Physician
Asthma
Care
Education
Plus

Training Manual & Speaker's Guide

IMPROVING ASTHMA OUTCOMES THROUGH CROSS-CULTURAL COMMUNICATION

Table of Contents

Introduction

Rationale and Aims of the Program

Although our understanding of the pathogenesis and treatment of asthma has increased greatly in recent years, morbidity and mortality from asthma are on the rise. Although better treatments for asthma are available, either physicians are not using the treatments, or patients are not following physicians' recommendations.

Some professionals have been slow to adopt new asthma therapies for a variety of reasons. Cost, perceived inconvenience, resistance from patients, and the belief that patient education will take too much time all play a role in keeping new therapies out of clinicians' treatment plans.

However, many patients whose clinicians are recommending the latest, best therapy for asthma still suffer from poorly managed asthma. Research shows that many clinicians do not use the most effective strategies for communicating with and providing education for patients. Patients are not satisfied with clinicians' communication or with the quality of education they provide about disease and therapy.

This program aims to address both these problems. It provides education for clinicians in how to use the best current therapy for asthma. It provides information on how to better communicate with patients and teach them, so that they will be able to take advantage of the clinicians' recommendations. We believe that better care will result from building a partnership between patients and their health professionals.

Bases of the Program:

APPLICATION OF SELF-REGULATION THEORY

Social cognitive theory provides the theoretical foundation for the intervention. One principle of this theory, self-regulation, has been studied extensively as a way to improve learning. Research has shown that learning is enhanced by self-regulation, that is, the learner's efforts to observe, evaluate, and react to his or her own responses to a problem.

When learners self-observe, develop strategies to reach goals, and evaluate the success of these strategies, they gain an increased sense of self-confidence (self-efficacy), greater intrinsic motivation, and higher academic achievement. The seminar uses a self-regulation format to present new material to be learned and behaviors to be performed, an approach that appeals to clinicians.

Clinicians make decisions and take action based on previous experiences and the consequences they anticipate. When desired consequences are achieved, behavior is reinforced. This increases the clinician's motivation to use the behavior again. The motivation is experienced as an increased sense of self-efficacy and confidence that the behavior can be used again successfully to achieve similar or better results.

The seminar enables clinicians to use self-regulation to improve their treatment decisions and delivery of self-management education for the family. It provides clinicians with education strategies and tools that can easily be introduced into their ongoing practice, requiring minimal increases in time but having maximum impact on the patient's ability to retain and use treatment advice and education. Clinicians will also be taught to self-regulate their ability to use these tools successfully with patients.

Cross-Cultural Communication

A number of recent studies have shown that interactions between clinicians and patients are influenced by their ethnicity. Patients from diverse racial and ethnic groups respond differently to clinicians' advice and use health care in different ways. African American and Latino/Hispanic children bear the greatest burden of asthma regarding symptoms, family disruption and health care use. Cross-cultural communication with patients from these groups is, therefore, a focus of this program. It enables clinicians, whose backgrounds are not the same as their patients, to develop skills for productive interactions with patients that acknowledge their cultural experience.

Tips for Running the Seminar

The following are general tips for running the seminar. In addition, each segment is preceded by a "tips for instructors" section, which provides more specific suggestions.

Scheduling

The program consists of two, 2 1/2 hour sessions held about a week apart. It is most effective whenever possible to hold the second session about a week after the first in order to give participants an opportunity to try out the concepts learned in the first session. Their experiences can then be discussed at the second session.

Instructors

The seminar works best when there are three instructors: (1) a primary care provider, (2) an asthma specialist, and (3) a behavioral scientist/health educator who is also skilled in aspects of cross-cultural communication. The primary care provider should be a respected and well-known physician in the community. He or she introduces each of the segments, leads the case discussions in session 2, segments 3 and 5, and helps other primary care providers think through how to implement new material in everyday practice. The asthma specialist, (i.e., a pulmonologist or allergist) presents clinical aspects of asthma in session 1, segment 1 and adds an additional perspective to the case discussions in session 2, segment 3 and 5. Finally, the behavioral scientist/health educator leads session 1, segment 2 on patient communication, session 2, segment 2 on patient education and session 2, segment 4 on cross-cultural communication.

Group Size

In terms of group size, eight to ten clinicians is ideal. A smaller group tends to limit the discussion, and in a larger group, some members may not get a chance to participate.

Equipment

The sessions should be held in comfortable surroundings where audiovisual equipment is available. You will need a computer and projector to present the slide shows and videos. A microphone can be helpful, but we recommend that instructors do not stand behind a podium. It is imperative that the audiovisual equipment has working speakers in order to adequately view the videos.

Binder

You will also want to prepare a binder for each participant. There is a sample of binder handouts at the end of the manual which can be copied for each participant.

Refreshments

Serving refreshments before the session can be a way to "break the ice." Soft drinks and snacks should be available throughout the session, but we found that a formal break in the middle of the session was not a good idea as it broke up the flow of the presentations.

Terminology

"Cultural competence" is the common term recognized by government agencies, accrediting bodies, and other institutions for the method of training healthcare providers in this area. However, the term "cultural competence" can impact physician receptivity to training efforts, as the term often implies proficiency in *all* cultures. In this seminar, we will opt to use the term "cross-cultural communication."

Practice

A practice run of the sessions is enormously helpful in ironing out problems before the start of the formal sessions. Previewing the video is a requirement for success. You can obtain the PACE program video via the PACE website or by contacting the National Heart, Lung, and Blood Institute (NHBLI).

Incentives

It is important that you provide incentives for participation in the program. Stressing the cost-effectiveness of the program's recommendations may appeal to some. Better asthma care in the office can reduce referrals to specialists and emergency department visits. This is a special plus for those practicing in managed care. Also, when patients become better self-managers, the clinician saves time. Educational materials for clinicians to give to patients are a major incentive for participation. CME credit can be arranged for participants. The fact that a rigorous evaluation of the program showed positive changes in physicians' behavior, patient health status, and health care utilization may be motivating to some clinicians.

Priority Messages from the EPR-3 Guidelines Implementation Panel (GIP)

The NHLBI's National Asthma Education and Prevention Program's (NAEPP) most recent Guidelines for the Diagnosis and Management of Asthma (EPR-3) focus on monitoring asthma control.

To reinforce the essential aspects of effective asthma management, the EPR-3's companion Guidelines Implementation Panel (GIP) Report: Partners Putting Guidelines into Action prioritizes six clinical practice recommendations.

http://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.pdf

Throughout Session 1, Segment 1 *Clinical Aspects of Asthma and Long-Term Management* presentations slides, we highlight the six **Priority Messages from the EPR-3 Guidelines Implementation Panel (GIP)**. You should take a moment at each of these slides to reinforce the importance of following these recommendations for effective asthma control.

Six Priority GIP Messages

1. **Use Inhaled Corticosteroids**
   Inhaled corticosteroids are the most effective medications for long-term management of persistent asthma and should be utilized by patients and clinicians as is recommended in the guidelines for treatment of asthma.
2. **Use Written Asthma Action Plans**
   All people with asthma should receive a written asthma action plan to guide their self-management efforts.
3. **Assess Asthma Severity**
   All patients should have an initial severity assessment based on measures of current impairment and future risk in order to determine type and level of initial therapy needed.
4. **Assess and Monitor Asthma Control**
   At planned follow-up visits, asthma patients should review their level of asthma control with their healthcare provider based on multiple measures of current impairment and future risk in order to guide clinician decisions to either maintain or adjust therapy.
5. **Schedule Follow-up Visits**
   Patients who have asthma should be scheduled for planned follow-up visits at periodic intervals in order to assess their asthma control and modify treatment if needed.
6. **Control Environmental Exposures**
   Clinicians should review each patient's exposure to allergens and irritants and provide a multipronged strategy to reduce exposure to those allergens and irritants to which a patient is sensitive and exposed, that is, that make a patient's asthma worse.

Program Overview: Session 1

Segment 1:

CLINICAL ASPECTS OF ASTHMA AND THE LONG-TERM MANAGEMENT
(PCP/Asthma Specialist)

This segment is a slide presentation. On each page of this manual in the section titled "Slides, Scripts and Instructions" you will find hard copies of each slide. Underneath each slide are suggested "additional comments." The instructor should read each slide aloud. The spoken points can be used as a guide to elaborate on the ideas presented on the slides. The emphasis is the clinical treatment of asthma.

SLIDE PRESENTATION OBJECTIVES

- Provide an overview of the clinical aspects of asthma, including the goals and prescribing patterns considered the standard of practice in asthma care today.
- Introduce methods clinicians can use to teach patients to respond to changing conditions by adjusting medications at home.
- Emphasize the importance of formulating a long-term treatment plan in partnership with the family that acknowledges their social and cultural experience.

DISCUSSION OBJECTIVES
Using the guidelines recommended in the presentation as a framework, participants will discuss how to treat children with different patterns of symptoms.

Segment 2:

COMMUNICATION STRATEGIES
(Behavioral Scientist/Health Educator)

This segment consists of a slide presentation, a video demonstration, and discussion. Directions for the slide presentation are presented as described above. For the video demonstration and discussion, directions for the instructor, and a suggested script for each segment is provided. The script is meant to be used as a general guide: the instructor can modify the script to fit his or her own presentation style. *Note that Segment 2 concludes with summary slides following the video presentation*.

SLIDE PRESENTATION OBJECTIVES

- Explain why good communication is essential.
- Provide a theoretical framework which, when used to guide communication and behavior, can increase the likelihood that patients will follow clinician recommendations.

VIDEO OBJECTIVES

- Demonstrates communication techniques, which have been shown to enhance patient satisfaction with medical care and increase adherence to the treatment plan.

DISCUSSION OBJECTIVES
Participants will review the techniques depicted in the video and discuss ways the techniques can be tailored to fit each clinician's own style, practice, and patient population.

ASSIGNMENTS FOR NEXT SESSION

- Participants are asked during the following week to try one or more communication techniques they have not yet tried to see how they work with their patients.
- They are asked to observe and rate their own communication behavior using protocols provided.
- Participants are asked to bring in an asthma case with a patient of a different race/ethnicity than their own from their practice for discussion during the next session.

Program Overview: Session 2

Segment 1:

REVIEW FROM LAST WEEK (PCP/Asthma Specialist)
The primary care physician instructor will review key points discussed during the last week's session.

REVIEW OF COMMUNICATION SKILLS & SELF-RATING SCALE
(Behavioral Scientist/Health Educator)
This segment will provide a review of communication strategies discussed last week and the corresponding handout in the physician binder. A discussion on the use of the self-rating scale will also be facilitated.

Segment 2:

PATIENT ASTHMA EDUCATION
(Behavioral Scientist/Health Educator)
This segment is organized as a video demonstration and discussion of patient asthma education messages. Again, directions for the instructor are listed and discussion of cultural differences in patient responses encouraged.

VIDEO OBJECTIVES

- Demonstrate the basic messages patients and families must receive in order to effectively manage asthma on a day-to-day basis.

DISCUSSION OBJECTIVES
Participants will discuss how best to provide the educational messages depicted in the video. What are some barriers, including social and cultural, to getting the messages across, and how can they be overcome?

Segment 3:

TRICKY CASE DISCUSSION
(Asthma Specialist/Behavioral Scientist)
The asthma specialist will present a case that focuses on treatment but requires consideration of culture in counseling. A discussion will be facilitated on this case.

Segment 4:

Cross-Cultural Communication
(Behavioral Scientist/Health Educator)
This segment presents a mini-lecture and video on cross-cultural communication strategies.

SLIDE PRESENTATION OBJECTIVES

- Provide an overview of factors related to cross-cultural communication.
- Highlight important aspects of interacting with patients when they are of a different race/ethnicity than the clinician, emphasizing care for African American and Latino/Hispanic pediatric patients.
- Help clinicians feel more comfortable working across cultures.
- Provide guidelines for cross-cultural communication and counseling regarding asthma.

VIDEO OBJECTIVES

- Demonstrate approaches posited as enhancing communication between African American and/or Latino/Hispanic families and physicians not of these race/ethnicities.

DISCUSSION OBJECTIVES
Participants will review techniques depicted in the video and consider how these might be incorporated into practice.

Segment 5:

CLINICAL CASE DISCUSSION
(Asthma Specialist/Behavioral Scientist)
This segment consists of a discussion of cases of two types. First, the asthma specialist will present two cases provided in the manual. Second, participants will provide cases from their clinical experience. A guide for facilitating discussion is provided. Emphasis is on the social/cultural experience of the patient.

DISCUSSION OBJECTIVES
Participants will discuss asthma cases from their own practices. Cross cultural communication and education will be addressed regarding how they influence medical and pharmacological factors.
The asthma specialist instructor will wish to review carefully in advance the two program cases provided in Session 2, Segment 5 and prepare clinical advice and therapeutic issues to discuss with participants and consider the role of social/cultural factors.

APPENDIX

- Classification, assessment, and therapy charts, ages 0-4, 5-11, and ≥12
- Sample asthma action plans
- Communication strategies
- Key asthma messages for the patient and family
- Review of concepts
- Physician's record: categories of asthma messages provided
- Physician's self-rating on interaction with the family
- Cross-Cultural communication strategies
- Cross-Cultural Communication Self-Assessment Scale
- Communicating with your Latino/Hispanic Patients and African-American patients
- Tips for working with interpreters
- Additional resources
- Master trainer contact list
- Bibliography

Slides, Scripts, & Instructions

MANUAL KEY:  **= TIPS/POINTERS**  **= THINGS TO REMEMBER**  **= SUGGESTED SCRIPT**

Session 1

Session 1, Segment 1

Clinical Aspects of Asthma and the Long-Term Management

SUGGESTED SCRIPT – *PRIMARY CARE PROVIDER/ASTHMA SPECIALIST* ***(10 minutes)***
We are delighted that you have agreed to take part in this seminar. I am _____.

The fact that you are here today shows that you recognize that our community does have problems with asthma and that you are dedicated in your search to learn new ways to help your patients.

The purpose of the seminar is twofold. First, we will review medical regimens considered most helpful in keeping asthma symptoms under control. Second, we will discuss communication strategies including those related to working cross-culturally and educational messages that best enable families to manage asthma at home. There will be equal emphasis on both aspects of clinical management because both are crucial to improved asthma care.

The seminar has no commercial sponsorship from pharmaceutical companies. It is supported by the National Heart, Lung, and Blood Institute.

ABOUT THE BINDER IN FRONT OF YOU:
a. Everyone should have a binder.
b. There are copies of any materials to which a speaker might refer.
c. There are also educational materials for you to use in your practice including materials to rate yourself on aspects of interactions with patients.

Please place your pagers and cell phones on silent mode out of respect for our speakers and colleagues.
Public restrooms are located _____.

THE FIRST SEMINAR TODAY WILL COVER 2 TOPICS:
1. *(Asthma Specialist's/Primary Care Provider's Name)* will present:
   a. current concepts of therapy for asthma
   b. a preventive approach to care
   c. specific treatment plans for children with mild/moderate asthma
   d. after the presentation, there will be time for discussion.

2. *(Behavioral Scientist/Health Educator's Name)* will present:
   a. Strategies to enhance/strengthen your communication with patients about managing asthma
   b. These strategies will help your patients adhere to the treatment plan and become better self managers.

Before (*Asthma Specialist's/Primary Care Provider's Name)* begins, I want to share with you some background information about asthma management. **(Begin Slide Show)**

TIPS FOR INSTRUCTORS- *PRIMARY CARE PROVIDER/ASTHMA SPECIALIST* ***(45 minutes)***

THE MAIN POINTS TO CONVEY IN THIS SEGMENT ARE:

1. Assessment of severity and control forms the basis of the treatment plan.

2. Appropriate asthma management requires the proper use of long-term controller *and* quick relief medications.

3. Because asthma symptoms are variable, families need to recognize symptoms and adjust medications at home according to the clinician's plan.

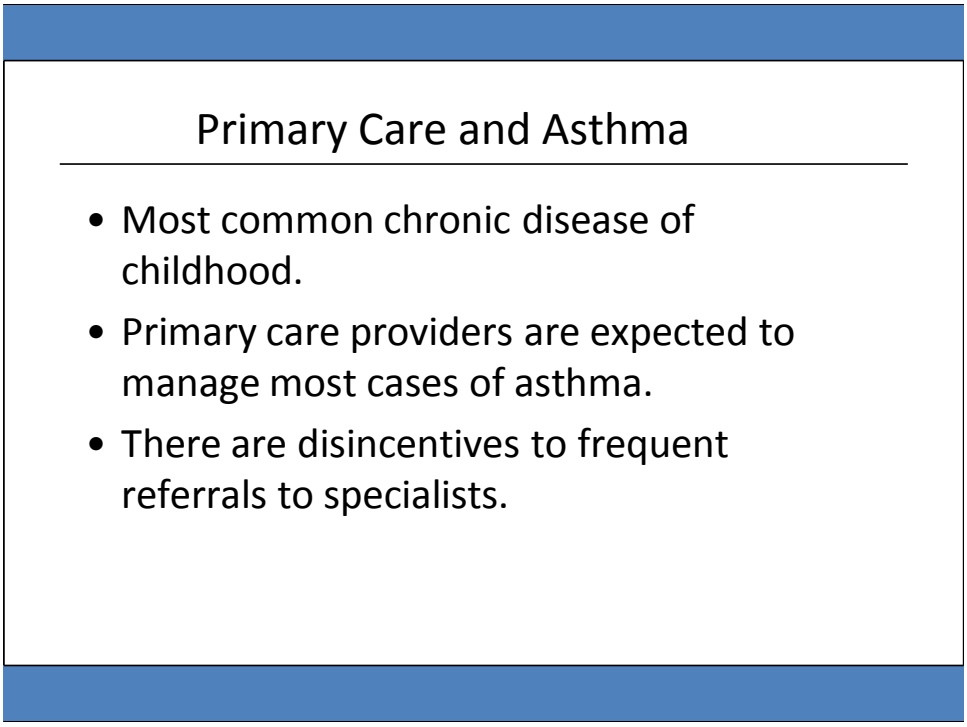
REMEMBER

The particulars of any plan are flexible and may change as newer drugs are introduced – the important point is to give a plan to the patient for adjusting medicine as needed. Cultural factors are important considerations in deciding on and communicating about the treatment plan.

Allow time for discussion, but remind participants that they will have a chance to discuss specific cases during the next session.

Clinical Aspects of Asthma and the Long-Term Management

SLIDE PRESENTATION



Slide 1

ADDITIONAL COMMENTS

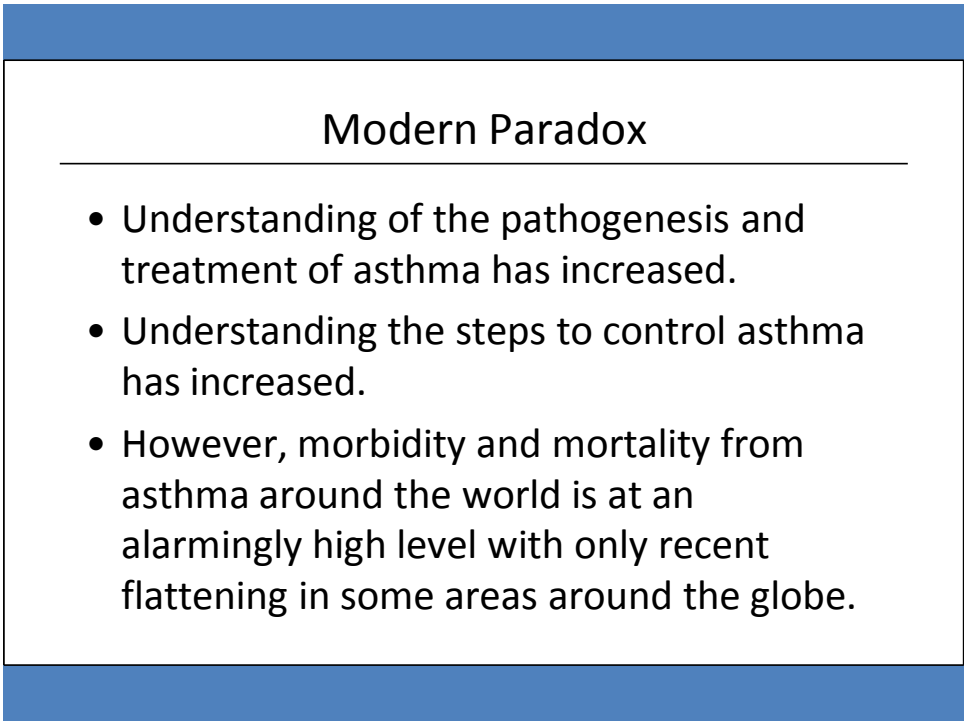
- 7.1 million children in the U.S. have asthma.
- Asthma prevalence among school-aged children in the Bronx is 15.5%, which is nearly twice the national average. The Bronx has a hospitalization rate of children with asthma that is 9.2 per 1,000, and 4.2 per 1,000 for emergency department visits, which is the highest of any New York City borough. Bronx children are also more likely to die from asthma than other U.S. children.
- With the medical home movement, the majority of chronic disease is now cared for by primary care providers.
- Most cases of asthma — perhaps 80% — can be successfully managed by the generalist in the office.
- Primary care pediatricians and family physicians are under pressure to limit referrals and emergency care visits.
- Better management of asthma in the office can reduce referrals to specialists and trips to the emergency department.

Reference:

Forrest, C. B., & Reid, R. J. (1997). Passing the baton: HMOs' influence on referrals to specialty care. *Health Affairs (Project Hope), 16*(6), 157-162.

Centers for Disease Control and Prevention. FastStats- Asthma. http://www.cdc.gov/nchs/fastats/asthma.htm

Garg R, Karpati A, Kelighton J, Perrin M, Shah M. Asthma Facts. Second Edition. New York City: Department of Health and Mental Hygiene; 2003. May,



Slide 2

ADDITIONAL COMMENTS

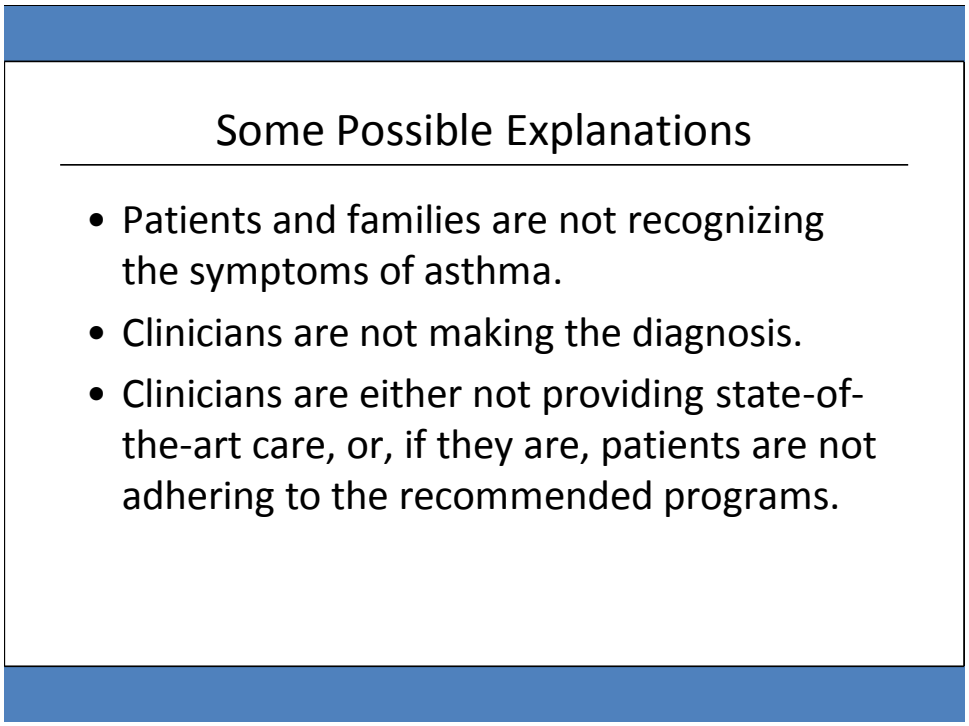
- As we have developed more effective treatments for asthma, we have not seen a corresponding decrease in morbidity and mortality worldwide.

