The Challenge of Improving the Health Care Literacy of the Asthma Community

Only recently has the inflammatory basis of asthma been appreciated and communicated to the medical community at large. This has occurred largely as the result of published asthma-management guidelines.[1] Asthma can be considered a disease that results from lack of patient and caregiver education. The patient and family need to be a part of a larger strategic partnership, the foundation of which is education on every aspect of asthma management: understanding inflammation, triggers, and comorbidity factors; effective use of inhalers and medications; and exacerbation management. Hopefully, this education translates into less emergency care and better quality of life, both for patient and family. Asthma education[2] and management[3] were recently addressed in RESPIRATORY CARE.

SEE THE ORIGINAL STUDY ON PAGE 1691

The paper by Saville et al[4] in this issue of RESPIRATORY CARE raises a pertinent question: what is asthma education, and how does it pertain to the "asthma community"? Asthma education is designed to be patient-specific, portable and useful in almost any situation, and presented at a level of sophistication beyond initial assessment, diagnosis, and treatment. Ideally, the primary-care physician, in consultation with an "asthmatologist," develops an individualized asthma plan, calls in other multidisciplinary experts, and recommends strategies to monitor patient adherence to the plan.

Working as a team, physicians, allied health practitioners (including respiratory therapists), and asthma educators (who are also often respiratory therapists) build a program to improve the health care literacy of patients and families regarding the severity of the patient's asthma. The team listens as the patient and family speak. Specific long-term and short-term medications are recommended and discussed, and explicit directions are given as to when and how the patient should use them. The team also provides tips on household allergens, housekeeping and indoor and outdoor air quality, and how to avoid provocative agents that might worsen or trigger the disease. The person with asthma should continuously monitor it with a peak flow meter[5] and asthma diary, and take their medications as prescribed, with the goal of good asthma control.

The framework for individualized asthma education has been consistent since the National Asthma Education and Prevention Program (NAEPP) guidelines were first published in 1991, and revised in 2007.[6] They have 4 components: initial assessment and diagnosis plus periodic assessment and monitoring; control factors that contribute to asthma severity; pharmacologic therapy; and education for a partnership in asthma care.

If implemented correctly, asthma education improves the patient's health care literacy by involving the patient and family as active participants in asthma management. The patient, family, primary-care physician, asthma specialists, and physician extenders work together to follow the recommendations, to monitor the patient's progress, to act on the advice of team members, actively to listen to all parties, and to make measurable positive choices in the consumption and provision of limited health care resources.

Though the definition of asthma education could be argued, it seems that most asthma education programs provide training across the social and demographic boundaries of time, talent, and the patient's ability to pay. Is there an optimal point in the patient's life at which asthma instruction should start or stop? Is there time in the curriculum for a school-based asthma education program? Are the outcomes of asthma education nebulous? Is asthma education too costly for third-party reimbursement? Who should be included in the multidisciplinary education team process? Are there other family members of the team who might have been forgotten or overlooked?

In this issue of RESPIRATORY CARE, Saville et al[4] report a study in which they conducted an asthma-education session for childcare workers from preschools. They measured the childcare workers' asthma knowledge, abilities, and intentions before and after the education session. Measuring knowledge outside of the patient/family unit extends asthma education into the community and measures learning and knowledge outside of the traditional asthma-education boundaries.

In its region, the asthma education clinic at East Tennessee State University deployed the concept of improving the health care literacy of an "asthma community." The person with asthma is surrounded by an "asthma community"—a group of people who can assist the patient with asthma management, including, but not limited to, parents and immediate family, babysitters, teachers, coaches, clergy, co-workers, and other individuals. These people

could be better educated and prepared to assist the person with asthma and his or her family with prevention and avoidance strategies, such as avoiding provocative foods or pets, pollution and indoor air quality issues, and cigarette smoke. No asthma plan is complete without asthma training for those individuals. The success of the program depends on the rigor they apply in keeping the patient within the asthma plan.

Research on asthma-education strategies, such as the study by Saville et al,[4] must continue if we are to decrease asthma morbidity and mortality. Likewise, we must reconsider who should be the primary targets and beneficiaries of asthma education.

Dr Masini has had a relationship with Astra Zeneca's Pediatric Advisory Committee. Dr Krishnaswamy has had relationships with Key Pharmaceuticals, GlaxoSmithKline, Merck, AstraZeneca, Sanofi, Hawthorne, ZLB Behring, UCB, Novartis/Genetech, and Schering-Plough. The authors report no other conflicts of interest related to the content of this editorial.

Correspondence: Douglas E Masini EdD RPFT RRT-NPS AE-C FAARC, Department of Respiratory Therapy, Armstrong Atlantic State University, 11935 Abercorn Street, Savannah GA 31419. E-mail: douglas.masini@armstrong.edu.

Douglas E Masini EdD RPFT RRT-NPS AE-C FAARC
Department of Respiratory Therapy
Armstrong Atlantic State University
Savannah, Georgia

Guha Krishnaswamy MD
Department of Internal Medicine
Quillen College of Medicine
East Tennessee State University
Johnson City, Tennessee

REFERENCES

1. Myers TR. Guidelines for asthma management: a review and comparison of 5 current guidelines. Respir Care 2008;53(6):751-769.
2. Jones MA. Asthma self-management patient education. Respir Care 2008;53(6):778-786.
3. Kallstrom TJ, Myers TR. Asthma disease management and the respiratory therapist. Respir Care 2008;53(6):770-777.
4. Saville SK, Wetta-Hall R, Hawley SR, Molgaard CA, St Romain T, Hart TA. An assessment of a pilot asthma education program for childcare workers in a high-prevalence county. Respir Care 2008; 53(12):1691-1696.
5. Sorkness CA. Traditional and new approaches to asthma monitoring. Respir Care 2008;53(5):593-599.
6. National Asthma Education and Prevention Program (NAEPP). Expert panel report 3(EPR3): guidelines for the diagnosis and management of asthma. Update on selected topics 2007. Bethesda, MD: US Department of Health and Human Services; July 2007. http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm. *Accessed October 6, 2008.*