

Asthma best practice model following discharge from ED of the Northern Hospital

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Asthma, with its increasing prevalence and severity in children, is the most common reason for hospital admissions in children and a major cause of school absenteeism. The project aims to improve health outcomes for children and adults with asthma who present at ED of the Northern Hospital for asthma exacerbation.

Objectives:

- Implement a best practice education and support model to enhance the uptake of written asthma management (action) plan in collaboration with GPs, nurse educator and patients
- Improve asthma self-management through education and empowerment.
- Improve patients' adherence to asthma medications and action plans through patients' follow up and coordination of care with GPs.
- Team up those patients who do not have a GP, with a GP of their choice
- Encourage awareness and uptake of asthma action plans by GPs, practice nurses and patients
- Promote the utilisation of MBS items for asthma care planning and 3+ visits plan as an incentive for optimal asthma management by GP.

Methods: The project is a partnership between Department of General Practice, The University of Melbourne, the Northern Hospital, and Northern and North West Melbourne divisions of GP and Dianella and Darebin community health centers. The target population is patients attending the ED of The Northern Hospital for asthma exacerbations aged 4-64 years. Patients are identified from the ED database every few days and project staff contact the patients by phone to discuss the project and invite them to participate. Once patients have agreed to participate, the Asthma Educator (AE) obtains formal consent. The AE assess patients at baseline and at 3, 6 and 12 months using structured interview protocol, and administer patient-based self-management program in collaboration with their GP. The evidence-based self-management program includes education and support on asthma triggers; medication devices and adherence, written asthma action plan and frequent reviews. The AE organises extended appointment with their treating GP and provides patients and their GPs with a one-page summary on patient's gaps in knowledge, management and adherence and lung function test.

Findings: The success of the partnership is based on a written MOU, clear roles and commitment of partners. The major barriers to implementation were patient's recruitment from the ED and delivering the intervention in the general practice.

Initially we proposed that the medical and nursing staff of the ED of the Northern Hospital would recruit patients and get their consent. We realised that recruitment of patients was very slow because of workload and memory issues. The ethics committee approved the use of the hospital ED computer database therefore the hospital is now providing us with a list of eligible patients every 2-3 days. We are contacting patients and discussing the project with each eligible patient and ask for verbal consent. The project is now running smoothly as planned.

Up to now, we are conducting our initial assessment, self-management education, medication review and spirometry at the general practice clinics. The use of private rooms is very important when delivering the intervention due to confidentiality and privacy issues. However, not all GP clinics are able to provide the AE with a private room, therefore the hospital has provided us with access to an appropriate alternative venue, The After Hours Clinic, to conduct the initial face-to-face assessment and self-management education.

Significance: This project will improve patients' knowledge about asthma, trigger factors, adherence to medication and self-management skills via increased uptake and use of written asthma plans. It should lead to improved quality of life for patients with asthma, reduced morbidity and mortality, reduced hospital admissions and improved use of medications, which in turn could reduce the cost to

individuals and the community. The AE package and methodology will be generalisable to other settings.