- Note to facilitator: bring context back to the local setting in which the physicians practice (e.g. the city, community).

References:

Akinbami, L. J., Moorman, J. E., Garbe, P. L., & Sondik, E. J. (2009). Status of childhood asthma in the United States, 1980-2007. *Pediatrics, 123 Suppl 3*, S131-45.

Moorman, J. E., et al. (2007). National surveillance for asthma--United States, 1980-2004. *MMWR. Surveillance Summaries: Morbidity and Mortality Weekly Report. Surveillance Summaries / CDC, 56*(8), 1-54.



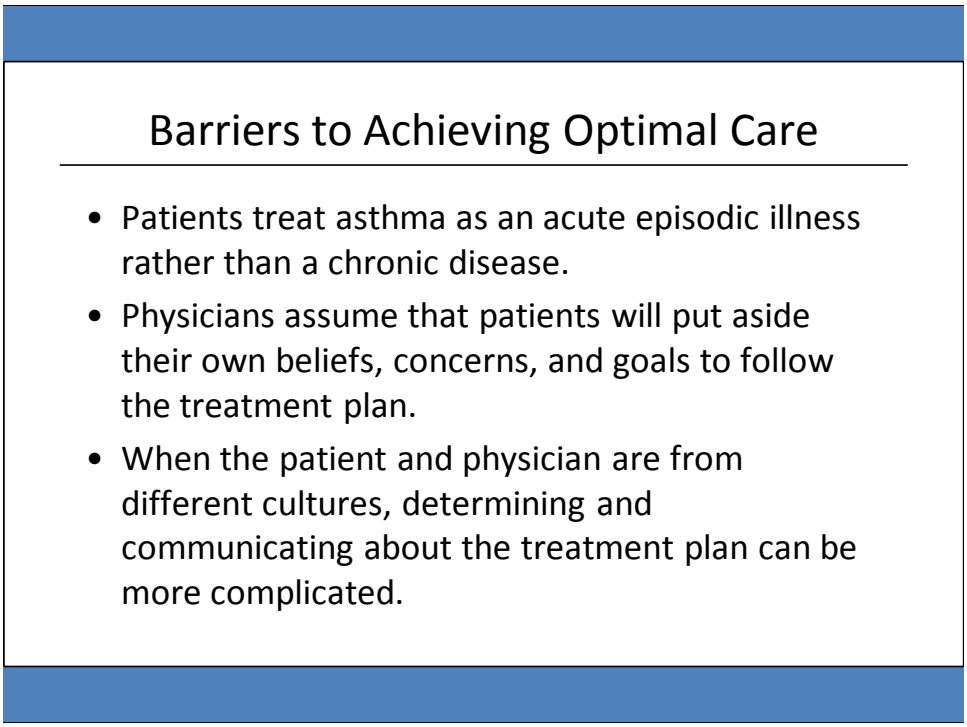
Slide 3

ADDITIONAL COMMENTS

- Many factors contribute to the under diagnosis and under treatment of asthma.
- Education of both providers and patients is the key to improving asthma care.

Reference:

Werk, L. N., Steinbach, S., Adams, W. G., & Bauchner, H. (2000). Beliefs about diagnosing asthma in young children. *Pediatrics, 105*(3 Pt 1), 585-590.



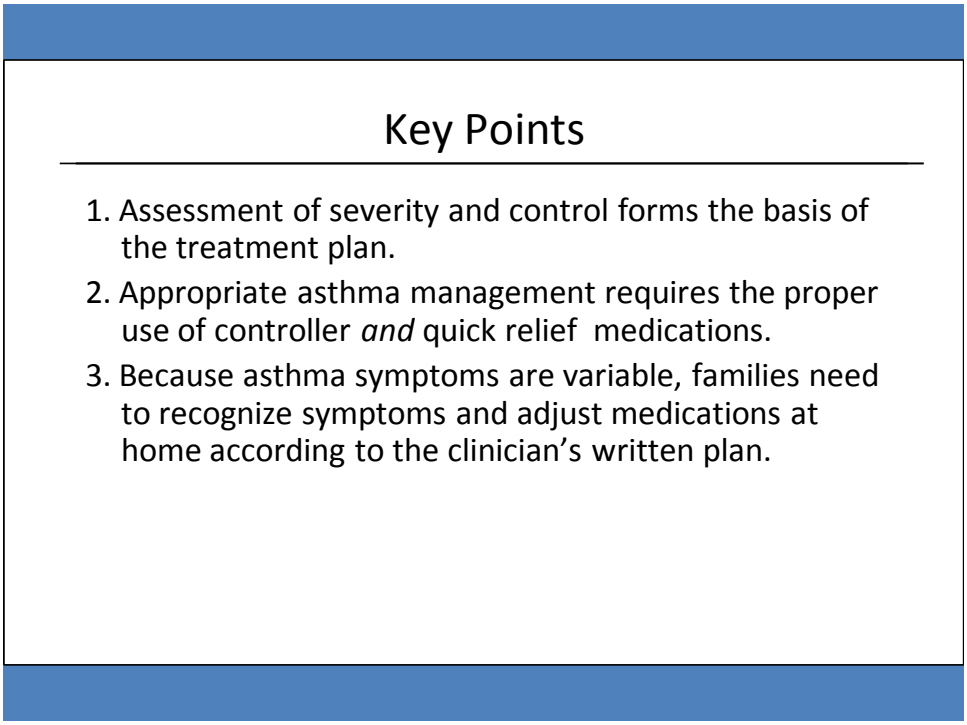
Slide 4

ADDITIONAL COMMENTS

- Patients need better understanding of the role of inflammation in asthma— that is, it is there even without symptoms.
- Physicians might assume that the patient's goals and concerns are the same as the clinician's goals.
- Patients may also misinterpret symptoms, especially parents observing children, which causes acute episodes to occur.
- We will talk more about working with patients of different cultures as we move along.

Reference:

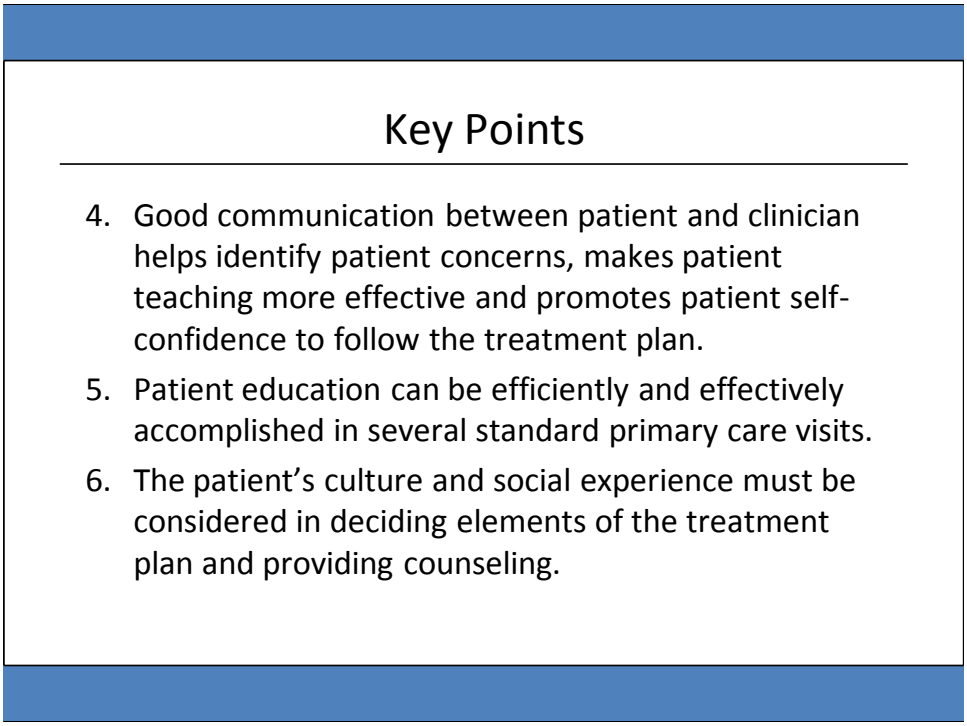
Kieckhefer, G. M., & Ratcliffe, M. (2000). What parents of children with asthma tell us. *Journal of Pediatric Health Care: Official Publication of National Association of Pediatric Nurse Associates & Practitioners, 14*(3), 122-126.



Slide 5

ADDITIONAL COMMENTS

- There are six main points we will emphasize over the next 2 sessions.



Slide 6

ADDITIONAL COMMENTS

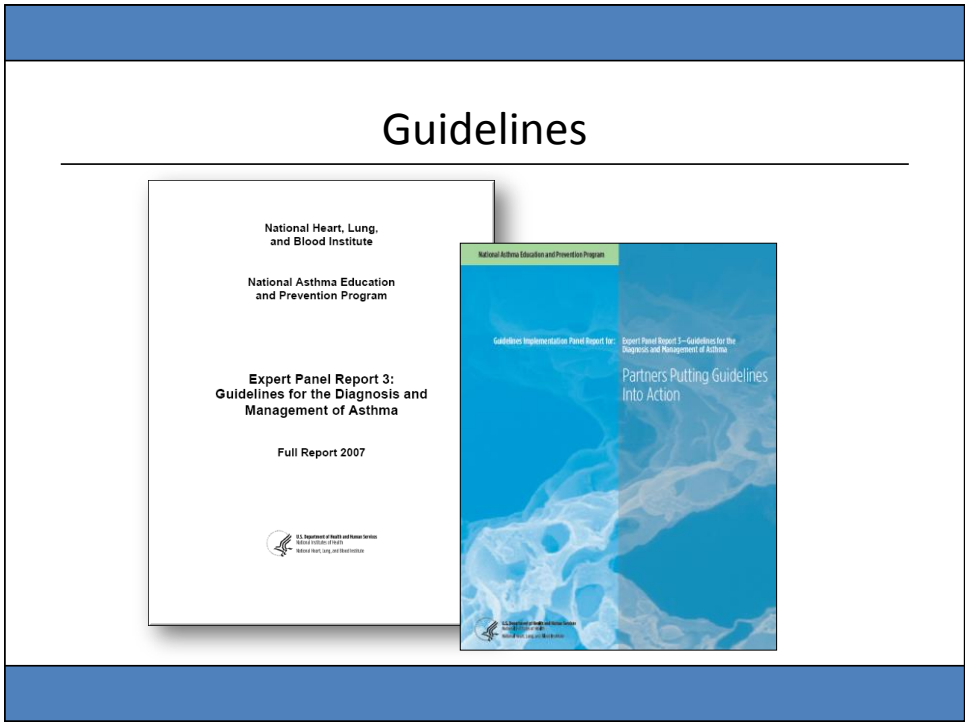
- Studies show that good clinician communication and patient teaching does not take more time. In fact, good clinician educators take less time in a patient visit because their communication is more focused and efficient.

References:

Clark, N. M., Gong, M., Schork, M. A., Evans, D., Roloff, D., Hurwitz, M., et al. (1998). Impact of education for physicians on patient outcomes. *Pediatrics, 101*(5), 831-836.

Cabana, M. D., Slish, K. K., Evans, D., Mellins, R. B., Brown, R. W., Lin, X., et al. (2006). Impact of physician asthma care education on patient outcomes. *Pediatrics, 117*(6), 2149-2157.

Clark, N. M., Cabana, M., Kaciroti, N., Gong, M., & Sleeman, K. (2008). Long-term outcomes of physician peer teaching. *Clinical Pediatrics, 47*(9), 883-890.



Slide 7

ADDITIONAL COMMENTS

First, some background information...

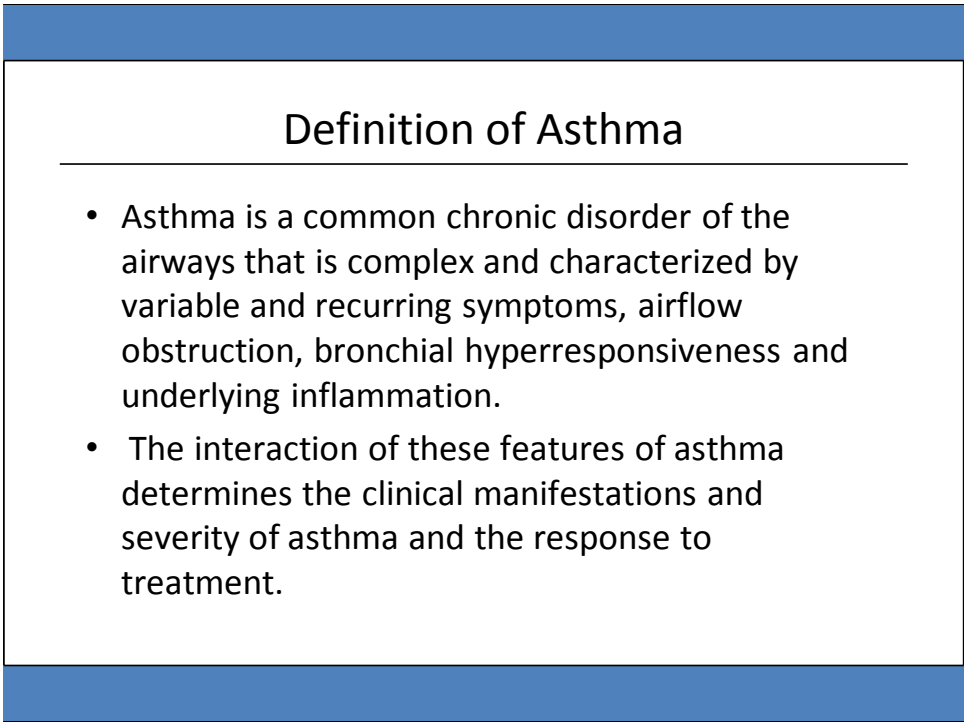
- Our reference is, “Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma." It is a set of treatment recommendations, updated August 2007, endorsed by the National Heart, Lung, and Blood Institute’s (NHLBI) National Asthma Education and Prevention Program (NAEPP).

- Our second reference is the Guideline Implementation Panel report (GIP) that identifies barriers and provides priority recommendations for implementing the NAEPP guidelines.

Reference:

NHLBI (2007). Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* Retrieved from *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm

NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* Retrieved from *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm

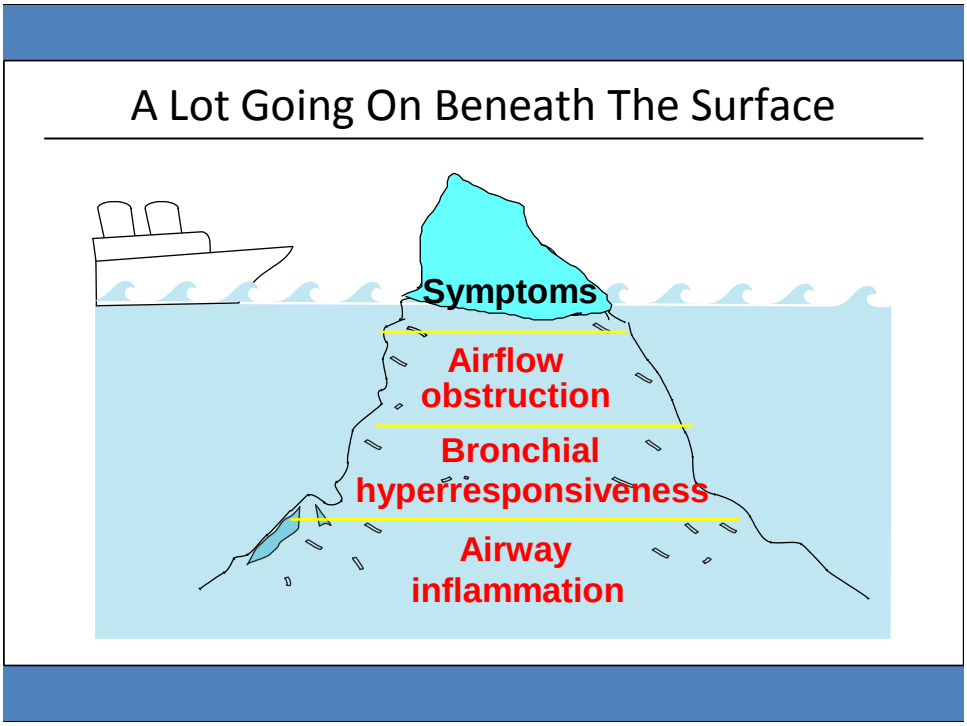


Slide 8

ADDITIONAL COMMENTS

Reference:

NHLBI (2007). Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* Retrieved from *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm

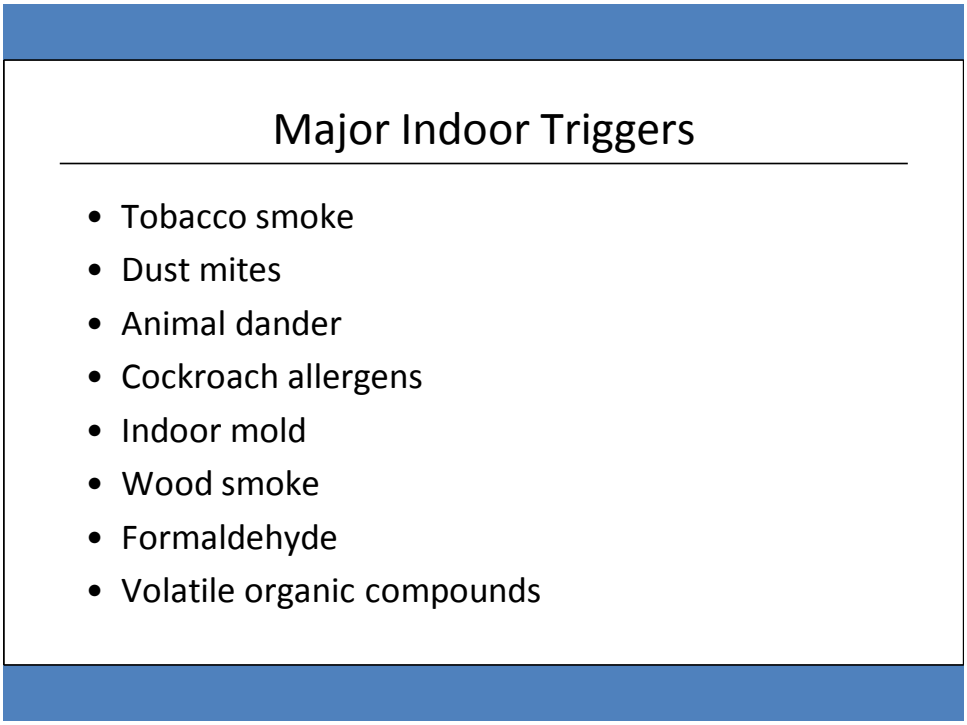


Slide 9

ADDITIONAL COMMENTS

With asthma, what we see is the tip of the iceberg: the symptoms.

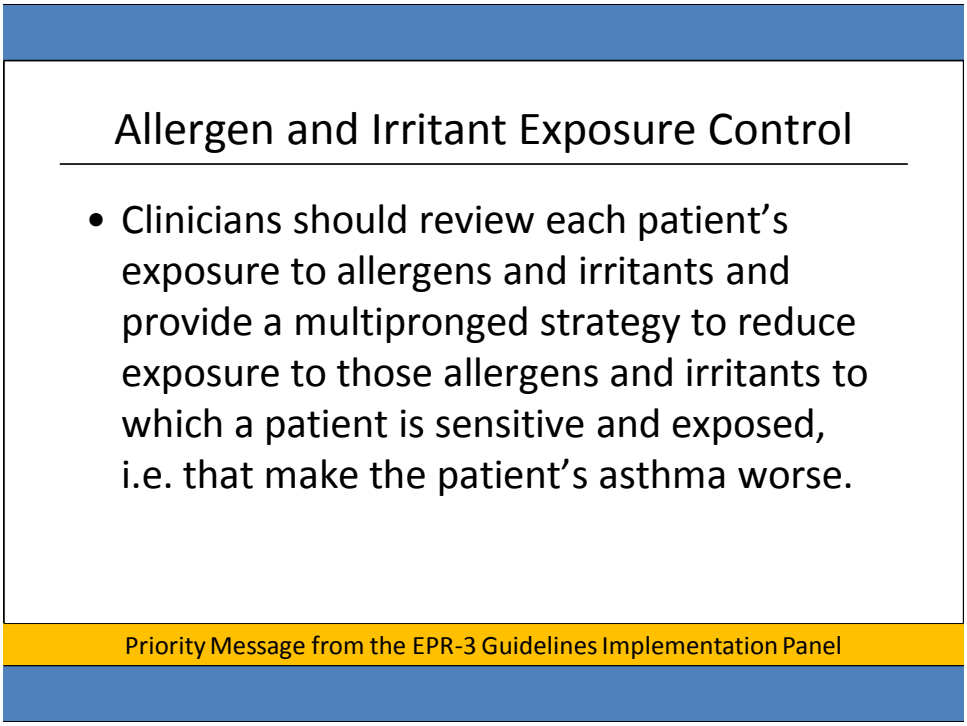
- At the base of the iceberg is the airway inflammation.
- This inflammation underlies the bronchial hyperresponsiveness of asthma, the air flow obstructions, and the culmination of the inflammatory process is the tip of the iceberg, the symptoms.
- Active inflammation of the airways can be present for 6 to 8 weeks following a severe respiratory infection.
- Airflow obstruction results from bronchoconstriction, bronchial edema, mucus hypersecretion, and inflammatory cell recruitment including eosinophils, a key inflammatory cell.



Slide 10

ADDITIONAL COMMENTS

- Indoor and outdoor triggers exacerbate asthma. These are common indoor triggers.
- Triggers are a part of clinical history that must be considered.
- Not all children are sensitive to all triggers.
- Families need to discover with your help which triggers are problems for the child.
- Work on addressing triggers that a family/child finds problematic.
- In general, families should try to reduce these.
- NOTE: These are examples to illustrate the idea of triggers.



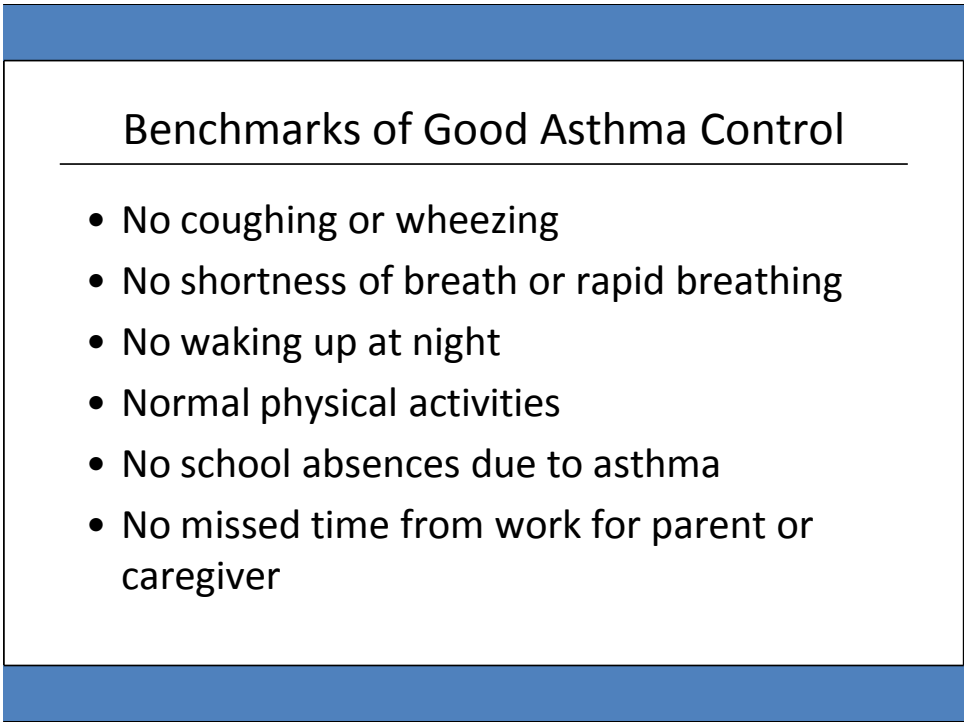
Slide 11

ADDITIONAL COMMENTS

- This is a **priority GIP Message**: Control Environmental Exposures
    - Evidence demonstrates that for an allergen- and irritant-sensitive person who has asthma, substantially decreasing exposure to inhalant allergens may significantly reduce inflammation, symptoms, and the need for medication.
    - A patient's asthma action plan should identify individual allergens and irritants that worsen the patient's asthma.
    - Community resources, including in-home support for allergen and irritant reduction, are helpful in controlling environmental factors that can make asthma worse.

