

Community Asthma Project

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Overview

Asthma is a major cause of emergency demand at The Royal Children's Hospital (RCH). In 2001-02, there were 2338 presentations to the RCH emergency department with a principal diagnosis of asthma. For 2002-03, full year estimates for asthma presentations are 2735 (based on YTD as at March 2003) representing a 15% increase over 12 months.

Asthma presentations are the fourth largest presentation group to the RCH emergency department.

The increased demand for emergency asthma services at RCH is reflective of the increasingly high burden of disease caused by asthma:

- Approximately 20% of all Australian children have asthma (Al-Yaman et al 2002)
- The prevalence of paediatric asthma is increasing at the rate of 1.4% per year (Woolcock et al 2001)
- Asthma is the leading cause of admission to hospital for children aged 1-14 years accounting for 21% of total hospital paediatric admissions in Australia (Al-Yaman et al 2002).
- Asthma is the leading cause of the total burden of disease in children (18.2%) (Al-Yaman et al 2002)

Target group

This initiative will target paediatric asthma. In particular it aims to target all children presenting to the RCH emergency department from the north and western metropolitan regions with asthma (ages 0-18yrs). Seventy five percent of total asthma related presentations to ED at RCH were from the northern and western regions in Melbourne (postcodes 3000-3099).

An expansion of the existing project to cover the whole geographical area is logical, and more effective and equitable. It will also facilitate a more cohesive RCH referral system ensuring greater continuity of services and consistency of protocols and community interventions.

Concern has been expressed by practitioners that hospital diversion programs are often fragmentary and inconsistent across metropolitan Melbourne. A particular strength of this proposal is the capacity to involve General Practitioners and other primary care services in a program, which is consistent across North Western Melbourne and articulated closely with similar projects. The project will facilitate linkages with the HARP Paediatric Asthma Project about to be implemented by Western Health and the HARP Asthma Project currently in place at Northern Health.

It is an important step in developing a consistent and innovative Asthma Diversion project for all of Metropolitan Melbourne.

The model of care will build on the model developed with the Community Asthma Project for the areas of Hume, Melbourne and Moonee Valley, which in turn drew on the Asthma Linking Project - a partnership between RCH and North Richmond Community Health.

The existing project focuses on a combination of community and clinical based intervention with children and their families. Referrals are received from RCH ED as well as local GPs, self and others. It addresses social circumstances of the target group with particular reference to ethnicity, low SES, mental health, disability, and family stress in addition to the clinical management issues. A broad range of services are drawn on to provide both clinical health and social support to assist families in the management of the asthma conditions of their children. Individual age and culturally sensitive programs of education and support are created with each family and/or child. Adolescents are encouraged to self manage and recognise and minimize risk factors.

This project will extend to cover other high demand areas identified in the north and west and will also incorporate a linkage mechanism to other paediatric asthma projects including those funded through HARP. This linkage will aim to foster expertise, build capacity and ensure greater efficiency through sharing of resources, learnings, and training opportunities. The model will gain from the use of existing protocols and resources.

A further element, not in the existing project but identified as a major risk factor, will be to address parental smoking. Parents will be offered individual support to give up smoking. (This will also link to an existing program at RCH, "Fresh Air for Kids") The project will engage trained local smoking educators. It has been estimated that approximately 42% of children admitted to the RCH live in a household with at least one smoker. (Roseby, Strong and Borland et al 2002, cited in Huang (2003, unpublished). Parental smoking exacerbates asthma in children contributing to more acute episodes and longer hospital stays.

A further element, consistent with research findings, will be family based sport/action sessions provided by a trained activator. An outcome of childhood asthma is reduced engagement in sporting activities and a consequent potential risk for childhood obesity and higher risk of more severe asthma episodes (research analysis supplied by Asthma Victoria).

Specific components of the model are:

Referral and intervention process:

- A community asthma liaison nurse at RCH ED identifies all presentations from the target populations, contacts parents/children for consent and links them to the Community Asthma Project (CAP) co-ordinator in the community.
- Referrals also come from GPs, others or self.

- The CAP co-ordinator allocates cases to the asthma support workers who are based at local community health centres in the north and west.
- The asthma support worker will contact them, undertake an assessment, liaise with their GP or help them make contact with a local GP. S/he will draw in other resources at local community health centres or make referrals as needed eg social worker, smoking cessation worker, physical activity co-ordination, and with the family/child prepare a plan and provide other supports as required. (There is no predetermined number of contacts).
- The team will also target more intensively those children and families who have significant identified psycho/social risk factors who are more likely to represent to ED. Key issues will be cultural sensitivities, use of interpreters and a focus on self empowerment.
- Service Co-ordination tools which meet the requirements of the multiple PCPs involved will be used where appropriate to ensure consistency and cohesiveness of referrals.

Feedback Process:

- The CAP clinical co-ordinator will provide feed back to referring agencies and GPs etc to ensure an integrated and co-ordinated approach.
- The family will be followed up at 6 months and 12 months for evaluation and reinforcement purposes.

Capacity building:

- The community development co-ordinator in conjunction with the rest of the team will work with other community service providers eg child care, schools, MCHN etc to identify both general and specific (in relation to a particular child) asthma education needs.
- The co-ordinator will also establish links with other paediatric asthma projects to establish a Community based paediatric asthma network (PAN). This role will be to facilitate links with like projects and programs in Victoria to ensure consistencies of protocols, minimize overlap in project service provision, disseminate and harvest learnings, share resources and protocols and evaluation frameworks etc.
- The co-ordinator will work with Divisions of GP to provide support and training in best practice asthma management.
- The co-ordinator will also work with RCH Asthma Liaison Nurse to strengthen linkages between the community and other key RCH stakeholders.
- This model will continue to support and facilitate the use of the 3+ Plans by GPs.

The model combines clinical and health promotion/community development approaches through the expansion of the current paediatric asthma community team to cover geographic areas not yet covered and also to increase the position of community through the support of a paediatric asthma network (PAN).

This will also support the long-term sustainability and continuity of paediatric asthma support in the community through the formation of a network and a focus for paediatric asthma based on activities in the community.

In addition, the RCH community asthma liaison nurse will be increased to a full time role to support the internal and external facilitation of referrals. This will include monitoring presentations; referral to the CAP, linking with clinical guidelines and pathways within RCH (particularly the Dept of General Paediatrics) and strengthening existing partnerships with asthma support co-ordinators in the community. Gaps in linkages and support for GPs will be identified in conjunction with the relevant Divisions of General Practice.

The specific objectives of the proposal are:

- Reducing the numbers of children with asthma presenting/being admitted to the Royal Children's Hospital (RCH)
- Improving the health outcomes and quality of life for children (and their families) with asthma presenting at the emergency department of the RCH and within the project catchment area
- Increasing the ability of families and children to manage asthma and reduce contributing risk factors
- Developing a best practice community based education, support and collaborative program to enhance the knowledge of asthma management, including the importance of written asthma action plans.
- Developing better integration and co-ordination of combined paediatric asthma approaches and services (as detailed in section 4.1)

List the stakeholders who comprise the community/hospital partnership.

A diverse range of providers has committed to stage one of the project. The expanded list of stakeholders is as follows:

- Asthma Victoria
- Darebin Community Health
- Dianella Community Health
- Divisions of General Practice (Northern, North West Melbourne and Melbourne)
- Doutta Galla Community Health
- Hume-Moreland, Moonee Valley/Melbourne and Westbay PCPs
- ISIS Primary Care
- Moreland Community Health
- Nth Yarra Community Health
- Royal Children's Hospital
- University of Melbourne Department of General Practice
- Western Region Health Service