plan

The 3+ Visit Plan arose from the need to develop a practical method of applying asthma research to everyday practice. GPs face time constraints which limit their ability to cover all steps of the Six Step Asthma Management Plan in a normal consultation, and often do not see patients for regular, planned review of their asthma. Care tends to
be reactive, episodic and initiated by the patient presenting to the surgery. This program will deliver assistance to GPs to encourage effective uptake of the Six Step Asthma Management Plan in general practice and to move GPs from reactive to proactive care. It will serve as a practical demonstration activity which will be promoted widely across Divisions of General Practice, and hence to GPs, around Australia. Rural Divisions are to be targeted for the program.

The 3+ Visit Plan is supported by Level 1 evidence for asthma education, a written asthma action plan and regular review.\(^1\) It fits into the environment of proactive primary care being fostered nationwide, and has synergies with the Enhanced Primary Care items, which encourage GPs to plan care and to involve other health professionals in the management of people with asthma. In addition, it is an adherence model that can be extended into other disease areas, eg chronic conditions such as diabetes and heart disease. In a rural or remote setting, the inclusion of other health professionals in the program, whether the local pharmacist, health educator or community nurse, will strengthen existing networks or develop new ones, promoting collaboration and resource-sharing. Wherever possible, the support and involvement of local asthma support groups and state Asthma Foundations will be used to enhance the program and provide additional consumer resources.

The 3+ Visit Plan program provides printed resources consisting of two parts. The first is a physician’s aid memoire which outlines the steps to be covered at each visit and provides illustrations for patient education on asthma. The patient receives a tear-off information sheet which outlines the purpose and content of each visit in consumer language, with provision for appointment times to be entered for the follow-up visits. These resources have been piloted and focus-group tested.

The Asthma Partnerships Program

Asthma Partnerships is a complementary adherence model: a behaviour-change program developed in response to evidence that patients’ beliefs about their illness have a significant impact on their outcomes. Many Australian and international studies support this, showing that patients may have different beliefs about inhalers for symptom relief and inhalers for prevention, and demonstrating the discrepancy between self-management knowledge and actual behaviour. In addition, physicians generally have been shown to have a poor perception of patients’ attitudes towards treatment, often tending to overestimate patient adherence. Lack of patient commitment, often unrecognised by the medical practitioner, can reduce the effectiveness of even the best clinical intervention.

Asthma Partnerships identifies what GPs need to do in usual care settings to win patient commitment. It gives GPs the measurement tools to assess what patients actually think and do, and it teaches them the skills to enlist patients to a process of behaviour change that increases commitment and significantly improves outcomes. This combination of precise interventions and valid measurement tools creates a process able to be taught to GPs and tested in pilot studies. To date, 2,550 GPs nationally have been trained in Asthma Partnerships.

Asthma Partnerships supports and complements the 3+ Visit Plan; it gives GPs the skills to reach patients who are poorly adherent and break down the barriers to effective
asthma management. Once the relationship between the clinician and the patient is established, and the patient accepts the shared responsibility for achieving the desired outcomes, then the clinical and education process of the 3+ Visit Plan follows.

The NAC believes that the integrated program is more sustainable than either program alone. Divisions enrolled will be asked to collect simple data sets to show baseline data and progressive measures of health outcomes over the life of the project.

**PRACTICAL STRATEGIES FOR SUPPORTING RURAL HEALTH PROFESSIONALS**

The National Asthma Campaign is aware that rural asthma presents particular problems. While prevalence and hospital admissions for asthma do not appear to be significantly higher in rural Australia, managing asthma is much more demanding. Rural health professionals face resourcing issues including reduced opportunity for peer support and less convenient access to ongoing clinical education than urban health professionals. There are other factors for patients that mitigate against best practice asthma care: access to health professionals and hospitals, the tyranny of distance, rural asthma patients may be less able to limit their exposure to seasonal and occupational triggers, and may thus be more liable to disease exacerbations. There are practical strategies that can be used to reduce the impact of these limitations and improve health outcomes.

**Asthma in the rural setting**

As Professor Roger Strasser has said, “Optimal care is always context specific”. Asthma care in rural and remote settings will vary according to the resources available. Resources will vary according to the population density of the area, and GPs may find their workloads substantially increased in areas with few GPs and few other health professionals.

The management of any medical condition in rural Australia involves non-medical issues. For example, these may be political: economic policies and hospital closures; structural: the provision and support of rural health workers; financial: the costs of environmental modification; or geographical: the climate and flora of the area. Awareness of these non-medical issues may not make working in this area easier, but at least provides a context for adopting strategies to manage workloads and improve care where possible.