Reference:

NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm

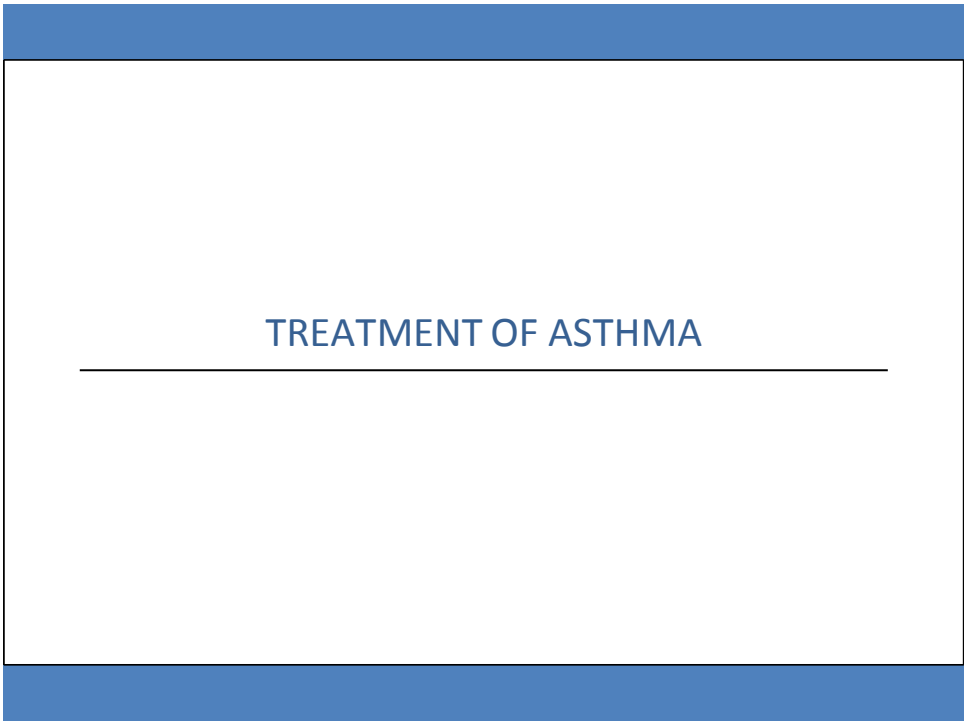


Slide 12

ADDITIONAL COMMENTS

- Parents and physicians sometimes allow asthma to limit activity or expectations.
- This slide lists benchmarks of good asthma control.
- This leads us to key point # 1.

SLIDE PRESENTATION – *ASTHMA SPECIALIST*

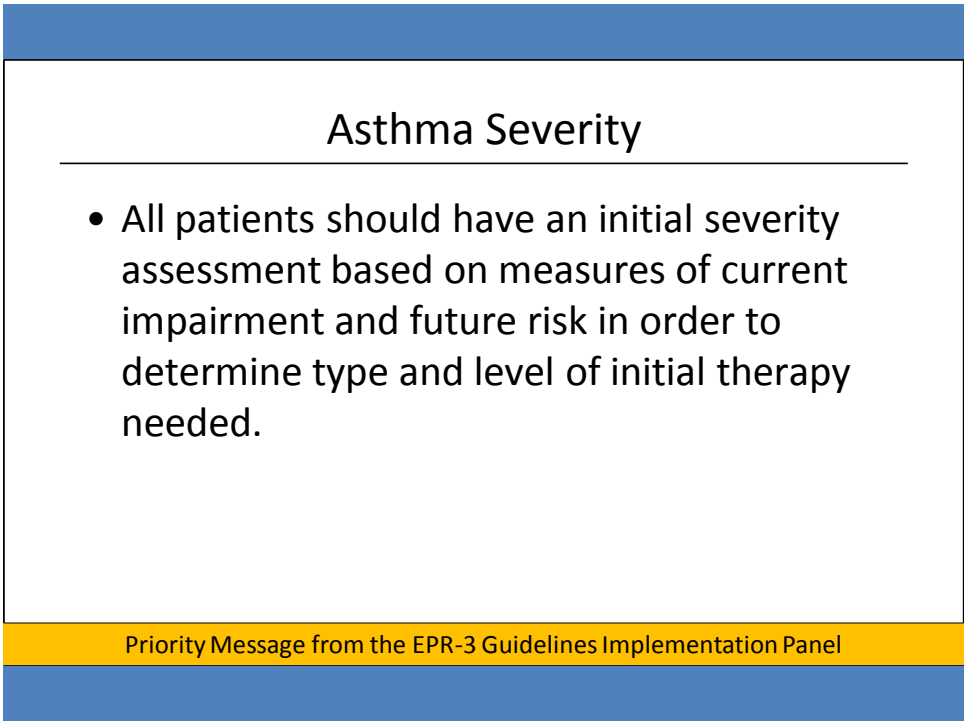


Slide 13

Key Point #1

- Assessment of severity and control forms the basis of the treatment plan.
- Severity is assessed before the patient is provided treatment.
- Control is determined once a regimen has been initiated.

Slide 14



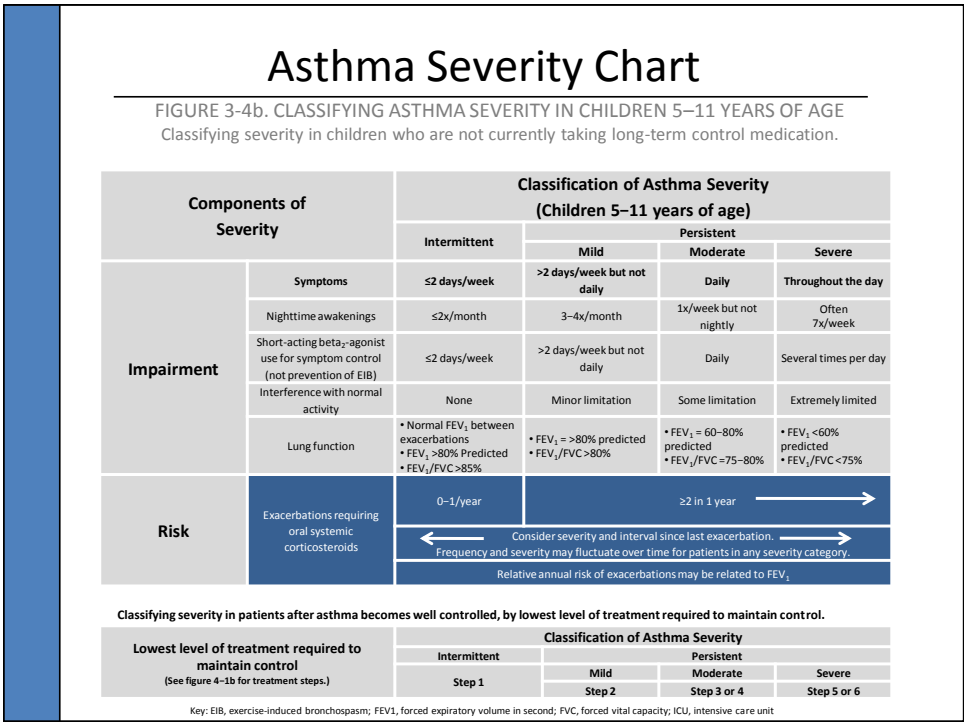
Slide 15

ADDITIONAL COMMENTS

- This is a **priority GIP Message**: Assess Asthma Severity
  - Clinicians should determine severity of asthma as part of their initial assessment of patients who have asthma.
  - Asthma severity should be documented in the patient's record and the significance of this assessment explained to the patient. Patients should know that regardless of severity classification, all asthma is serious and requires patients to follow their treatment plans.

Reference:

NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm



Asthma Severity Chart

FIGURE 3-4b. CLASSIFYING ASTHMA SEVERITY IN CHILDREN 5–11 YEARS OF AGE

Classifying severity in children who are not currently taking long-term control medication.

Components of Severity		Classification of Asthma Severity (Children 5–11 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	1x/week but not nightly	Often 7x/week
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	• Normal FEV_1 between exacerbations • FEV_1 >80% Predicted • FEV_1/FVC >85%	• FEV_1 = >80% predicted • FEV_1/FVC >80%	• FEV_1 = 60–80% predicted • FEV_1/FVC =75–80%	• FEV_1 <60% predicted • FEV_1/FVC <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2 in 1 year →		
		← Consider severity and interval since last exacerbation. → Frequency and severity may fluctuate over time for patients in any severity category.			
		Relative annual risk of exacerbations may be related to FEV_1			

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.

Lowest level of treatment required to maintain control (See figure 4–1b for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
	Step 1	Mild	Moderate	Severe
		Step 2	Step 3 or 4	Step 5 or 6

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in second; FVC, forced vital capacity; ICU, intensive care unit

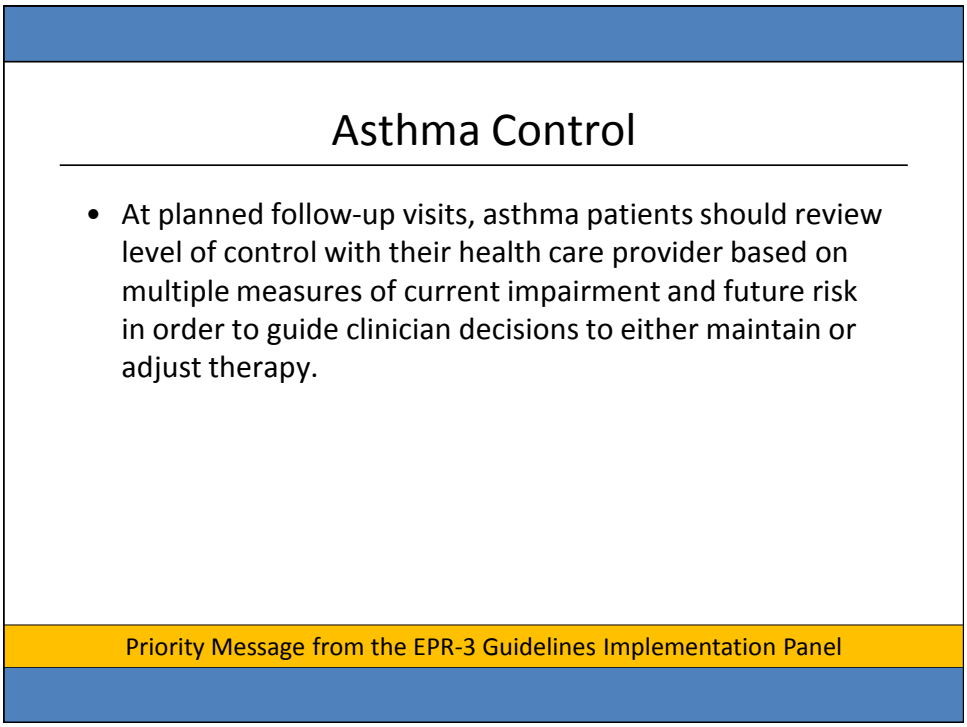
Slide 16

ADDITIONAL COMMENTS

- Here is a summary of the general classifications of asthma severity. A copy of the charts is available in your binder. The chart breaks down severity into two domains: intermittent and persistent classifications with increasing degrees of mild, moderate and severe symptom experience under persistent classification. This chart represents the 5-11 year old age group and each age cohort may have different aspects that help describe the severity of the patient's asthma for the clinician.
- Classification of asthma severity for each of the three age groups is based on the assessment of impairment and risk.
- Patients should be assigned to the most severe step in which any feature occurs. Clinical features for individual patients may overlap. An individual's classification may change over time.
- Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.
- Note that peak flow does not discriminate between milder forms of asthma.
- Use the patient's personal best peak flow or FEV_1 and not the predicted normal.
- Peak flow variability 20% or greater also suggests persistent asthma.

Reference:

NHLBI. (2007). Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* Retrieved from *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm



Slide 17

ADDITIONAL COMMENTS

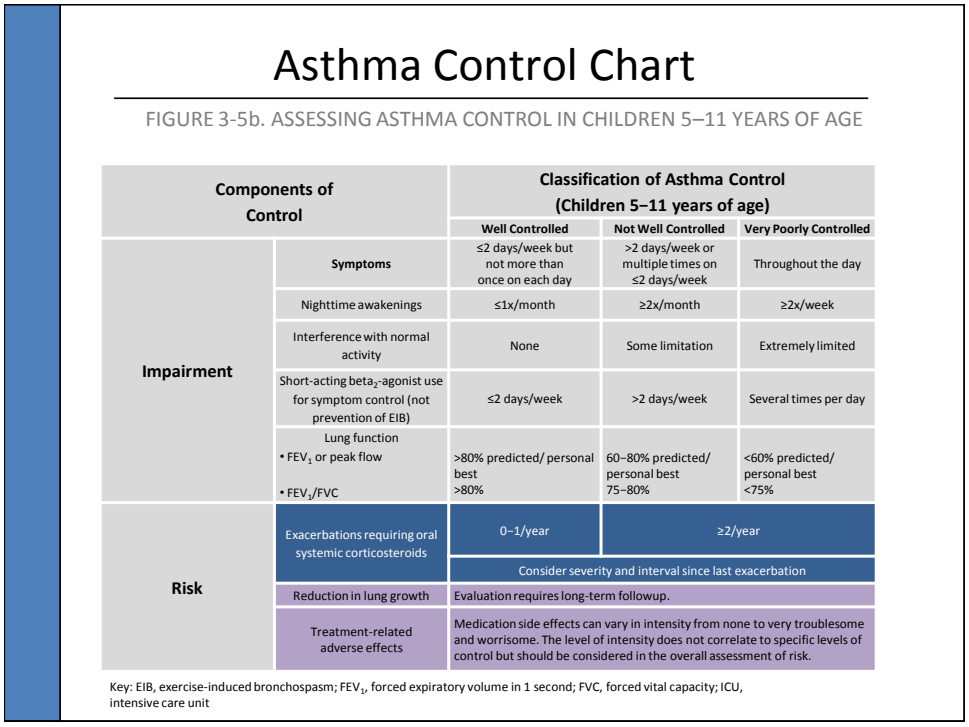
- Asthma control discussions can include specific questions by the clinicians or self evaluations such as the Asthma Control Test scoring system to help identify symptoms and triggers. Regularly scheduled follow-up visits during high risk times should be discussed at this visit and planned.

- This is a **priority GIP Message**: Assess and Monitor Asthma Control

  - In order to effectively communicate the role of assessing and monitoring asthma control in asthma management, clinicians and educators should understand patient perspectives on the concepts of impairment and risk and on the barriers patients face in implementing their treatment plans.
  - Patients should be scheduled for planned follow-up visits at periodic intervals in order to assess their asthma control and modify treatment if needed.

Reference:

NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health, w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm



Asthma Control Chart

FIGURE 3-5b. ASSESSING ASTHMA CONTROL IN CHILDREN 5–11 YEARS OF AGE

Components of Control		Classification of Asthma Control (Children 5–11 years of age)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	**Symptoms**	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	≥2x/month	≥2x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function • FEV_1 or peak flow • FEV_1/FVC	>80% predicted/ personal best >80%	60–80% predicted/ personal best 75–80%	<60% predicted/ personal best <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term followup.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		

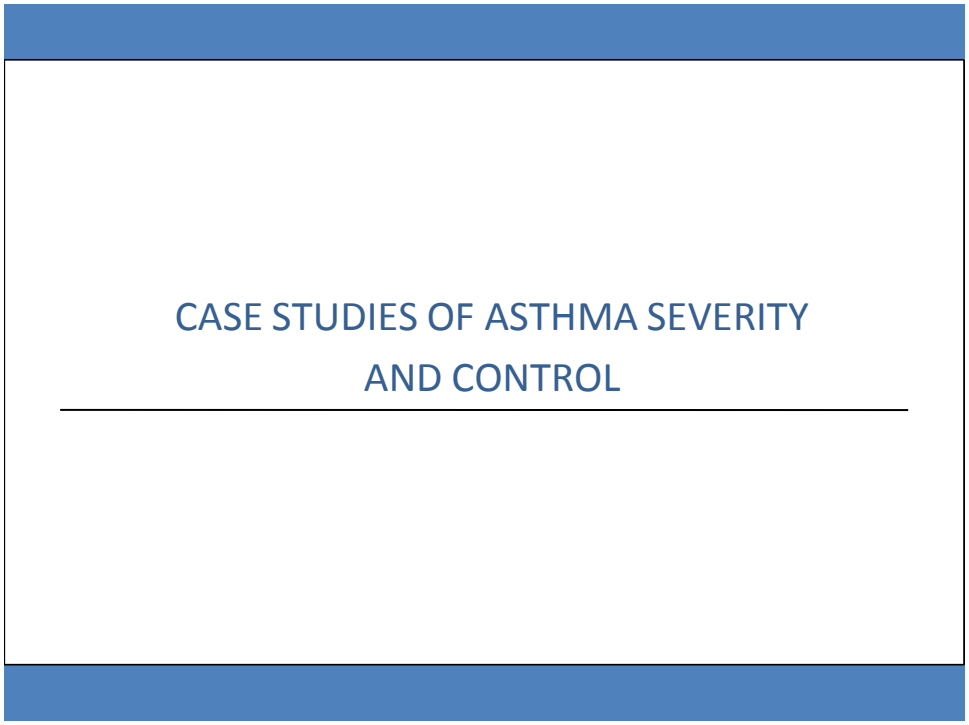
Key: EIB, exercise-induced bronchospasm; FEV_1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

Slide 18

ADDITIONAL COMMENTS

- This chart graphically represents clinical criteria that help the clinician determine the level of asthma control. This is divided into "Well Controlled"; "Not Well Controlled"; and "Poorly Controlled" categories. Note the changes in clinical impairment in addition to the overall risk of these clinical states to the patient. In different age groups, different clinical criteria may apply so use the age appropriate guidelines (available in your binder). For children 5-11 (the example), spirometry may be a factor to consider.
- Asthma control is assessed after therapy is initiated.
- Severity level does not define control.
- Patients should be assigned to the most severe step in which any feature occurs. Clinical features for individual patients may overlap. An individual's classification may change over time.

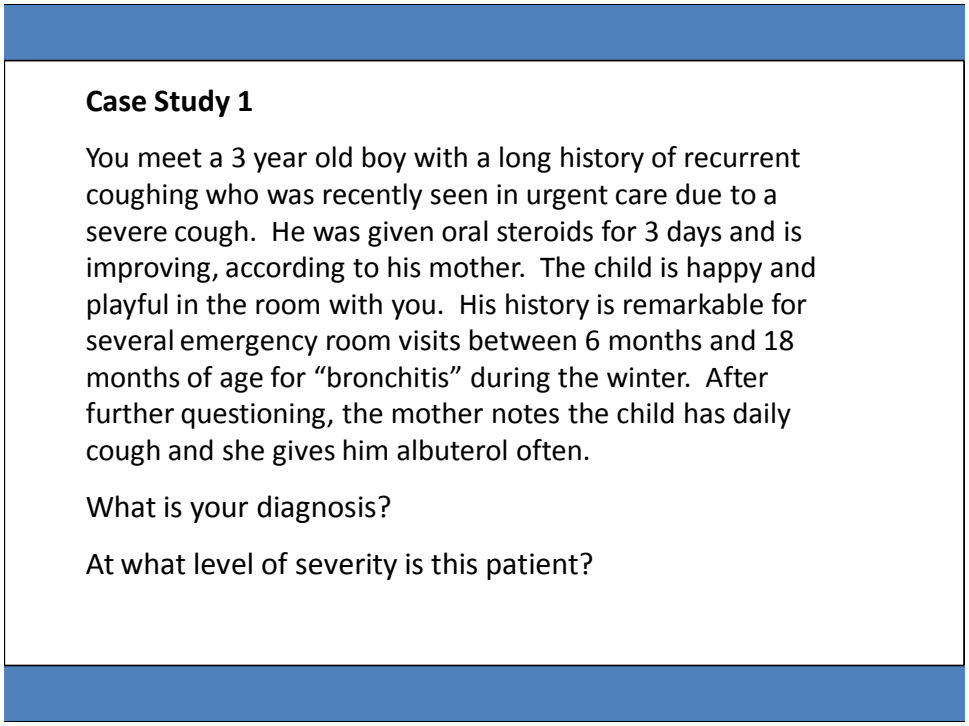
- **Note**: A pocket guide of all the asthma classification charts for asthma severity and control are located in the first section in the appendix of this manual and in the physician binders.



Slide 19

ADDITIONAL COMMENTS

- Let's look at a few case studies.



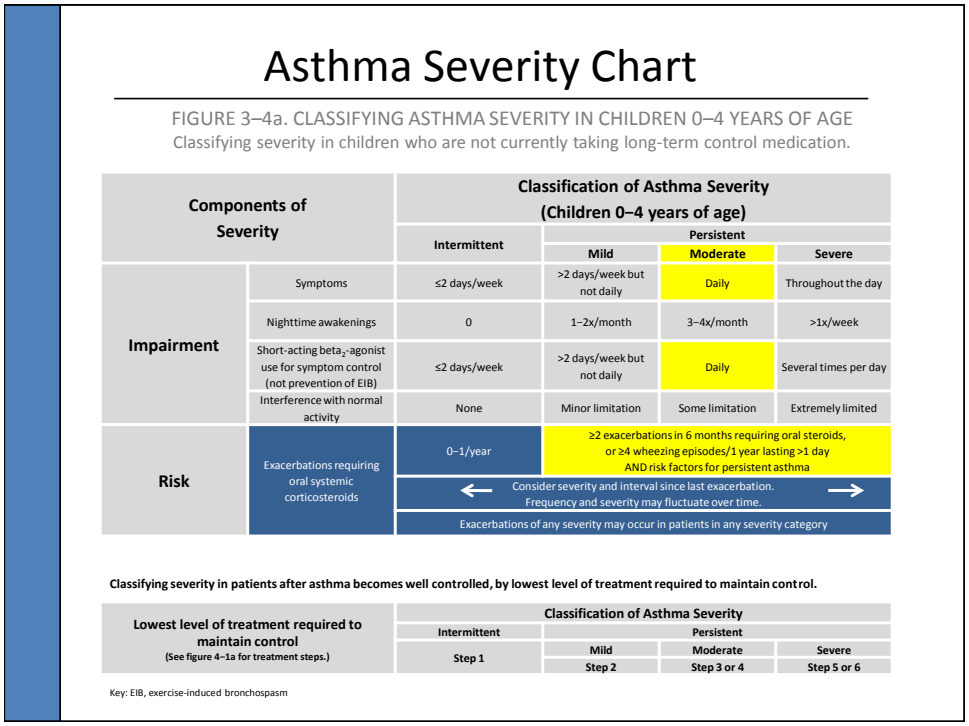
Slide 20

ADDITIONAL COMMENTS

- NOTE: 5 minutes should be allotted to discussion of this case.
- What is your diagnosis?

  Answer:
  This case allows the learner to confirm an initial diagnosis of asthma. It is appropriate here to discuss other diagnoses often given to asthma patients instead of asthma. The proper diagnosis of asthma not only allows the physician to better guide patient therapy, it also allows the patient's family to access appropriate educational resources outside of the medical home.

  The severity level is moderate persistent asthma since the patient exhibits daily symptoms.



Asthma Severity Chart

FIGURE 3–4a. CLASSIFYING ASTHMA SEVERITY IN CHILDREN 0–4 YEARS OF AGE
Classifying severity in children who are not currently taking long-term control medication.

Components of Severity		Classification of Asthma Severity (Children 0–4 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	0	1–2x/month	3–4x/month	>1x/week
	Short-acting beta$_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2 exacerbations in 6 months requiring oral steroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. →			
		Exacerbations of any severity may occur in patients in any severity category			

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.

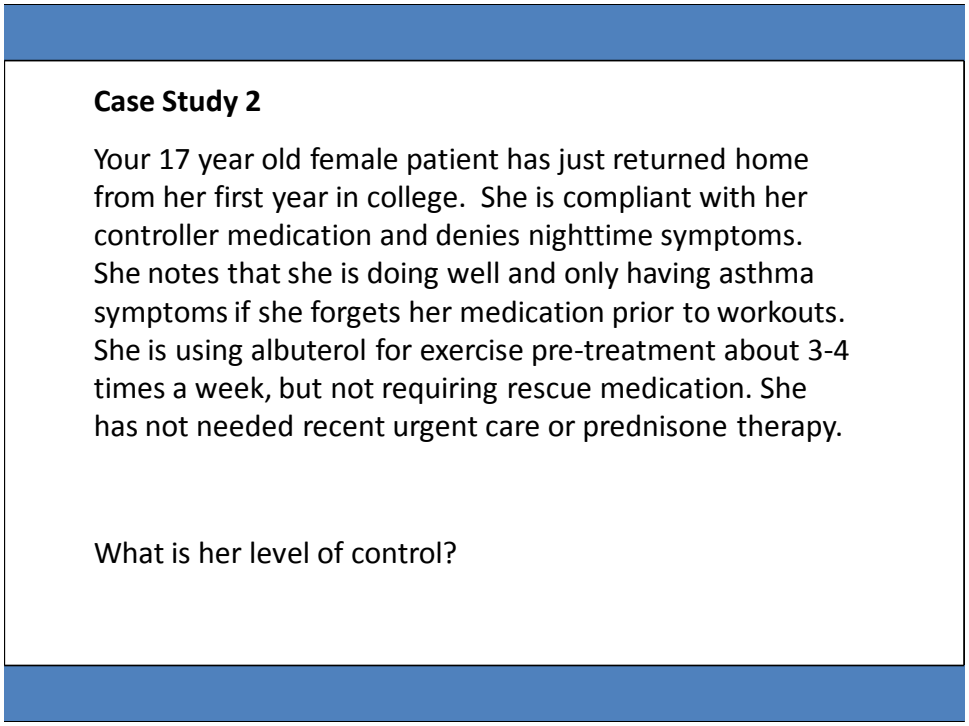
Lowest level of treatment required to maintain control (See figure 4–1a for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
	Step 1	Mild	Moderate	Severe
		Step 2	Step 3 or 4	Step 5 or 6

Key: EIB, exercise-induced bronchospasm

Slide 21

ADDITIONAL COMMENTS

- NOTE: NHLBI Classification of Severity or control chart follows each case study. This severity chart is also specific to children ages 0-4 years.



Slide 22

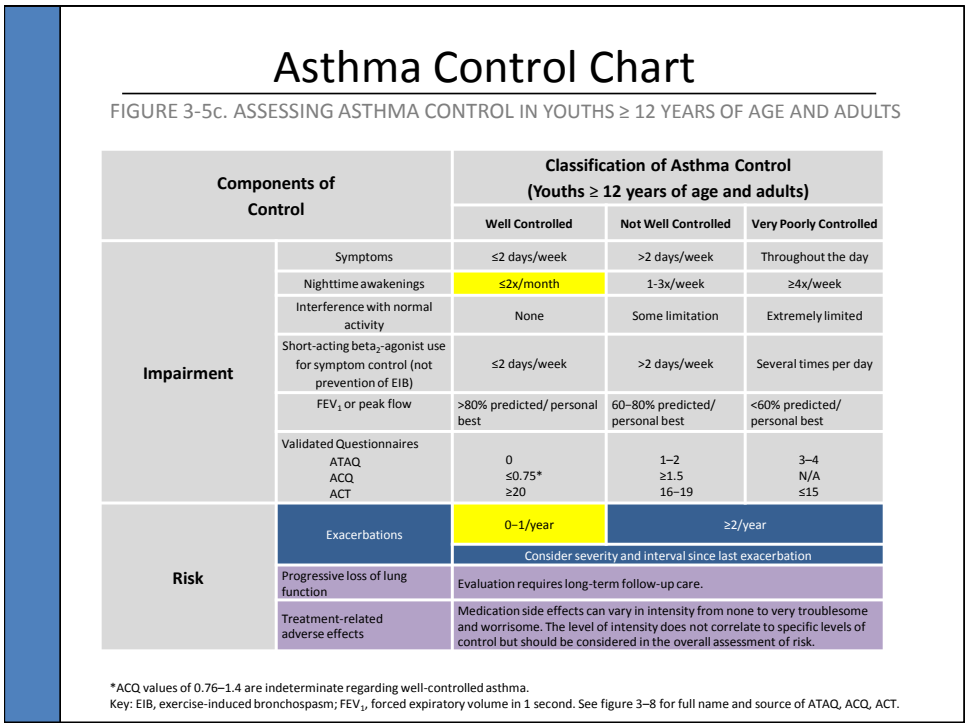
ADDITONAL COMMENTS

- NOTE: 5 minutes should be allotted to discussion of this case.
- What is her level of control?

  Answer:

  Well-controlled

  This patient is without active asthma symptoms and compliant with controller therapy. While she does exhibit exercise-induced bronchospasm, her albuterol use is preventative and does not negate her well-controlled status. Further, since she has had well-controlled asthma over a significant period of time, an appropriate clinician-patient conversation at this time might include mention of “step-down” controller medication adjustment.



Asthma Control Chart

FIGURE 3-5c. ASSESSING ASTHMA CONTROL IN YOUTHS ≥ 12 YEARS OF AGE AND ADULTS

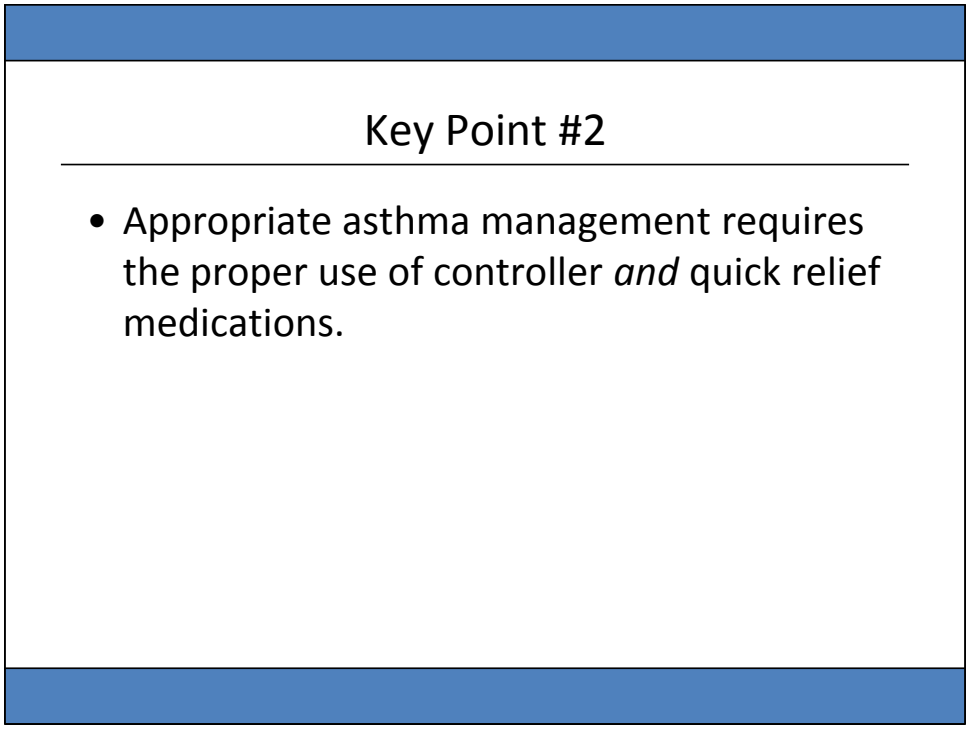
Components of Control		Classification of Asthma Control (Youths ≥ 12 years of age and adults)		
		Well Controlled	**Not Well Controlled**	**Very Poorly Controlled**
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤2x/month	1-3x/week	≥4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV_1 or peak flow	>80% predicted/ personal best	60–80% predicted/ personal best	<60% predicted/ personal best
	Validated Questionnaires ATAQ ACQ ACT	0 ≤0.75* ≥20	1–2 ≥1.5 16–19	3–4 N/A ≤15
Risk	Exacerbations	0–1/year	≥2/year	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term follow-up care.		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		

*ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.
Key: EIB, exercise-induced bronchospasm; FEV_1, forced expiratory volume in 1 second. See figure 3–8 for full name and source of ATAQ, ACQ, ACT.

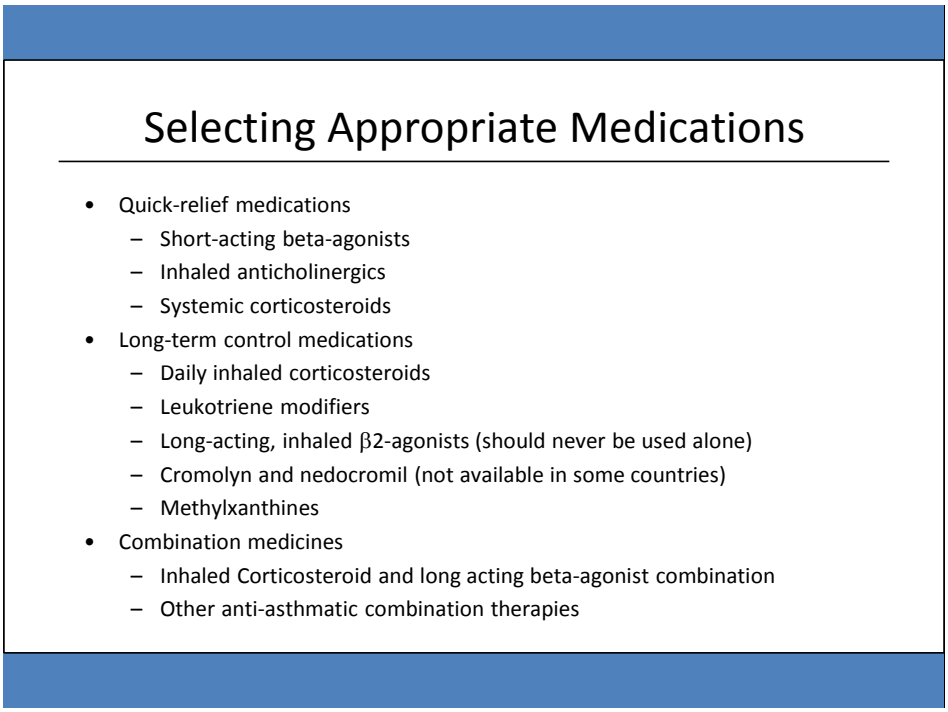
Slide 23

ADDITONAL COMMENTS

- NOTE: This control chart is also specific to youth ≥12 years of age.


Key Point #2
• Appropriate asthma management requires the proper use of controller *and* quick relief medications.

Slide 24



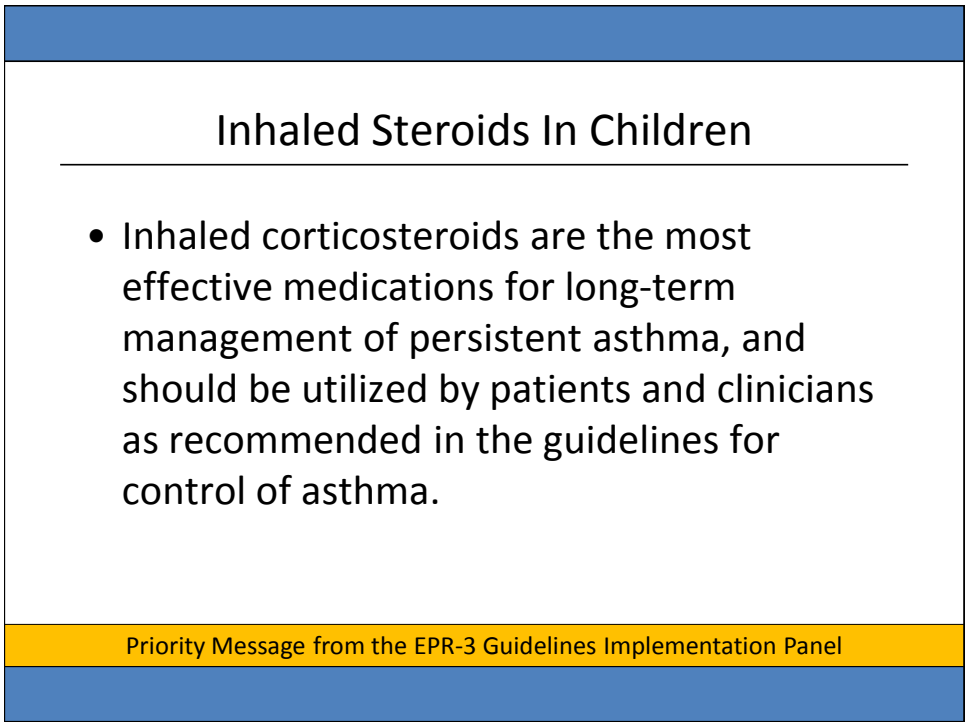
Slide 25

ADDITIONAL COMMENTS

- The NAEPP guidelines distinguish between quick relief medications and long-term control medications.
- Note that daily inhaled corticosteroids are the most effective long-term control medication.
- Note that cromolyn and nedocromil were scheduled for FDA phase-out in 2010.
- Theophylline was once helpful, but is now a fourth or fifth line agent by every professional society in the world.
- The NAEPP guideline concludes that the present evidence for treating asthma exacerbations with antibiotics is insufficient.
- Note to facilitator: discuss inflammation and pathogenesis.
- The original NAEEP guidelines discussed a step-down approach to treatment beginning with a combination of therapies needed to gain full control then stepping down to minimal medications and dose for maintaining control. The newer guidelines suggest stepping up is recommended as an appropriate therapeutic strategy. The stepwise approach recommended in the guidelines is provided in the physician binder.

Reference:

NHLBI (2007). Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* www.nhlbi.nih.gov/guidelines/asthma/index.htm



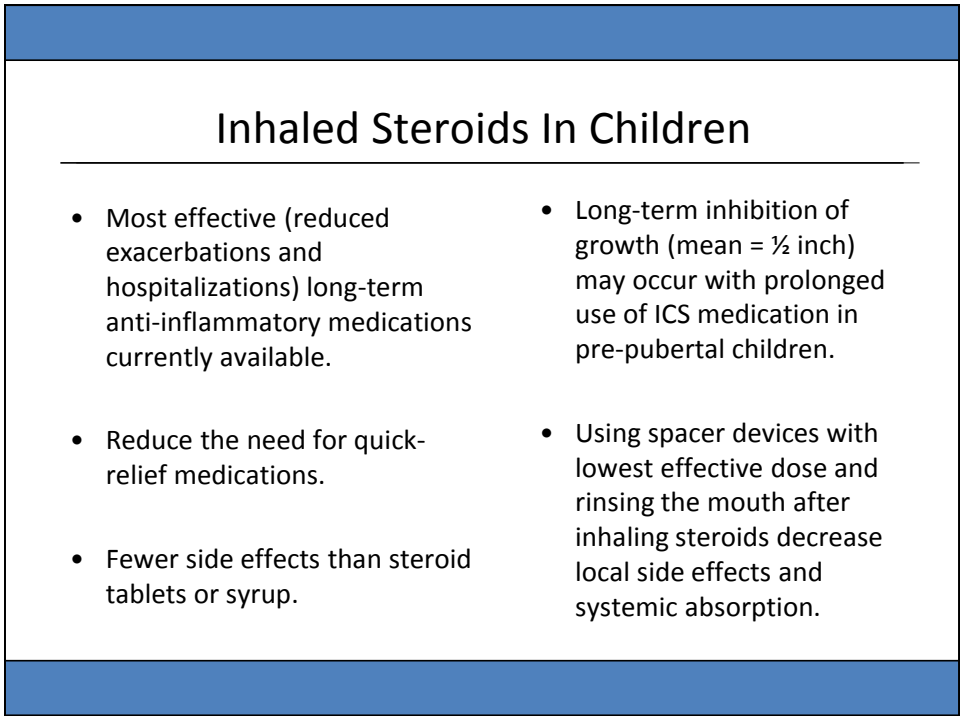
Slide 26

ADDITIONAL COMMENTS

- This is a **priority GIP message**: Use Inhaled Corticosteroids.

Reference:

NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health, w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm



Slide 27

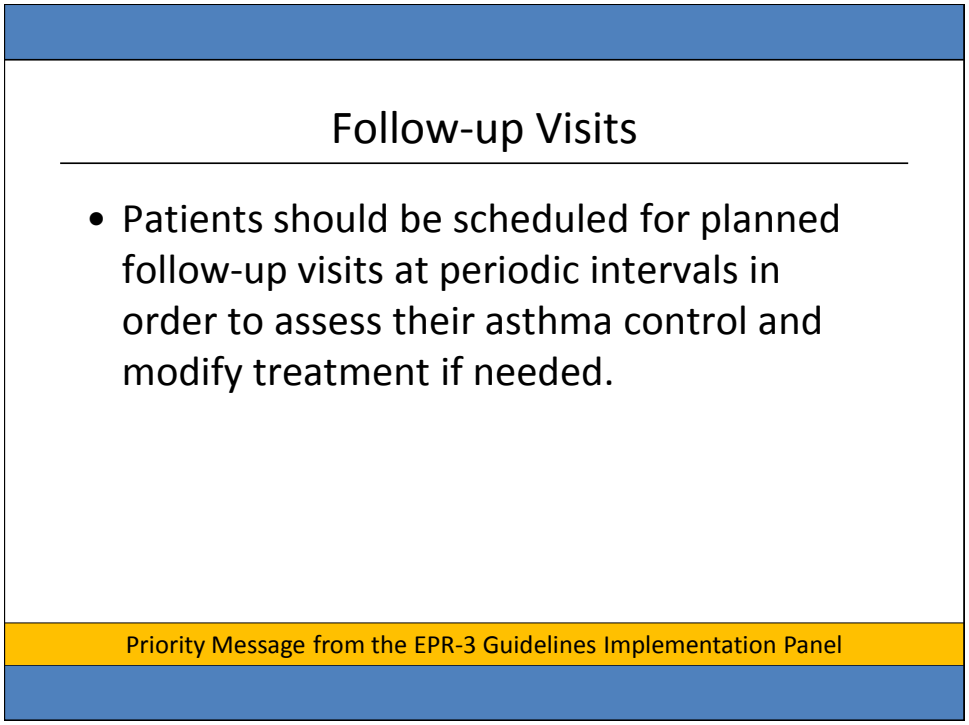
ADDITIONAL COMMENTS

- There is still considerable controversy that inhaled steroids may inhibit growth in children, but here is what we know now:
  - Families should also understand that poorly controlled asthma can lead to impaired growth as well and that risks and benefits have been weighed carefully in developing the treatment plan.
  - It is reassuring for patients to know that once the asthma is brought under good control, the dose of inhaled steroids will be reduced if at all possible.

- A review of the literature on inhaled corticosteroids and growth in children is available in your binder.

References:

Allen, D. B. (2002). Inhaled corticosteroid therapy for asthma in preschool children: Growth issues. *Pediatrics, 109*(2 Suppl), 373-380.



Slide 28

ADDITIONAL COMMENTS

- This is a **priority GIP Message**: Schedule Follow-up Visits
  - Because response to asthma therapy may vary, periodic monitoring of asthma control through clinical visits is essential to "step up" therapy as necessary; or, "step down" when possible to the minimum amount of medication necessary to maintain control.
- In general, patient visits should be scheduled at 2-to-6 week intervals while initiating therapy or stepping up therapy to achieve control; at 1-to-6 month intervals after asthma control is achieved in order to monitor if asthma control is maintained; and, at 3-month intervals if a step-down in therapy is anticipated.

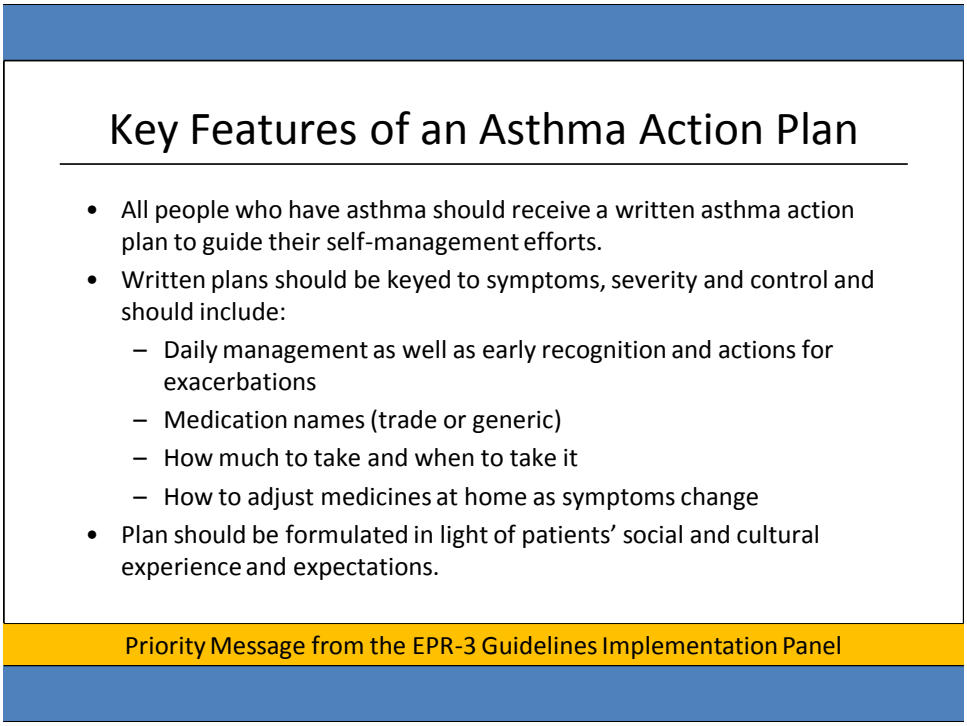
References:

NHLBI. (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health,* *w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm.

Key Point #3

- Because asthma symptoms are variable, families need to recognize symptoms and adjust medications at home according to the clinician's written plan.

Slide 29



Slide 30

ADDITIONAL COMMENTS

- There are many asthma action plans that can be useful. Here are key features to include in any successful action plan...

- These plans are designed for common cases. The unusual or very severe patients will need to be referred to specialists.