**Resources**

Maximising the available resources is one way to improve care. In smaller rural centres the key health professionals are likely to be the GP, the pharmacist and nurse. Teamwork between members of the asthma management team, including the person with asthma, is crucial. Developing good personal relationships and a support network is essential to improving communication between professionals and providing a consistent message to patients. Better health outcomes for people with asthma can be achieved through increased co-operation and networking within the framework of the new MBS Enhanced Primary Care items for complex chronic illness, with the bonus of better remuneration for the GP.
Environmental modification

Reducing asthma triggers assumes a large importance in agricultural areas. Some people with asthma are triggered by farm dusts and pollens, while chemical irritants, odours and physical exertion may also trigger symptoms. It may not be possible to avoid these precipitants without leaving the farm; this is simply not an option for many. There may be no easy way of reducing exposure, although environmental modification may be possible to some extent.

Modification of the home environment, for example to deal with damp or house dust mite, is one step. The use of protective equipment like personal respirators when working in dusty areas and during harvesting, or in areas heavy with fumes, can make a difference and should be encouraged.

Modification of the local environment also includes such measures as sealed and air-conditioned cabs on tractors and harvesters, covering chutes and spouts in dusty areas, and installing ventilation systems. In terms of the regional environment, there are larger issues. Agricultural practices that may affect some people’s lungs include “burning off”. Aerial crop dusting is another potent trigger, as are local pollens. Land stabilisation practices which minimise environmental dust need to be considered.

Any changes need to be seen in an integrated framework, with education of health care providers an essential part of the process. Access to information on occupational health and environmental issues and measures may be an issue for rural health practitioners. Web access to expert bodies and individuals may support professional education.

Self-management of asthma

For any person with asthma, good self-management is extremely important, especially where triggers may be unavoidable. The foundations are good awareness about asthma and an effective partnership with the GP allowing accurate diagnosis of symptoms of cough, chest tightness or wheeze. Smoking cessation and personal fitness are issues that need to be taken up by patients. There is no doubt that patient education leading to better self-management and regular reviews improves outcomes. Collaboration with the local pharmacist and nurse can be especially helpful in this area, and the support of the family must be encouraged.

Education for health professionals

Access to education and peer support is extremely important. Australia has been at the forefront of developing effective means of distance education, for example IT-based programs, and video or satellite broadcasts for health professionals. Such programs can reach many more people than those present at the base hospital satellite site on the night. Videos of the broadcast may be an effective means of reaching a wider range of health professionals, and can be incorporated into a CME or CPE program.

Asthma education websites are useful educational tools for those with Internet access, although this may be difficult in many rural areas. For example, the National Asthma Campaign website at: www.NationalAsthma.org.au contains a range of professional publications focusing on clinical asthma management and behaviour change which are important to good asthma care, such as the *Asthma Management Handbook* and *Asthma Adherence: A Guide for Health Professionals*. Web users can also print consumer
education material from this site, and can use email to request information and resources or to ask questions on asthma management.

How to assist in the provision of care in the rural setting
Change management has a place in the rural sector and needs to be handled sensitively. Local people should determine their own needs and will not accept the imposition of ideas developed in a different working environment. However, there is a role for innovation and adaptation of national programs to local circumstances and factors. Creative ideas and the changes that may follow must give rural health care workers time to think, learn, upskill and have the energy to understand and accept new ideas.

Those who are already working in these settings need support. It is necessary to provide assistance and encouragement to network them, and to accept differences in the provision of care that may relate to the place and personnel available to deliver that care. For rural Australia, the challenge is to work with the resources available to deliver the best sustainable health outcomes for people with asthma.

REFERENCES

AUTHORS
Dr John Fardy is Director of the Illawarra GP Teaching Unit in Wollongong, NSW and maintains a half-time clinical load as well as his education and research roles. He came to this position from rural general practice on the north coast of NSW. He is actively involved in general practice asthma research and has a particular interest in rural asthma management and computers in medicine. John is the Chairman of the National Asthma Campaign’s GPs’ Asthma Group (GPAG). He has been active in this group since its inception and has seen it evolve into a position of great authority within the NAC committee structure. John serves on the NAC National Committee as GPAG representative and sits on many other working groups within and without the NAC. He is also a key presenter for the NAC on general practice asthma management.

Dr Ron Tomlins is the Chairman of the National Asthma Campaign. He is the RACGP nominee on the Board and National Committee of the NAC. Ron is in general practice in Castle Hill, NSW and is also director of a medical education consultancy. Ron’s previous positions have included Acting Secretary General of the RACGP in 1998, and he has been associated with the college for many years in GP educator and clinical teacher, manager and media liaison roles. He has also been the Medical Director of the Health Insurance Commission and before that, the Manager of its Education Branch. Ron has a special interest in asthma underpinned by his expertise as a counsellor and educator, and this interest in the behavioural aspects of chronic illness and its treatment are crucial to his current activities with the Asthma Partnerships program and the National Asthma Campaign.