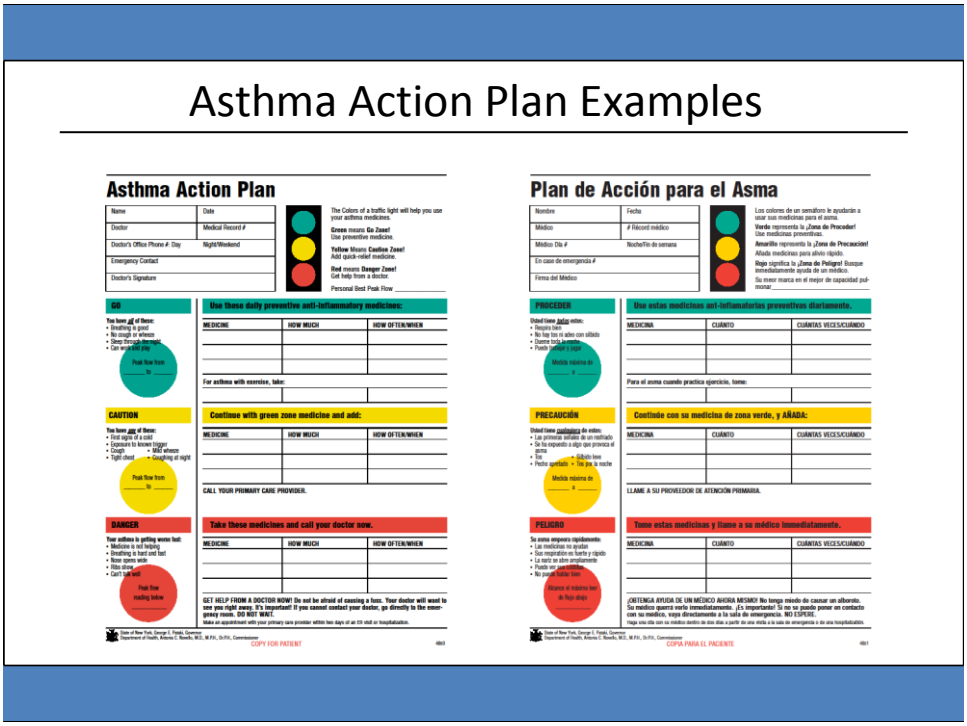
- This is a **priority GIP message**: Use written asthma action plans

Reference:

de Asis, M. L., & Greene, R. (2004). A cost-effectiveness analysis of a peak flow-based asthma education and self-management plan in a high-cost population. *The Journal of Asthma, 41*(5), 559-565.

Powell, H., & Gibson, P. G. (2003). Options for self-management education for adults with asthma. *Cochrane Database of Systematic Reviews (Online), (1)*(1).

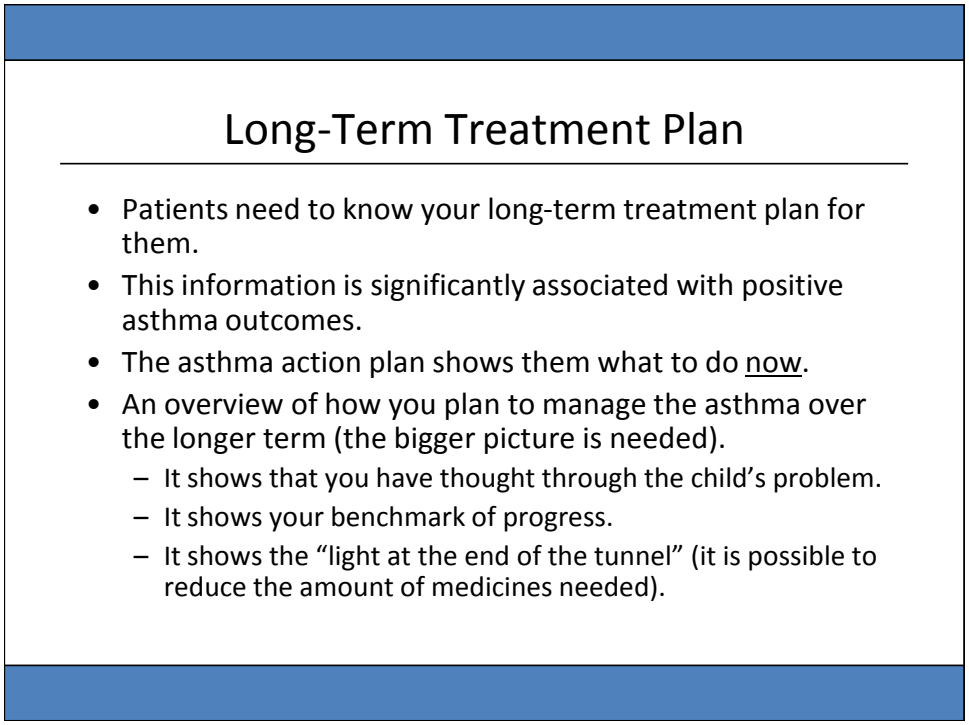
NHLBI (2008). Guidelines Implementation Panel Report, Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma. *National Institutes of Health, w*ww.nhlbi.nih.gov/guidelines/asthma/index.htm



Slide 31

ADDITIONAL COMMENTS

- Here is one example...
- This treatment plan is popular because the simple analogy (traffic light) is easy to understand.
- Directions are clear.
- <u>There are other completed examples in your binder.</u>
- Patients need to see the light at the end of the tunnel. If they follow the plan, get into control, then medicines can be stepped down.
- Patients need to know your long-term plan regarding their asthma therapy.



Slide 32

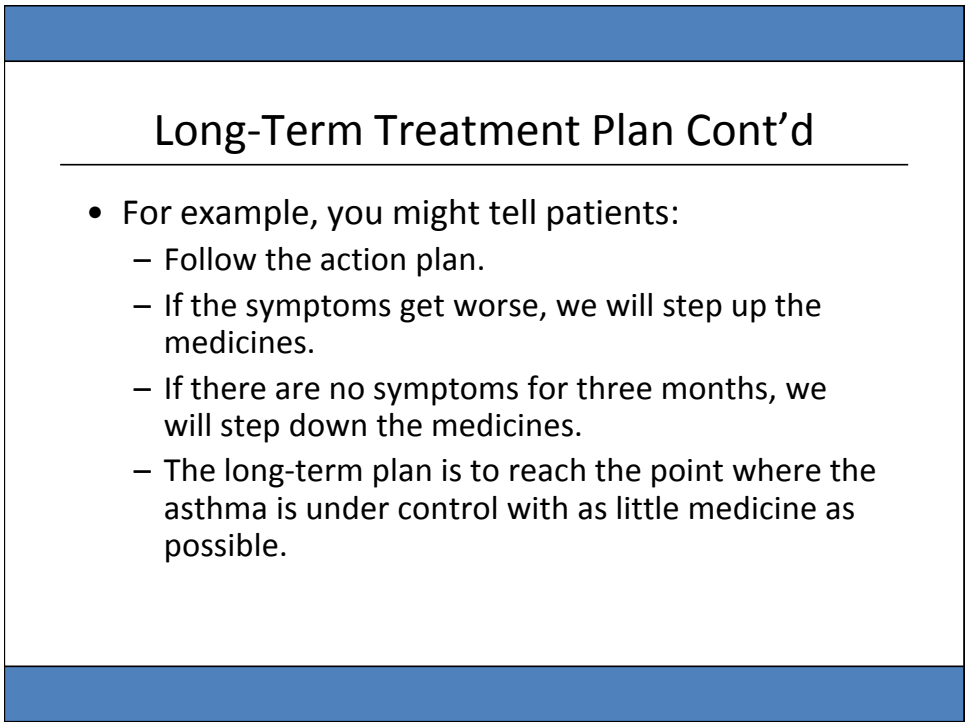
ADDITIONAL COMMENTS

- For some patients, focusing on long-term treatment goals and discussing the "big picture" of asthma control and how medications can be adjusted over time may improve adherence.

- Evaluation of PACE has indicated that giving the patient this long-term view enhances significantly desired clinical outcomes.

Reference:

Mellins R.B., Evans D., Clark N., Zimmerman B., Wiesemann S. (2000). Developing and communicating a long-term treatment plan for asthma. *Am Fam Physician*, 61(8), 2419-28.



Slide 33

ADDITIONAL COMMENTS

- Emphasize that medications can also be stepped down if needed.

- A copy of a sample long-term asthma action plan for a child with moderate persistent asthma is available in your binder.

Review of Key Points Covered

1. Assessment of severity and control forms the basis of the treatment plan.
2. Appropriate asthma management requires the proper use of controller and quick relief medications.
3. Because asthma symptoms are variable, families need to recognize symptoms and adjust medications at home according to the clinician's long-term plan.

Slide 34

WRAP UP – *PRIMARY CARE PROVIDER*

SUGGESTED SCRIPT

Thank you *(Asthma Specialist's Name).* We will now take a short break.

(Behavioral Scientist's/Health Educator's Name) will now present a slide show and video on communication strategies.

Session 1, Segment 2
Communication Strategies

TIPS FOR INSTRUCTORS - *BEHAVIORAL SCIENTISTS/HEALTH EDUCATOR*
(30 minutes)

THE MAIN POINTS TO CONVEY IN THIS SEGMENT ARE:

1. Patient non-adherence to clinician recommendations is a significant problem for all providers.

2. Ten simple communication strategies can significantly improve the interaction with the patient. A list of these strategies is available in the communication section of the physicians' binders.

3. Good communication and attention to the patient's cultural and social experience can increase patient knowledge, satisfaction, and compliance.

4. Using these strategies does not take a lot of extra time. In fact, it can save time.

Clinicians may be less interested in this segment or may initially believe it is irrelevant to their practice. Evaluation of the program (N.M. Clark et al. *Pediatrics* Vol 101, No 5, page 831-836, 5 May, 1998; MD Cabana et al. *Pediatrics* Vol 117 No 6, pages 2149-57; N. Clark et al. Long-term outcomes of physician peer teaching. 2008 *Clinical Pediatrics* 47(9), 883-90) showed that change in patients' health status and health care use only occurred with both effective medicine and health education. Further, good communication took no more time in the patient visit.

REMEMBER
Most clinicians think they are good communicators, but studies show that most patients do not agree. This diversity of opinion can be even greater when the physician and patient are from different cultures.

Acknowledge that most clinicians probably already employ some of the communication strategies. Encourage them to become more aware of their interactions with patients, or to try out some strategies that they do not already use. Encourage them to use the protocols you will provide to monitor their own communication skills in the time between sessions.

Some clinicians may have different personal styles than that of the clinician in the video. Reinforce that the strategies can be adapted to fit individual styles of communicating and in light of the patient's social experience.

This segment should be interactive. The instructor should model the strategies recommended by using them during the discussion – ask open-ended questions, show non-verbally that the speaker is attentive to participant responses, give verbal encouragement, etc.

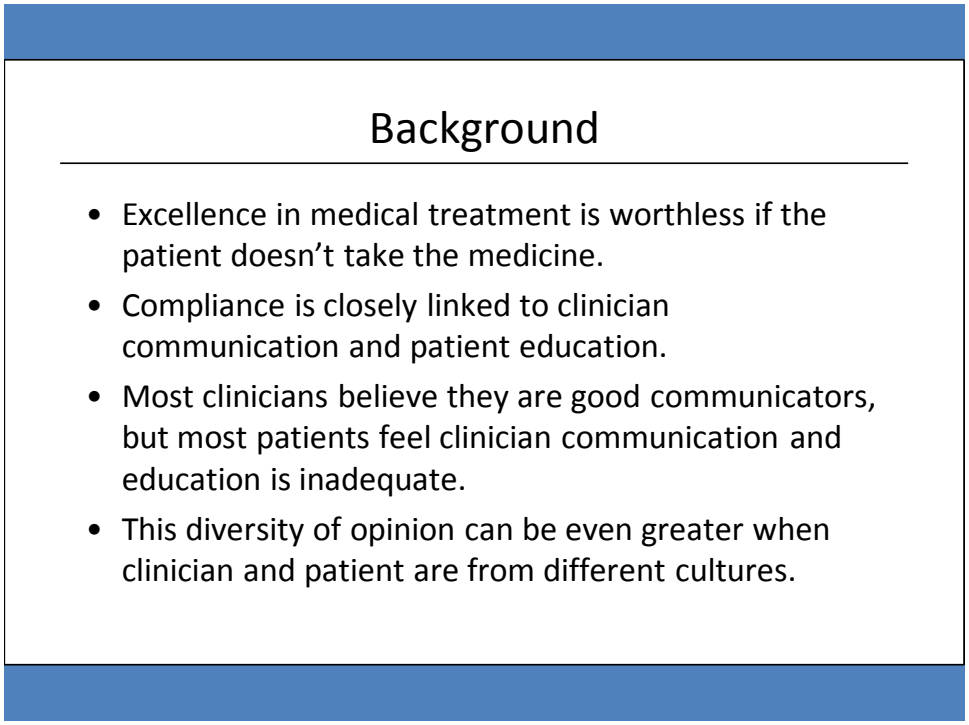
Communication Strategies

SLIDE PRESENTATION

Key Point #4

- Good communication between patient and clinician helps identify patient concerns that may:
  - -block adherence
  - -makes patient teaching more effective
  - -promotes patient self-confidence to follow the treatment plan.
- Communication across cultures requires special consideration and there are ways to make this more effective.

Slide 1



Slide 2

ADDITIONAL COMMENTS

- First, a little background...
- Clinician communication and patient education is central to a patient's compliance with the clinician's recommendations.

Recent Medicine Adherence Studies

Citation	Controller Medication	Percent Adherence	Method of Measuring Medication Use
Bender et al., 2000	Metered dose inhaler (MDI)	80% 43%	Mother report, child report, Canister weight, raw doser, adjusted doser
Smith et al., 2008	Steroid inhaler	39%	Telephone interviews with parents of children 2-12 years; Controller medication underuse was defined as suboptimal control and parent report of 6 days/week of inhaled steroid use
Mawhinney et al., 1991	Metered dose inhaler (MDI)	37%	Chronolog monitoring of MDI activations.

Slide 3

ADDITIONAL COMMENTS

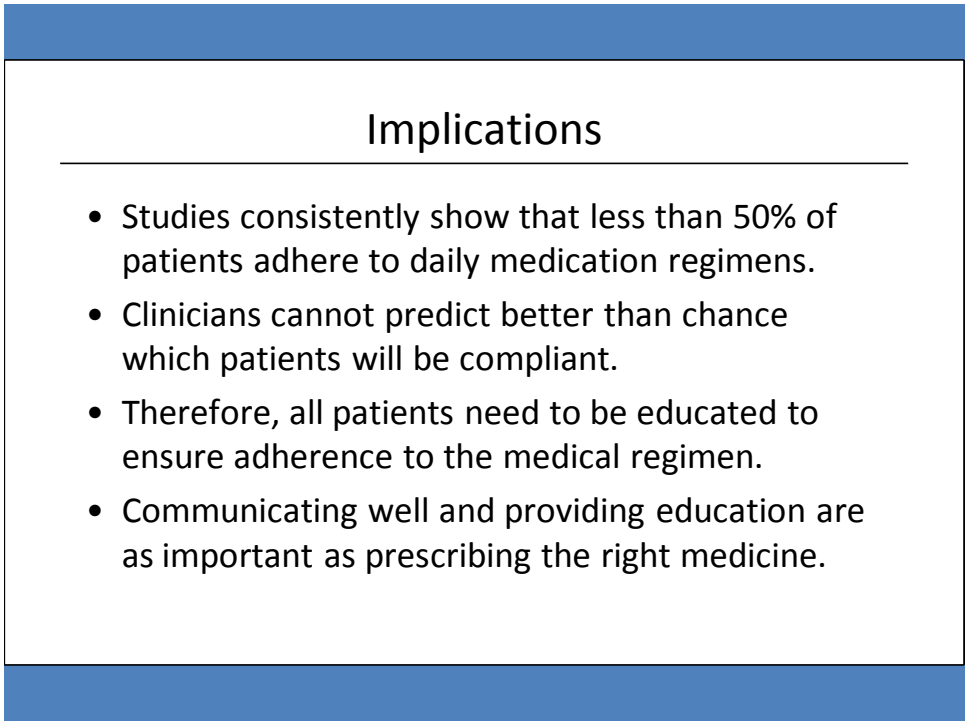
- This slide shows some recent studies demonstrating poor compliance in asthma.
- The first is a study by Bender et al.
- The second is a study by Smith et al.
- Both studies show adherence is 50% and lower than what self-reported measures portray.
- Adherence is bad among all patients, regardless of age, SES, culture, etc.
- In the study by Mawhinney et al., 1/3 of the patients activated the dosimeter 10 or more times in a single 4 minute period, usually the day before or the day of their scheduled visit for study follow up, because they knew that their compliance would be checked by the dosimeter, although they had no idea of how precise the dosimeter records would be.
    - Patients want their interactions with their doctor to go well. In other words, clinicians and patients share the same goal for the visit.
    - To ensure the visit goes smoothly, patients may avoid information they think the doctor won't like to hear or may modify information, that is, not give a completely accurate version of events.
    - The doctor's communication with patients should indicate to them that it is OK to say what actually occurred so that there can be a useful discussion about their experiences with medicines, the benefits and costs they see in using them, and changes in the treatment plan that might encourage more effective use of them.
    - Winning the patient's trust is important to achieving this open and honest communication and we will be discussing techniques that can help you enhance your interactions with the patient and family and build trust.

***References*:**

Bender et al. (2000). Measurement of children's asthma medication adherence by self-report, mother report, canister weight, and Doser CT. *Annals of Allergy, Asthma, and Immunology*. 85: 416-421.

Smith, L. A., et al. (2008). Modifiable risk factors for suboptimal control and controller medication underuse among children with asthma. *Pediatrics, 122*(4), 760-769.

Mawhinney et al. (1991). Compliance in clinical trials of two nonbronchodilator, antiasthma medications. *Annals of Allergy*, 66 (4), 294-299.

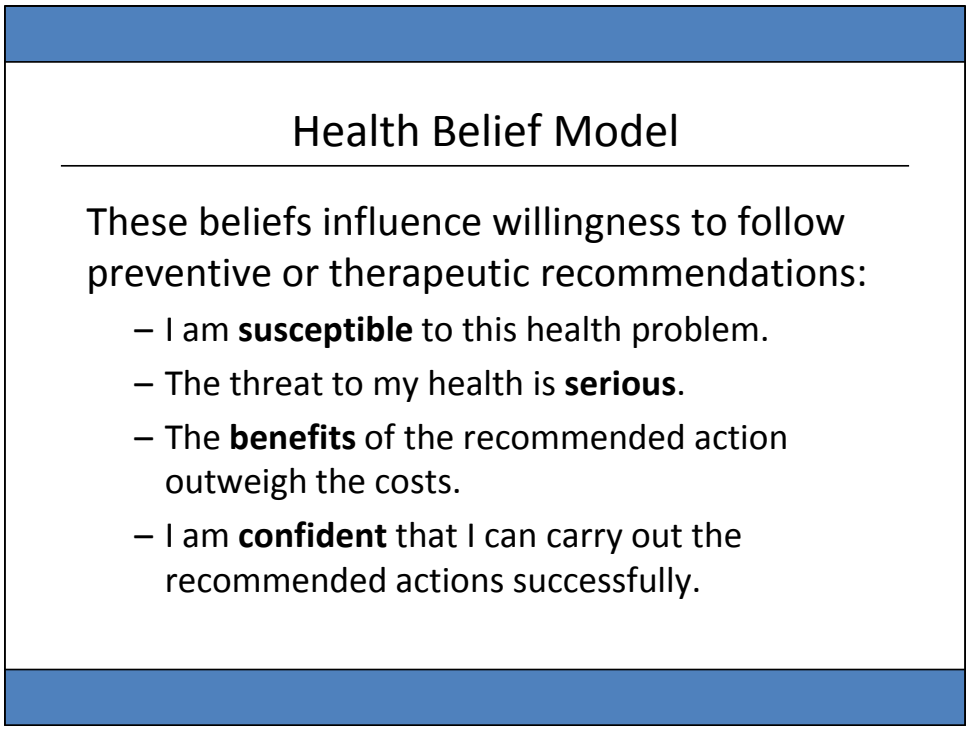

Implications
• Studies consistently show that less than 50% of patients adhere to daily medication regimens.
• Clinicians cannot predict better than chance which patients will be compliant.
• Therefore, all patients need to be educated to ensure adherence to the medical regimen.
• Communicating well and providing education are as important as prescribing the right medicine.

Slide 4

Aims of the Following Discussion

- To provide a theoretical framework - a way to think about clinician-patient communication cross-culturally.
- To demonstrate strategies that clinicians can use to improve communication and help patients be responsive to recommendations.

Slide 5



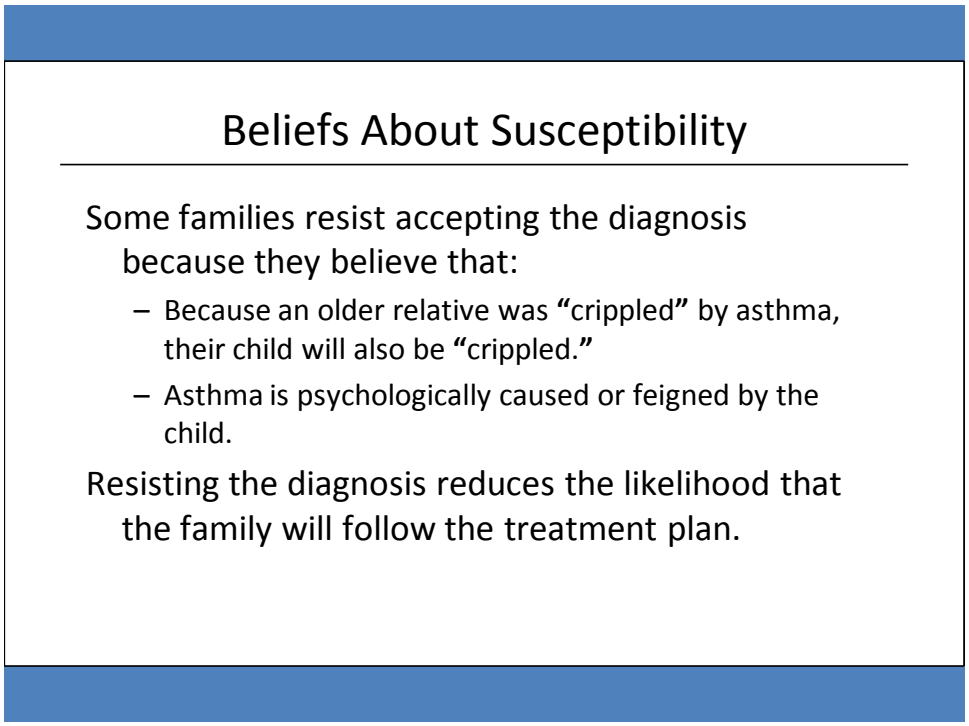
Slide 6

ADDITIONAL COMMENTS

- I'd like to introduce the Health Belief Model. Numerous studies have shown that these beliefs influence willingness to follow preventive or therapeutic recommendations.

Reference:

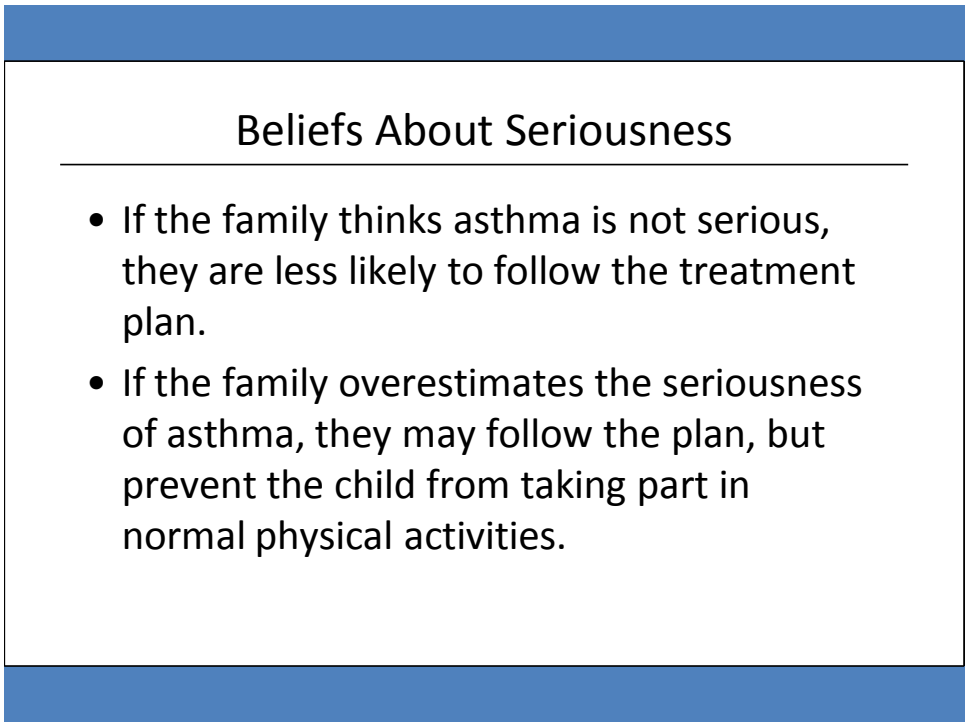
Glanz K., Rimer B., & Lewis F.M. (Eds.). (2002). *Health Behavior and Health Education Theory, Research, and Practice.* San Francisco, CA: Jossey-Bass.



Slide 7

ADDITIONAL COMMENTS

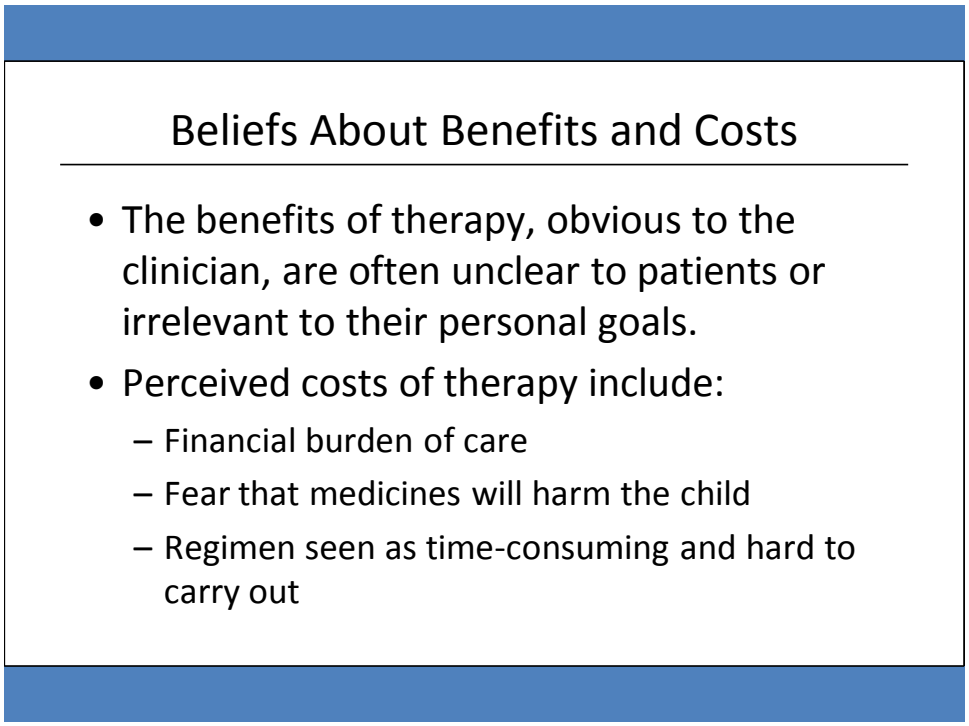
- These susceptibility beliefs are sometimes the main concern when patients come to see the clinicians, and discussion with the clinician can help dispel them.



Slide 8

ADDITIONAL COMMENTS

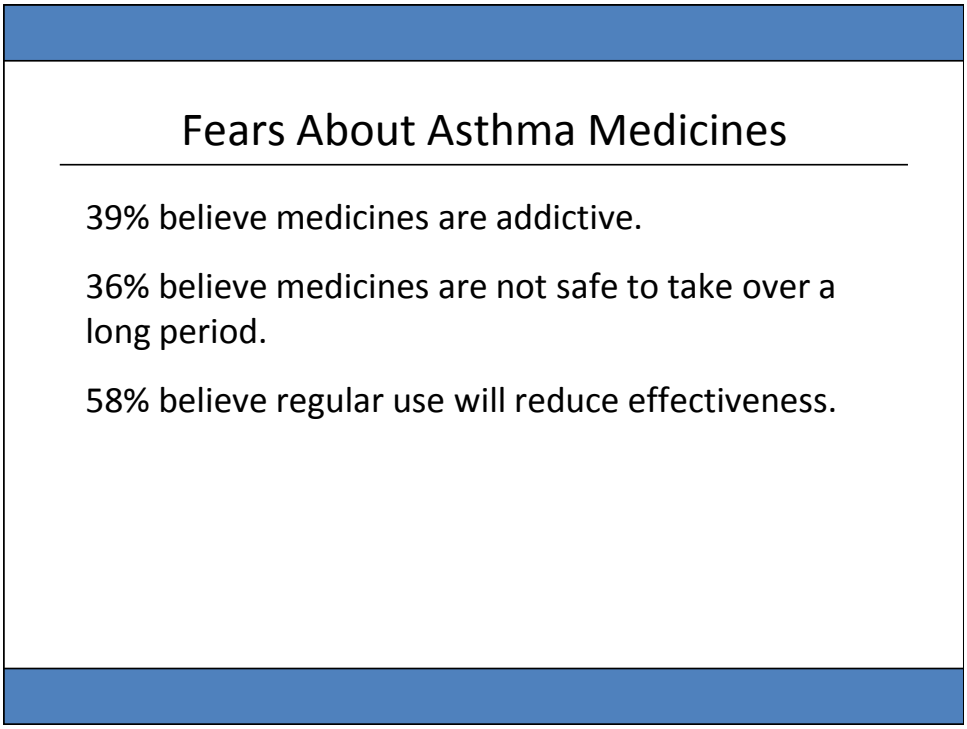
- Families need to learn that asthma is a serious disease, and by following an appropriate treatment plan, the child can be fully active.



Slide 9

ADDITIONAL COMMENTS

- The benefits of the therapy can be explicitly tied to the patient's personal goals, i.e., to play basketball, to sleep through the night, etc. In this way the "costs" of following the therapeutic plan are reduced and the physician's recommendations are seen as a way to reach one's personal goals.



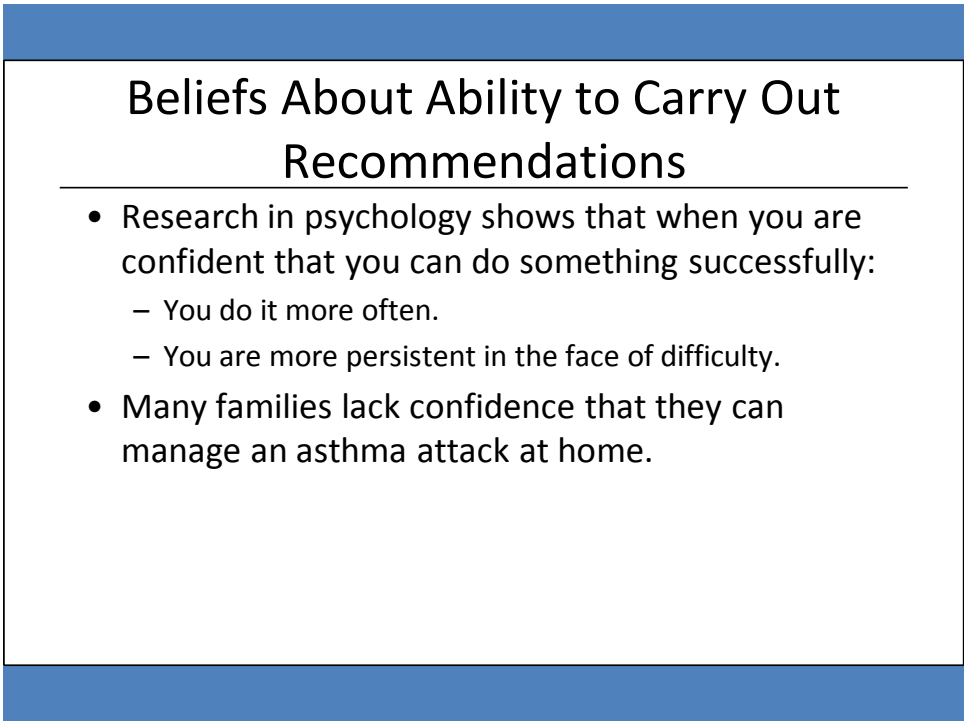
Slide 10

ADDITIONAL COMMENTS

- Fears about asthma medicines are an example of a perceived cost of therapy that blocks compliance.
- These figures are based on research conducted in a study of 445 parents of children with asthma.
- If parents hold these beliefs it is unlikely they will follow the treatment plan.

Reference:

Wasilewski, Y., Clark, N. M., Evans, D., Levison, M. J., Levin, B., & Mellins, R. B. (1996). Factors associated with emergency department visits by children with asthma: Implications for health education. *American Journal of Public Health, 86*(10), 1410-1415.



Slide 11

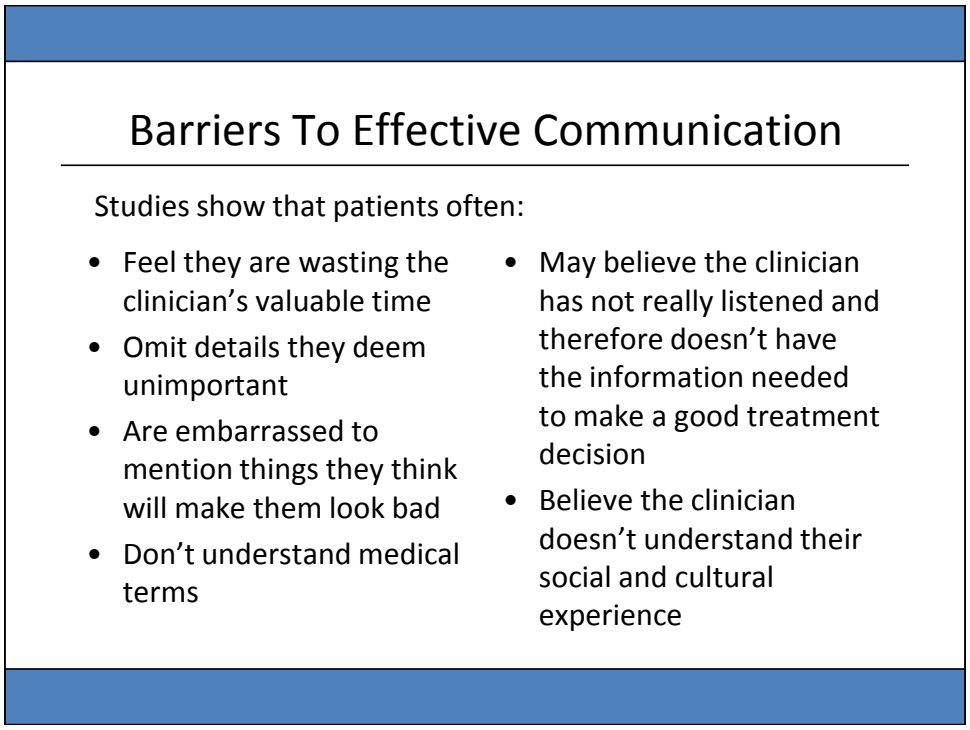
ADDITIONAL COMMENTS

- For example, many families go immediately to the emergency department even for mild asthma episodes instead of beginning appropriate treatment at home.
- Explicit efforts to build patient confidence for self-management are central to asthma control.
- When the physician acts as a sympathetic, encouraging coach, it helps patients gain confidence that they can manage an asthma attack at home.

Slide 12

ADDITIONAL COMMENTS

- Open communication is important, but there are often barriers to effective communication during the office visit.
- Families are often reluctant to bring up their beliefs or concerns; it is important to identify them so they can be dealt with.



Slide 13

ADDITIONAL COMMENTS

- Now we'll show you a video for improving effective communication with patients.

- You may note that the office visit in the video is rather lengthy. We realize this is not likely the reality in your practice; however, this vignette is used to portray all of the communication strategies. You will probably only be able to practice a few of the strategies in each of your office visits.

References:

Bigby, J.A. (2006). Navigating cross-cultural communication. In T.E. King, Jr., & M.B. Wheeler (Eds.), *Medical management of vulnerable and underserved patients: principles, practice, and population* (pp. 99-100). McGraw-Hill Companies, Inc.

Roter, D.L., & Hall, J.A. (2006). *Doctors talking with patients/patients talking with doctors: improving communication in medical visits* (2nd ed.). Westport, CT: Praeger.

Video Demonstration

COMMUNICATION STRATEGIES

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR* ***(52 minutes total)***

Several communication strategies have been identified that clinicians can use to reduce the barriers to effective interaction and enable them to be perceived as a "sympathetic coach." Using these strategies can make the interaction go more easily, speed up the process, and in the long run save both time and cost.

These techniques are illustrated in a video we are going to screen. It is about 15 minutes long and is an efficient way to highlight the most effective strategies. It may be a review of material for those in the audience who already have communication training, or who have learned the hard way. For some, the ideas may be reasonably new. The video doesn't depict everything that takes place in a visit. The main purpose is to show the communication strategies in action. A list of these strategies is available in the communication section of the physician binder.

Your personal style may be different from that of the clinician in the video. Of course, you will want to adapt the strategies to fit your own individual style.

SHOW VIDEO PART 1: COMMUNICATION STRATEGIES (17 minutes)

Discuss video with goal of getting participants to share their experience. The questions serve as triggers to discussion-they need not all be asked. **Question #6 should be posed.** If participants are not responding right away, wait 10 seconds after each question.

There may be cultural differences in making direct eye contact, or shaking hands. Mention that these will be discussed the next time we meet.

VIDEO DISCUSSION QUESTIONS (15 minutes)

1. What are your reactions to how the clinician handled Michael's concerns?

2. Which do you feel uncomfortable using?

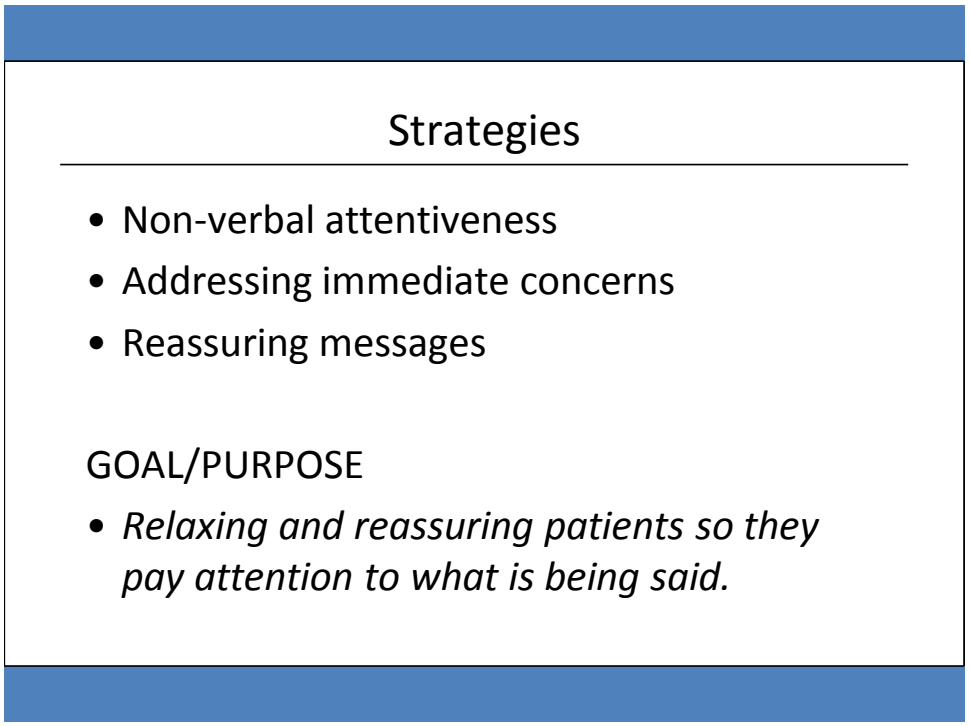
3. Which of these strategies are easiest to use given a very constrained time frame for seeing the patient?

4. Which strategies are not effective? What makes you think they are effective (or not effective)?

5. [For each strategy]: do you use this strategy? Why? Why not?

6. In your experience with patients of a different race/ethnicity than your own, which strategies are most effective?

Complete slide presentation slides 14 through 21 **(20 minutes)**



Slide 14

ADDITIONAL COMMENTS

- Now let's review the purpose of each strategy shown in the video. Let me emphasize that these strategies have been evaluated as part of two large clinical trials with pediatricians.

- It is disconcerting for patients only to see the doctor's back when he/she is using electronic medical record (EMR). Special effort is needed to maintain effective face to face communication. Most patients rely on the interpersonal relationship with the physician more than the medical record and this element of interaction can be lost with too much focus on the EMR.

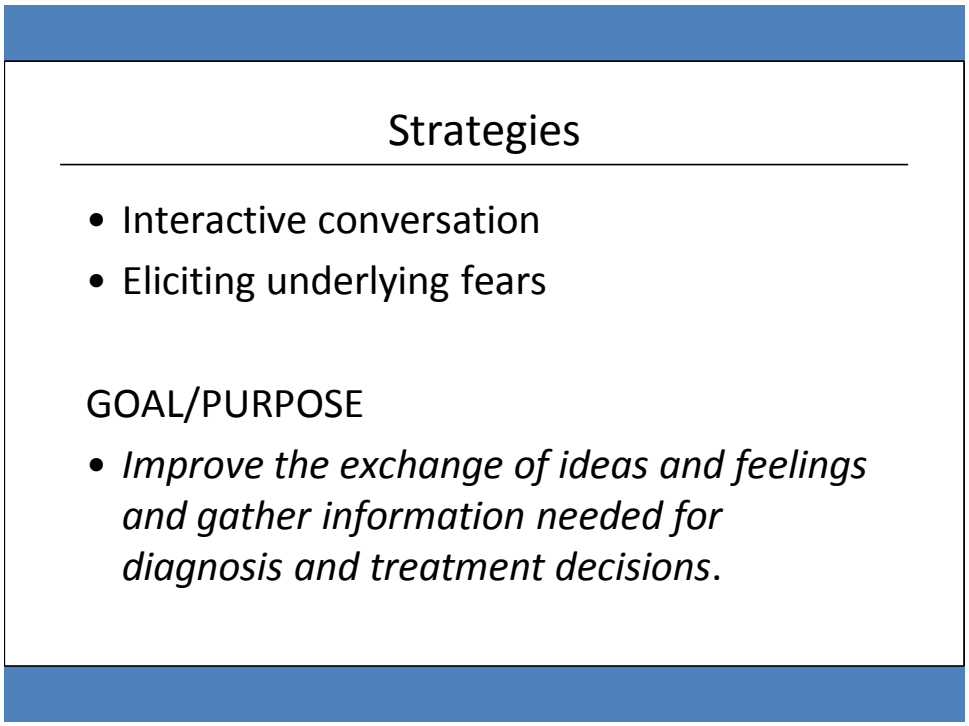
- When using EMR, be sure to stop, pause, and look at the family. It is important to share what you are doing with the family when using EMR during the visit. Failing to share information may raise suspicions.

References:

Frankel R, Altschuler A, George S, Kinsman J, Jimison H, Robertson NR, Hsu J. (2005). Effects of exam-room computing on clinician-patient communication: a longitudinal qualitative study. *J Gen Intern Med*, *20*(8), 677-82.

Shachak, A., & Reis, S. (2009). The impact of electronic medical records on patient-doctor communication during consultation: A narrative literature review. *Journal of Evaluation in Clinical Practice, 15*(4), 641-649.

O'Malley, A. S., Cohen, G. R., & Grossman, J. M. (2010). Electronic medical records and communication with patients and other clinicians: Are we talking less? *Issue Brief (Center for Studying Health System Change), (131)*(131), 1-4.



Slide 15

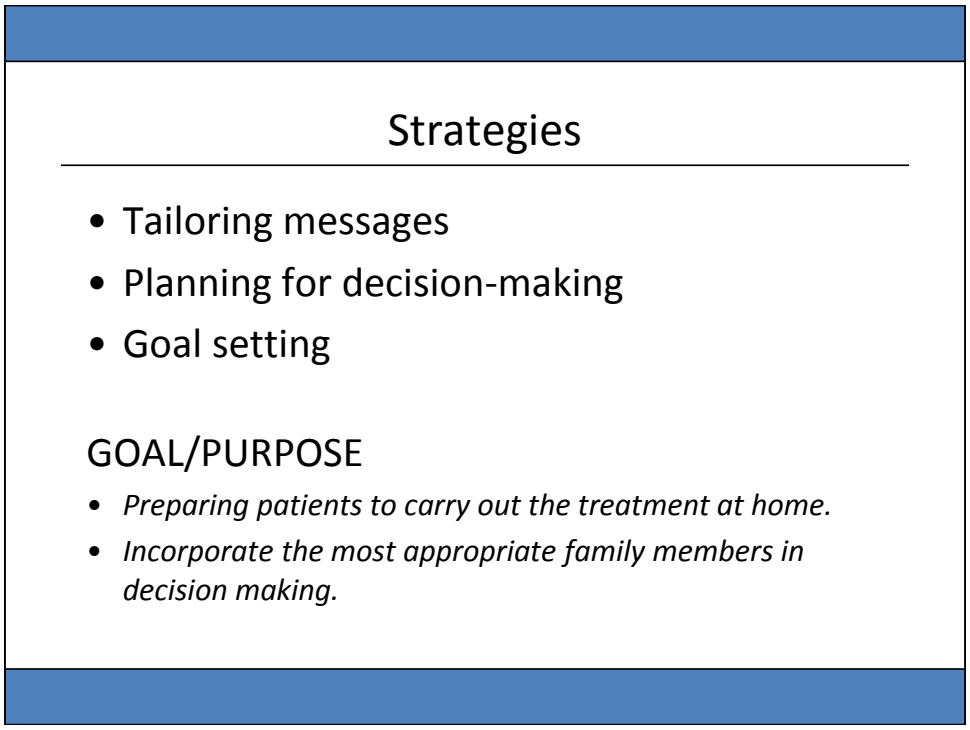
ADDITIONAL COMMENTS

References:

Clark, N. M., Gong, M., Schork, M. A., Evans, D., Roloff, D., Hurwitz, M., et al. (1998). Impact of education for physicians on patient outcomes. *Pediatrics, 101*(5), 831-836.

Cabana, M. D., Slish, K. K., Evans, D., Mellins, R. B., Brown, R. W., Lin, X., et al. (2006). Impact of physician asthma care education on patient outcomes. *Pediatrics, 117*(6), 2149-2157.

Clark, N. M., Cabana, M., Kaciroti, N., Gong, M., & Sleeman, K. (2008). Long-term outcomes of physician peer teaching. *Clinical Pediatrics, 47*(9), 883-890.


Strategies
• Tailoring messages
• Planning for decision-making
• Goal setting
GOAL/PURPOSE
• Preparing patients to carry out the treatment at home.
• Incorporate the most appropriate family members in decision making.

Slide 16

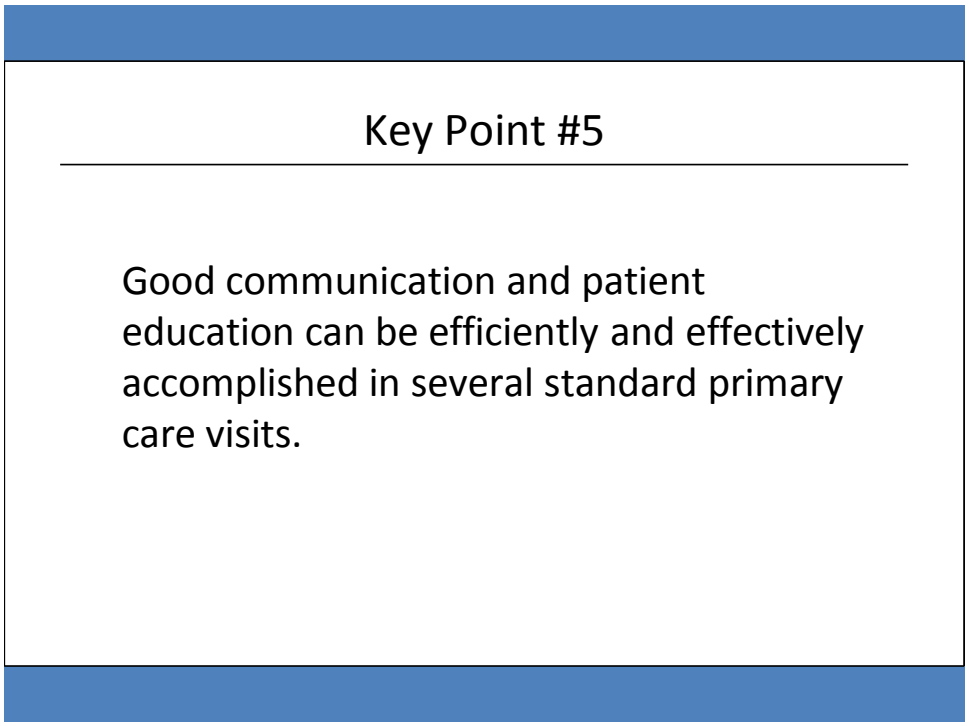
Strategies

- Non-verbal encouragement
- Verbal praise

GOAL/PURPOSE

- *Building self-confidence needed to carry out the plan.*

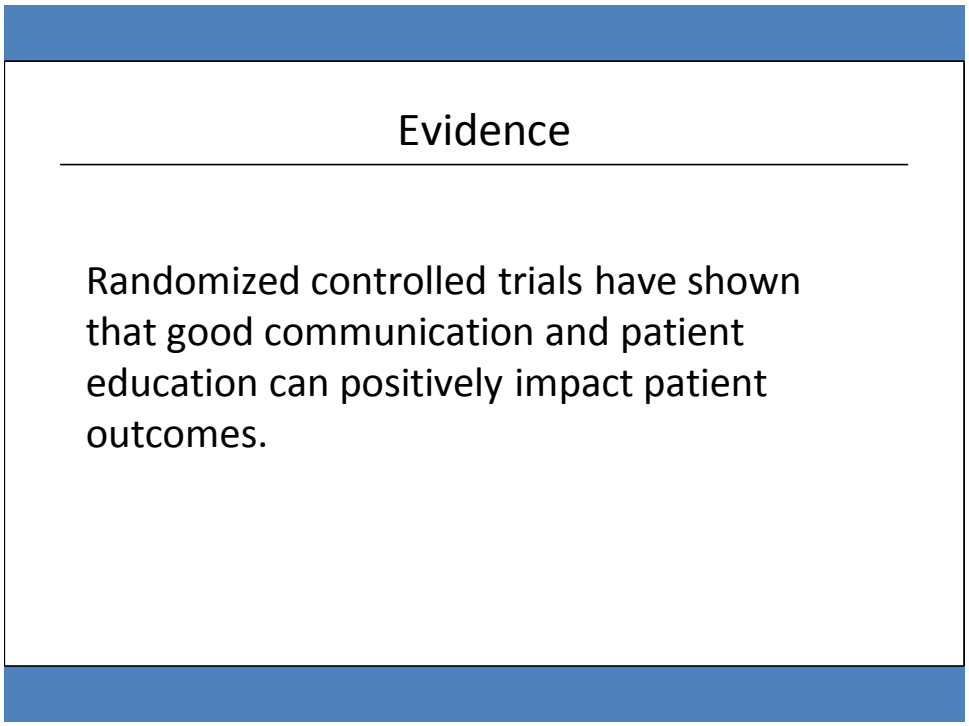
Slide 17



Slide 18

ADDITIONAL COMMENTS

- Three visits can usually enable sufficient initial tailoring of the therapy and delivery of educational messages.



Slide 19

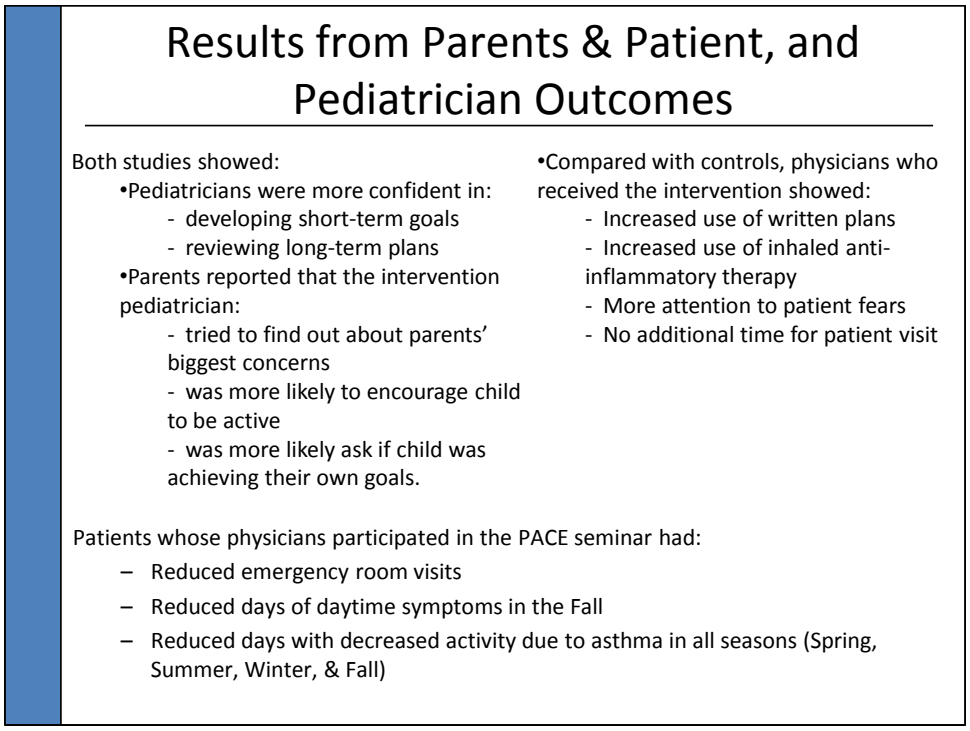
ADDITIONAL COMMENTS

- To see if this worked, Clark et al. conducted two controlled trials...
- Good communication does not mean more time. It's the same or less.
- Copies of the articles from these trials are available in the reference section of your binder.

References:

Clark, N. M., Gong, M., Schork, M. A., Evans, D., Roloff, D., Hurwitz, M., et al. (1998). Impact of education for physicians on patient outcomes. *Pediatrics, 101*(5), 831-836.

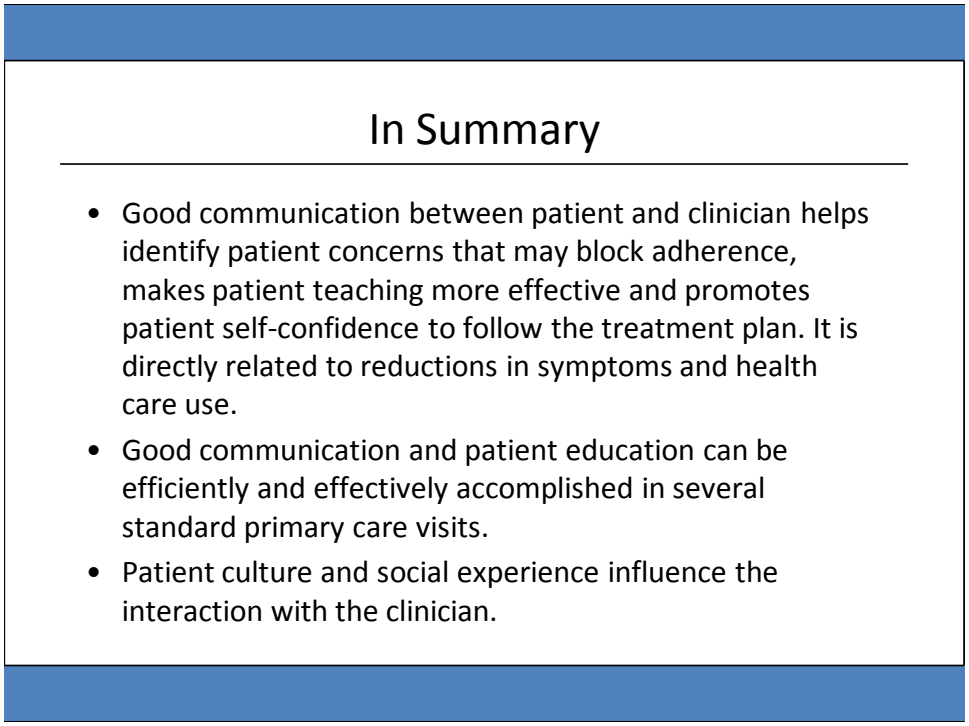
Cabana, M. D., Slish, K. K., Evans, D., Mellins, R. B., Brown, R. W., Lin, X., et al. (2006). Impact of physician asthma care education on patient outcomes. *Pediatrics, 117*(6), 2149-2157.



Slide 20

ADDITIONAL COMMENTS

- **NO ADDITIONAL TIME FOR PATIENT VISIT:** This is important as some clinicians think good communication takes more time. These studies showed this is not the case.
- The evidence demonstrates that there is no question that good communication can change patient outcomes.
- Physicians rated higher on satisfaction from patients.



Slide 21

ADDITIONAL COMMENTS

- We'll talk more about patient culture and its effect on patient management next week.

Session 1 Wrap-Up

SUGGESTED SCRIPT – *PRIMARY CARE PROVIDER/ASTHMA SPECIALIST* **(10 minutes)**

Most professionals can improve their communication skills whether in medicine, law, business, or other fields. An effective way to do this is through self-observation and evaluation. The communication self-rating scale is a kind of communication crib sheet that outlines the strategies demonstrated in the video. A copy of this is located in the communication section of your binder. Reviewing the form before seeing a family and completing it after a visit can alert you to areas of communication behavior where you may want to place more emphasis when interacting with a patient and parent. Using the scale initially for several weeks while you are consciously trying to change your communication style is very helpful. Thereafter, using it periodically to check yourself can help you maintain your use of the strategies.

We'll ask you to do four things to prepare for next week's seminar:

1. **Write any questions related to clinical or educational aspects of asthma on these cards. Give them to us today or at the beginning of next week's session. We will do our best to address them.**
2. **Bring to the discussion next week an asthma case from your practice that you want to continue to manage--not one you'd refer to a specialist. The case should be with a patient of a different race/ethnicity than your own. We will ask some or all of you to describe a case so the group can analyze it.**
3. **We would like you to use one of the communication strategies we've talked about today with your patients during the coming week. You might want to pick a skill that you don't currently use extensively. You can use it with asthma patients and other patients, too. We're especially interested in your experience with patients from different racial/ethnic groups than your own. We will review your experience when we meet next week.**
4. **Use the self-rating scale in your binder by assessing your behavior when interacting with families during asthma consultations. We will be discussing this during the next session.**

Before you leave I have a few reminders:

1. Don't forget Part 2 of the PACE seminars is _____ at _____.
2. Remember that you must attend the entire Part 2 seminar as a prerequisite for your CME credits.
3. You won't want to miss this next seminar because we will be discussing additional aspects of asthma management.

Thanks for coming, see you next week!

Session 2

Session 2, Segment 1
Review of Communication Skills & Self-Rating Scale

TIPS FOR INSTRUCTORS- *BEHAVIORAL SCIENTIST/ASTHMA SPECIALIST*

THE MAIN POINTS TO CONVEY IN THIS SEGMENT ARE:

1. Review the key points that were discussed last week and introduce the sixth point of considering the patient's social and cultural experience in elements of counseling and developing the treatment plan.

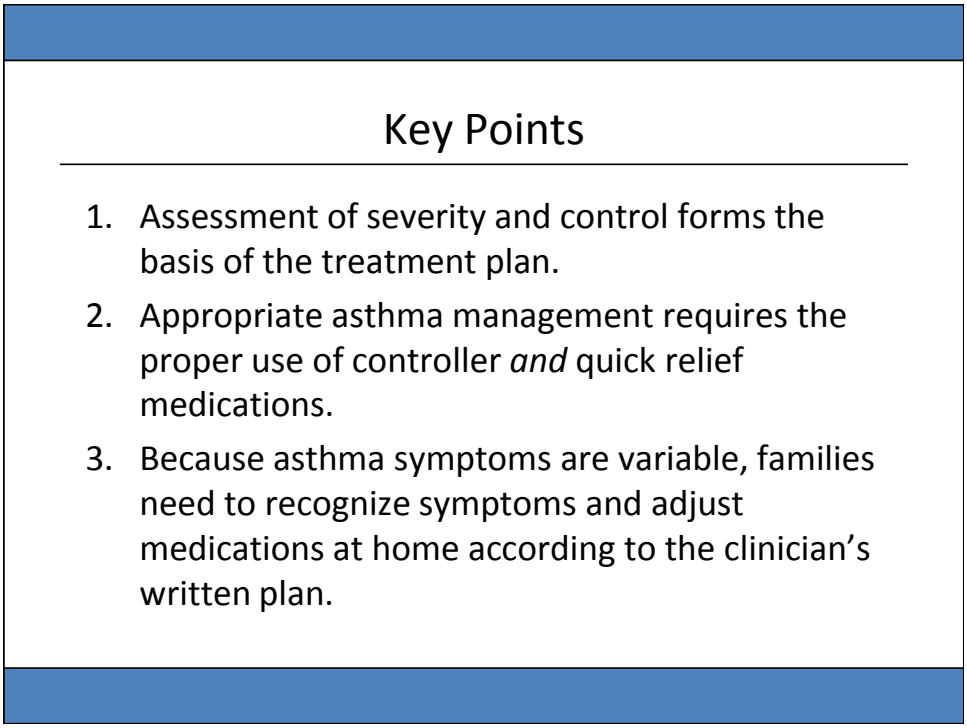
2. Encourage physicians to reflect on their experiences in implementing the communication strategies reviewed last week into their practice.

3. Encourage physicians to reflect on their experiences in using the Physician's Self-Rating Scale on Interactions with the Family.

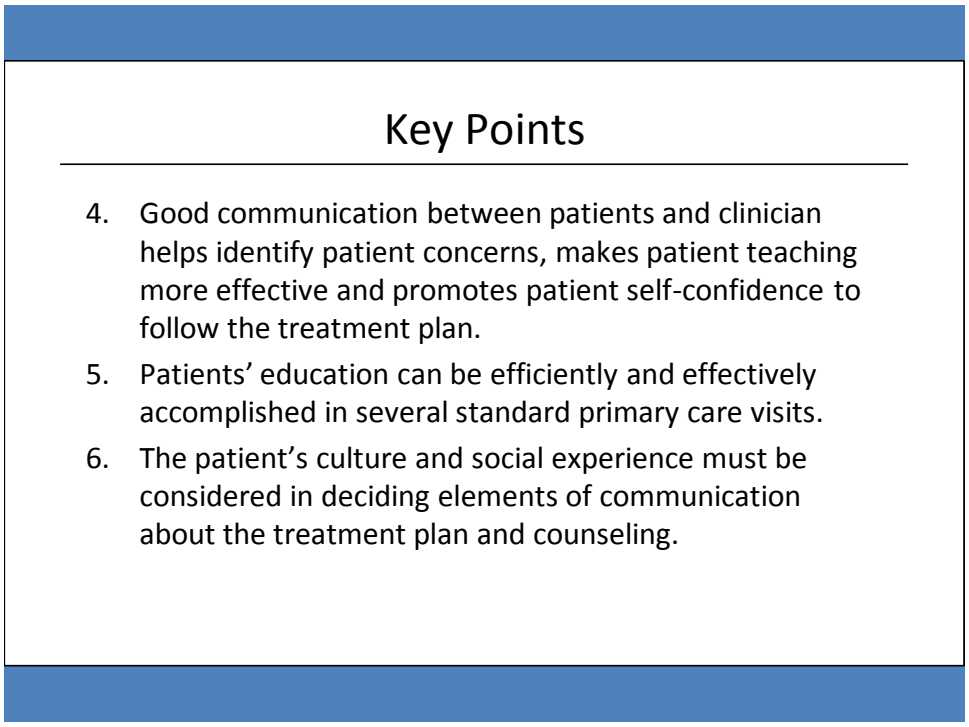
Session 2, Segment 1

SUGGESTED SCRIPT – *PRIMARY CARE PHYSICIAN/ASTHMA SPECIALIST* **(5 minutes)**

Welcome back! Today we are going to focus on working with examples of asthma patients who are of a different race/ethnicity than your own. After this, you will have a chance to discuss some specific asthma cases. First, let's review the six key points again from last week and introduce the sixth point that we'll emphasize today:



Slide 1



Slide 2

ADDITIONAL COMMENTS

- Now, we'll turn the presentation over to *(Behavioral Scientist/Health Educator's Name)*

REVIEW OF COMMUNICATION SKILLS AND SELF-RATING SCALE

INSTRUCTIONS:
See Physician's Self-Rating Scale on Interactions with the Family in Appendix 3.

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR* **(10 minutes)**
Please turn to the Communication section in the binder in front of you. It has a list of the key messages we talked about last time. You can use this, as well as the handout describing the messages in more detail to help you see if you have covered all the messages you planned to in each visit.

DISCUSSION QUESTIONS:

1. Did any of you use the self-rating scale to assess your communication following a visit with a patient or two during the past week? Did you see any communication strengths or weaknesses? Are there any changes you could introduce based on the communication principles we discussed last time?

2. Did any of you try using one of the communication skills we talked about last time? How did it go? Anyone else?

3. Did any of you try to use the asthma guideline charts on asthma severity, control, and step-wise treatment? How did it go? Anyone else?

INSTRUCTIONS:
Try to allow each person who tried one of the skills to say what he or she did. Emphasize learnings from interaction with patients of a different culture than the clinician.

4. What were your experiences using the self-rating scale?

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR*
It takes a combination of communication strategies and asthma messages to prepare the family to accept asthma and manage it effectively at home. All of these messages make an important contribution to the family's ability to control asthma and follow your treatment plan. And as you have said, it isn't really possible to deliver them all in one visit. We think this justifies scheduling a series of visits with patients who are having difficulty controlling asthma, or who you haven't seen for a while, to review their treatment plan and provide them with the teaching they need to control asthma.

Session 2, Segment 2

Patient Asthma Education

TIPS FOR INSTRUCTORS- *BEHAVIORAL SCIENTIST/ASTHMA SPECIALIST*
(29 minutes)

***The behavioral scientist will facilitate this section and the asthma specialist is encouraged to contribute to the clinical aspects of the discussions.

THE MAIN POINTS TO CONVEY IN THIS SEGMENT ARE:

1. There is a basic core of information that the patient needs in order to manage asthma effectively.
2. It is possible to convey these messages within the time constraints of a busy practice.
3. Using images and metaphors can increase the patient's understanding of medical concepts.

Clinicians may protest that they do not have time for the kind of comprehensive patient education depicted in the video. It is probably not realistic to expect clinicians to cover everything in one visit. Stress that the messages can be given to patients over a series of visits, and if they are incorporated into the visit, need not take up an excessive amount of time. Also, remind them that patient education up-front can lead to less investment of time in the long run because patients will be better able to manage on their own and follow-up visits will be much easier.

Remember to model the communication strategies (open-ended questions, interactive conversation etc.)

Give participants positive reinforcement if they report using the strategies. Ask them to describe their experience. Ask if anyone else has tried the same strategy.

NOTE: There are pauses after each of the three sections of the video to enable you to stop the tape and discuss the points made.

Patient Asthma Education

INTRODUCTION AND VIDEO PRESENTATION

 **SUGGESTED SCRIPT –** *PRIMARY CARE PHYSICIAN/ASTHMA SPECIALIST*

Now we are going to focus on patient education: the key messages that you need to convey to the family so they can manage asthma effectively at home.

 **SUGGESTED SCRIPT –** *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR*

In order to effectively manage asthma at home, patients must accept and act on the asthma messages you give them. If you haven't heard from some of your asthma patients in a long time, or know of some who have been experiencing symptoms, a good argument can be made for contacting the families and scheduling a series of visits to get them on track. You can begin by first ensuring they are on the right regimen, and second by providing the needed basic education, while keeping in mind principles of cross-cultural communication. As we have said, this up-front investment is well worth it down the road. Asthma education has been shown to reduce the need for emergency visits and hospitalizations among children with a history of such health care use, and also to help children do better in school.

To start our discussion, we are going to watch a second video. This video presentation outlines the core of basic messages the patient and family need to receive in order to manage asthma well at home. The video does not depict the entire proceedings of each visit (i.e., the physical exam). Rather, it provides an overview of the messages the families need.

The clinician in the video spreads the educational messages over three visits so that he can provide sufficient information about each topic. In actual practice, of course, the messages don't have to be spread over three visits- it may take more or less- nor do they have to be delivered in the order presented in the video. It is best to use your judgment about the family's need or interest to determine the order of the messages.

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST*

We will pause in between each of the three sections of this video to discuss the messages the clinician has conveyed. At the end of the third segment of the video, we'll discuss the feasibility of this kind of patient education and the ways that you have found you can be most effective in educating your patients.

All of the messages in the video are on a handout in your binder, so you do not need to take notes.

INSTRUCTIONS

- Show Video Part 2, Section 1- "Patient Visit: Offering Basic Information". **(5 minutes)**
- Pause video after Section 1 for discussion.
- Discuss Section 1 briefly. **(5 minutes)**

SUGGESTED SCRIPT- *BEHAVIORAL SCIENTIST*

In this visit, Dr. Esser focused on teaching the family about:

- What happens during an asthma attack
- How medicines work
- How to take the medicines
- How to respond to changes in asthma severity

DISCUSSION QUESTION FOR VIDEO PART 2 SECTION 1- *BEHAVIORAL SCIENTIST*

Now each of you has a lot of experience delivering asthma messages.

1. Are there any ways you have found to deliver these messages that are effective or help your patients understand asthma or learn what they need?

2. Are there differences in how diverse patient groups respond to your messages?

   Note to facilitator: In discussion, reinforce principles of cross-cultural communication presented in slides 16-22 in section 2.5 on cross-cultural communication.

INSTRUCTIONS

- Show video Part 2 Section 2- "Goals and Criteria of Successful Treatment". **(2 minutes)**
- Pause video after Section 2 for discussion.
- Discuss Section 2 briefly. **(5 minutes)**

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST*

In this visit, Dr. Esser focused on teaching the family about:

- Safety of medicines
- Goals of therapy
- Criteria for successful treatment

DISCUSSION QUESTION FOR VIDEO PART 2 SECTION 2- *BEHAVIORAL SCIENTIST*

1. Are there ways you have found to deliver these messages that are effective or help your patients understand asthma or learn what they need?

2. Are messages more or less difficult to deliver with particular groups of patients?
   Note to facilitator: In discussion, reinforce principles of cross-cultural communication presented in slides 16-22 in section 2.5 on cross-cultural communication.

INSTRUCTIONS

- Show video Part 2, Section 3- "Follow-up Patient Visit- Progress Report." **(5 minutes)**
- Pause video after Section 3 for discussion.
- Discuss how education depicted in video can be adapted to fit clinicians' own practices. **(5 minutes)**

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST*

In this visit, Dr. Esser focused on teaching the family about:

- Managing asthma at school
- Identifying and avoiding triggers
- Referral to further education

DISCUSSION QUESTION FOR VIDEO PART 2 SECTION 3- *BEHAVIORAL SCIENTIST*

1. What ways do you use to communicate about these topics to your patients?

2. How feasible is it to do this kind of comprehensive education with your patients?

3. What ways have you found to do this effectively in your settings?

WRAP UP – *BEHAVIORAL SCIENTIST*

SUGGESTED SCRIPT

A list of these key asthma messages are available in the communication section in your binder. We have also provided a checklist that you can keep for each patient to ensure adequate tracking of messages provided.

(Asthma Specialist's Name) will now present an asthma case that considers treatment across cultures.

Session 2, Segment 3

Tricky Case Presentation

INSTRUCTIONS- *ASTHMA SPECIALIST/BEHAVIORAL SCIENTIST*

- This segment requires preparation by the physician instructor. This case should be reviewed and salient issues identified to raise with participants in discussion.
- The behavioral scientist should contribute to the psychosocial, educational, and cultural aspects of the cases to assist the clinician.

SUGGESTED SCRIPT – *ASTHMA SPECIALIST* **(10 minutes)**

CASE

Mrs. Perez is a Puerto Rican mother who brings her 10-year old daughter, Fernanda, in to see you. Fernanda has a history of numerous asthma hospitalizations and emergency department visits over the past year. You find that Fernanda uses her medications faithfully as prescribed by her prior physician and even uses a spacer with her combination (inhaled steroid-LABA) medication. Mom had heard that asthma is a type of nervous condition and was worried that Fernanda had been misdiagnosed. Mom went to the local Botanica owner six months ago, who confirmed her suspicions and gave Fernanda herbal remedies to treat her symptoms. Fernanda's grandmother, who is also one of Fernanda's caretakers, often takes Fernanda to her clinical appointments. Grandmother has a history of severe depression and memory loss. She has determined that Fernanda is in very poor health and has insisted that the family switch to you as Fernanda's doctor.

DISCUSSION QUESTIONS (*BEHAVIORAL SCIENTIST/ASTHMA SPECIALIST*)

1. (BS) Who is the decision maker in the family regarding Fernanda's treatment?

   Fernanda's grandmother appears to be the decision-maker or at least an important decision-maker.

2. (AS) What are the family's beliefs about controller medicine?

   Although Fernanda uses her medication as prescribed, Mrs. Perez's beliefs about the controller medicine may be that they are not working because she believes that Fernanda has the wrong diagnosis. These beliefs could erode Fernanda's adherence.

3. (AS) How independent is Fernanda when using her medicine (i.e. how closely does a family member supervise her?)

   From the information provided, it is not clear how independent Fernanda is in using her medicine and further questioning may make this more clear. This information is important for targeting communication.

4. (BS) What are other issues that influence control of Fernanda's asthma?

   Grandmother's depression and memory loss; beliefs and practices of Botanica personnel. These issues can be ameliorated in patient communication and education.

5. (AS) What are your next steps?

   Reviewing asthma medications, adherence, frequency, and delivery techniques are important. In this case, upon further questioning, Fernanda is using a dry-powder inhaler (DPI) with her spacer. This is preventing delivery of any medication to her lungs.

Session 2, Segment 4

Cross-Cultural Communication

TIPS FOR INSTRUCTORS

The Cross-Cultural Communication component is designed to help clinicians enhance the priority skills posited by experts as essential when working cross-culturally, specifically as they relate to African American and Latino/Hispanic patients.

The main points and objectives of the segment are to:

1. Draw attention to important aspects of interacting with patients of a different race/ethnicity, emphasizing care for African American and Latino/Hispanic patients.

2. Increase clinicians comfort in working across cultures.

3. Provide guidelines for cross-cultural communication and counseling regarding asthma.

4. Enable clinicians to discern in apparently routine cases the potential cultural influences on patients' views and practices.

5. Enable application of specific techniques and approaches, i.e. use culturally appropriate skills for communication and counseling.

6. Encourage physicians to periodically check their cross-cultural communication approaches and areas to self correct.

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR*

In the first session we examined clinical aspects of asthma and ways to counsel effectively.

In this session we'll focus on cross-cultural communication and on how to use strategies to deliver important asthma educational messages.

The session comprises a mini lecture, discussion, video and introduction to a physician self-assessment tool.

The content in this session reflects the validated recommendations on curriculum content related to cross-cultural communication provided by the Association of American Medical Colleges.

OBJECTIVES

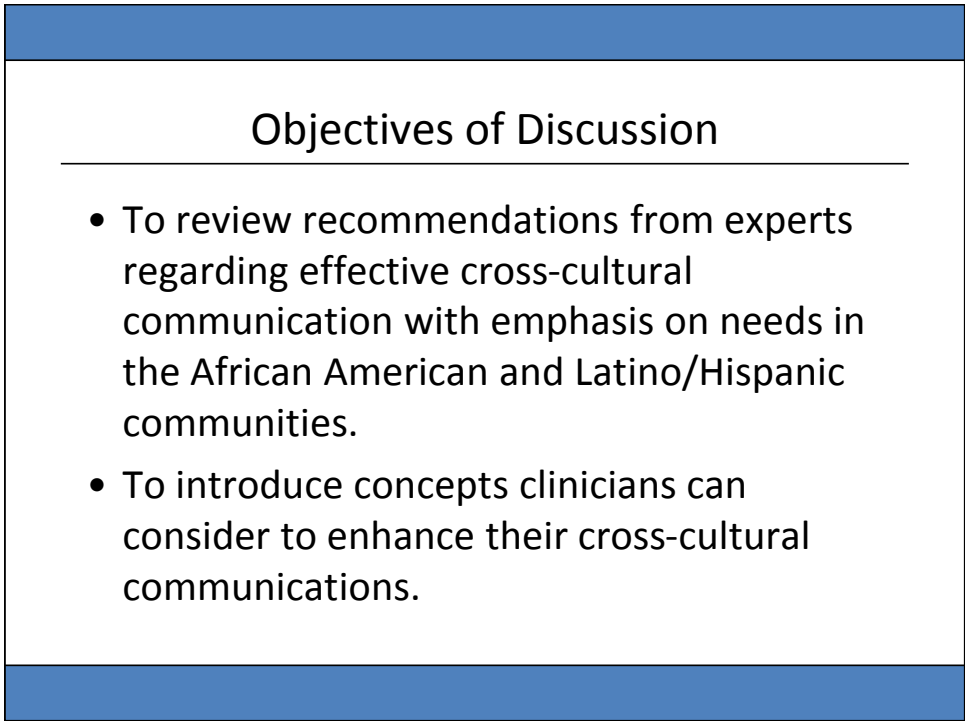
a. To highlight important aspects of interacting with patients when they are of a different race/ethnicity than the clinician, emphasizing care for African American and Latino/Hispanic pediatric patients.

b. To help clinicians feel more comfortable working across cultures.

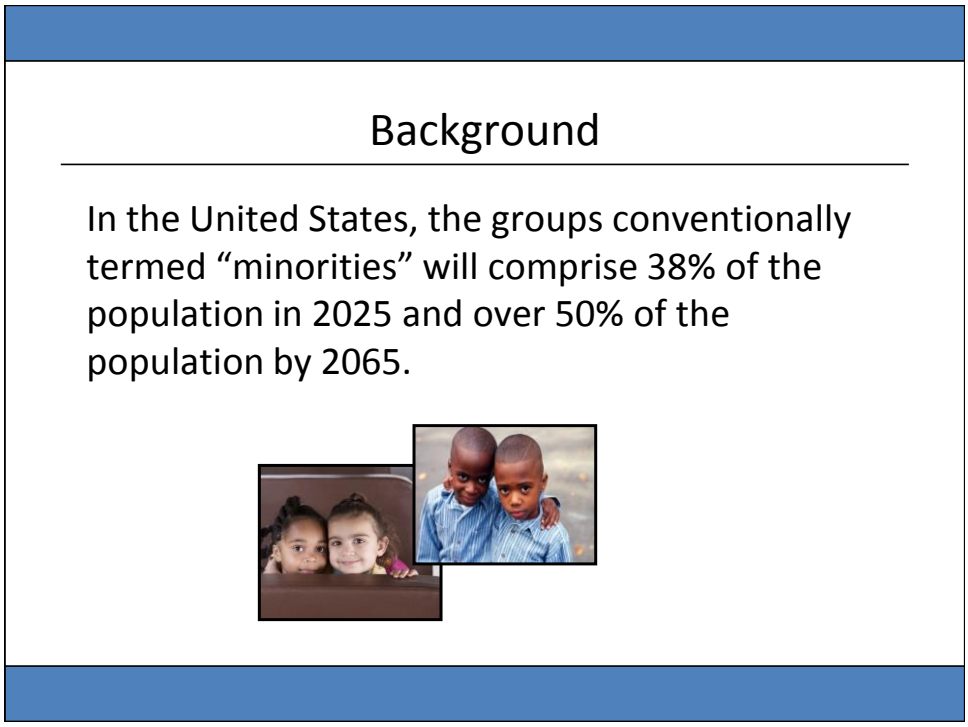
c. To provide guidelines for cross-cultural communication and counseling regarding asthma.

SLIDE PRESENTATION – *BEHAVIORAL SCIENTIST*

First I will review some principles when working cross-culturally, especially with African American and Latino/Hispanic families.



Slide 1

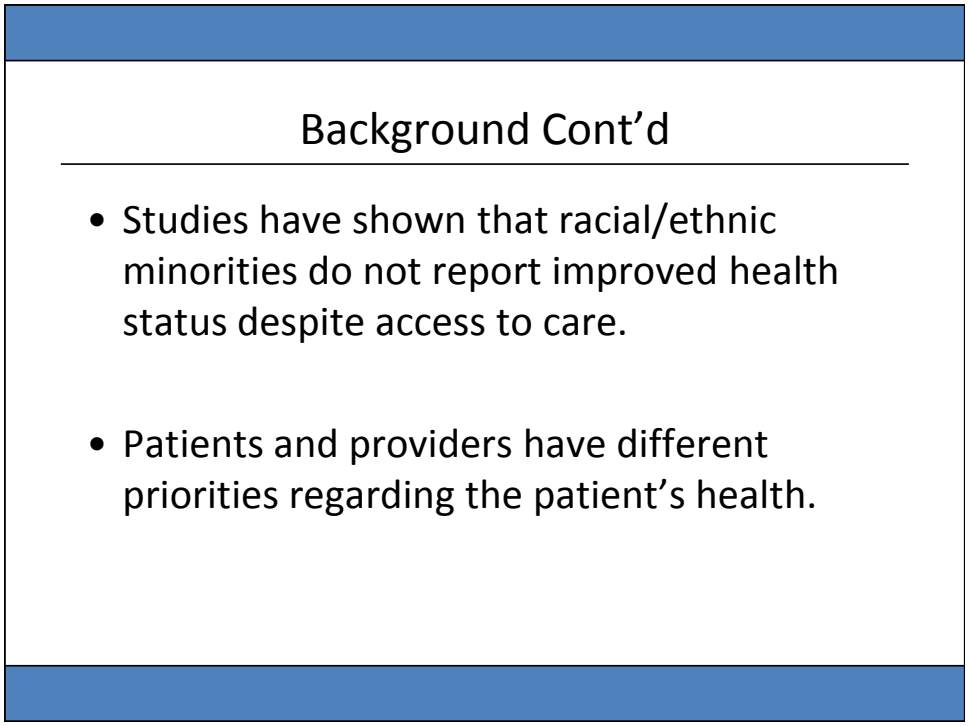


Slide 2

ADDITIONAL COMMENTS

Reference:

U.S. Census Bureau. (2000). *U.S. Populations Projections.* Retrieved from http://www.census.gov/population/www/projections.index.html



Slide 3

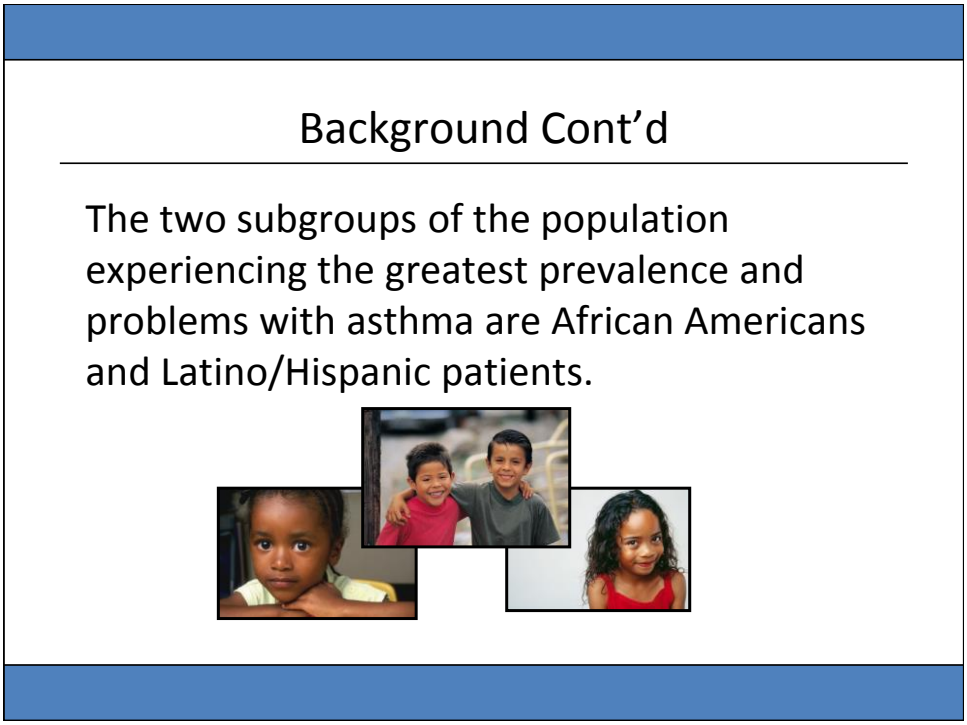
ADDITIONAL COMMENTS

References:

Zhu, J., Brawarsky, P., Lipsitz, S., Huskamp, H., & Haas, J. S. (2010). Massachusetts health reform and disparities in coverage, access and health status. *Journal of General Internal Medicine,* 1-7.

Stewart, K. A., Higgins, P. C., McLaughlin, C. G., Williams, T. V., Granger, E., & Croghan, T. W. (2010). Differences in prevalence, treatment, and outcomes of asthma among a diverse population of children with equal access to care: Findings from a study in the military health system. *Archives of Pediatrics & Adolescent Medicine, 164*(8), 720-726.

Zulman, D. M., Kerr, E. A., Hofer, T. P., Heisler, M., & Zikmund-Fisher, B. J. (2010). Patient-provider concordance in the prioritization of health conditions among hypertensive diabetes patients. *Journal of General Internal Medicine, 25*(5), 408-414.



Slide 4

ADDITIONAL COMMENTS

- The fastest growing sub-group of the United States population is Latino-Hispanic.

- These subgroups have experienced severe negative consequences from members of the medical community. Examples include:
  - African Americans: Tuskegee syphilis studies
  - Puerto Ricans: Massive sterilization of females
  - Guatemalans: Sexually transmitted infection studies

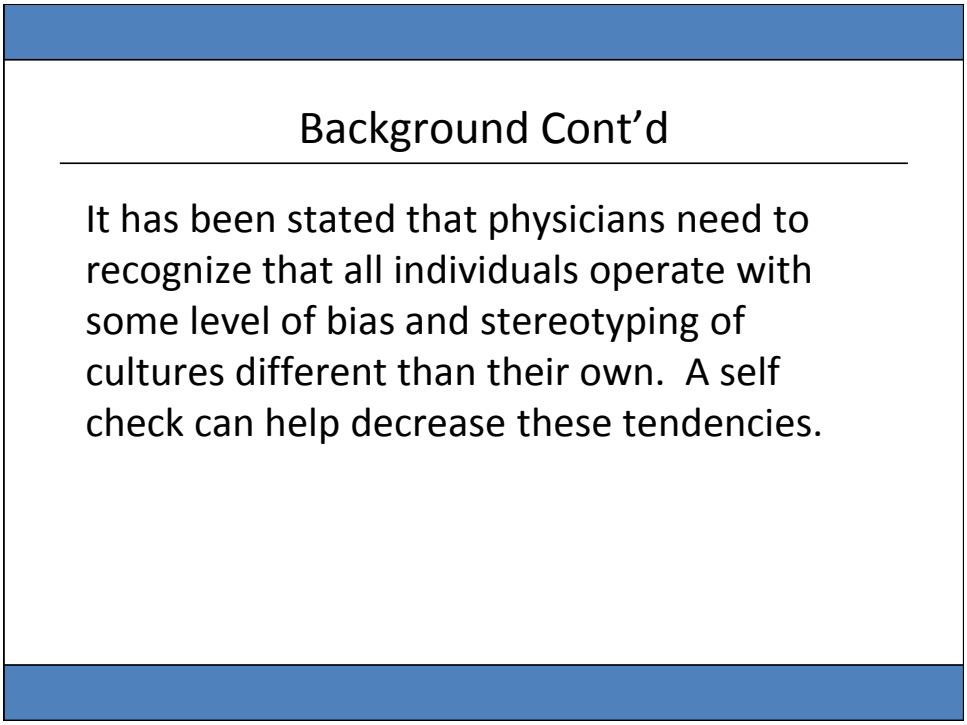
Reference:

Centers for Disease Control and Prevention. (2005). *National Health Interview Survey (NHIS) Data*. Retrieved from http://www.cdc.gov/asthma/nhis/05/data.htm

Stycos, J.M. (1984). Sterilization in Latin America: Its past and its future. *International Family Planning Perspectives*, 10 (2), 58-64.

Thomas, S.B., Quinn, S.C. (1991). The Tuskegee syphilis study, 1932 to 1972: Implications for HIV education and AIDS risk education programs in the black community. *American Journal of Public Health*, 81 (11), 1498–1505

Reverby, S.M. (2011). "Normal exposure" and inoculation syphilis: A PHS 'Tuskegee' doctor in Guatemala, 1946-1948. *Journal of Policy History*, 23(1), 6-28.



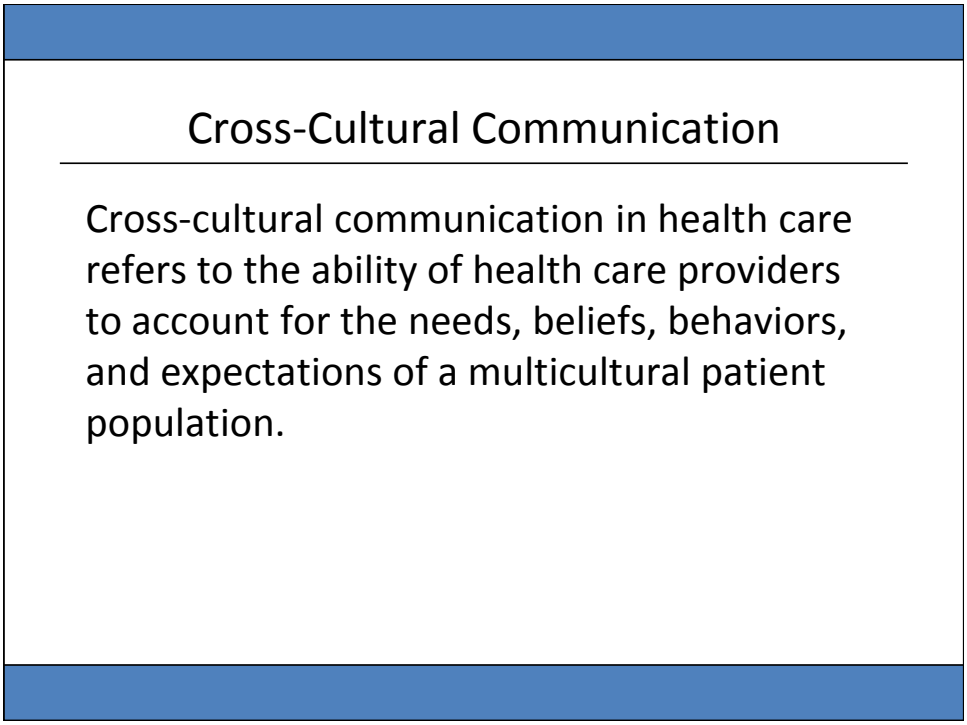
Slide 5

ADDITIONAL COMMENTS

- Let's focus on how to interact with families when they are of a different race, ethnicity, or culture than yours.
- Self check means taking time to assess one's real or potential biases.

Reference:

Roter, D. (2000). The medical visit context of treatment decision-making and the therapeutic relationship. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy, 3*(1), 17-25.

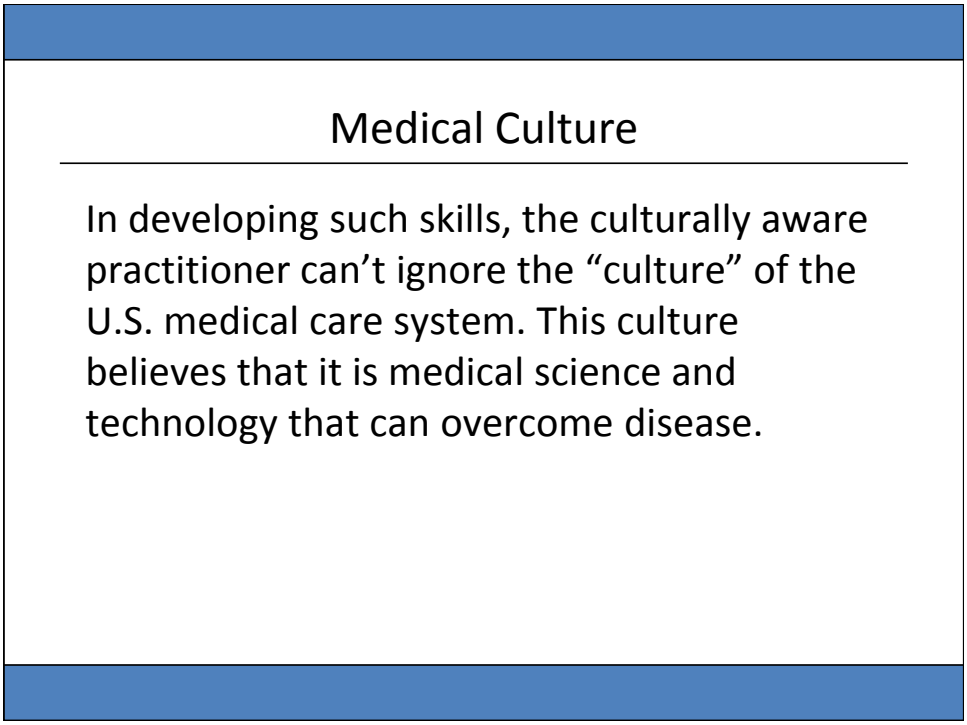


Slide 6

ADDITIONAL COMMENTS

Reference:

Betancourt, J. R. (2006). Cultural competence and medical education: Many names, many perspectives, one goal. *Academic Medicine: Journal of the Association of American Medical Colleges, 81*(6), 499-501.

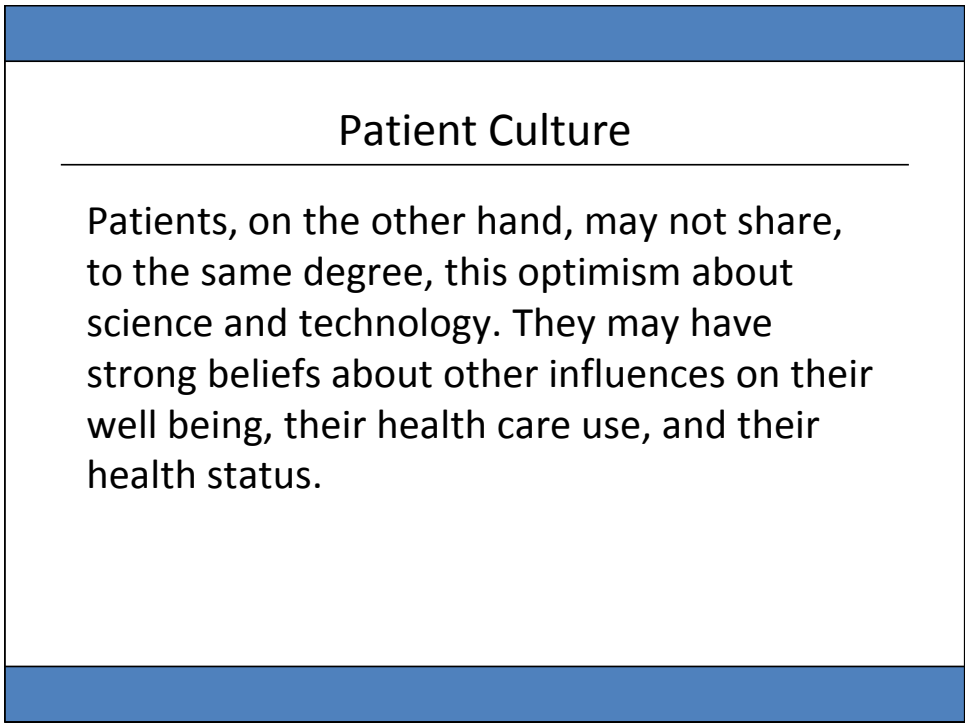


Slide 7

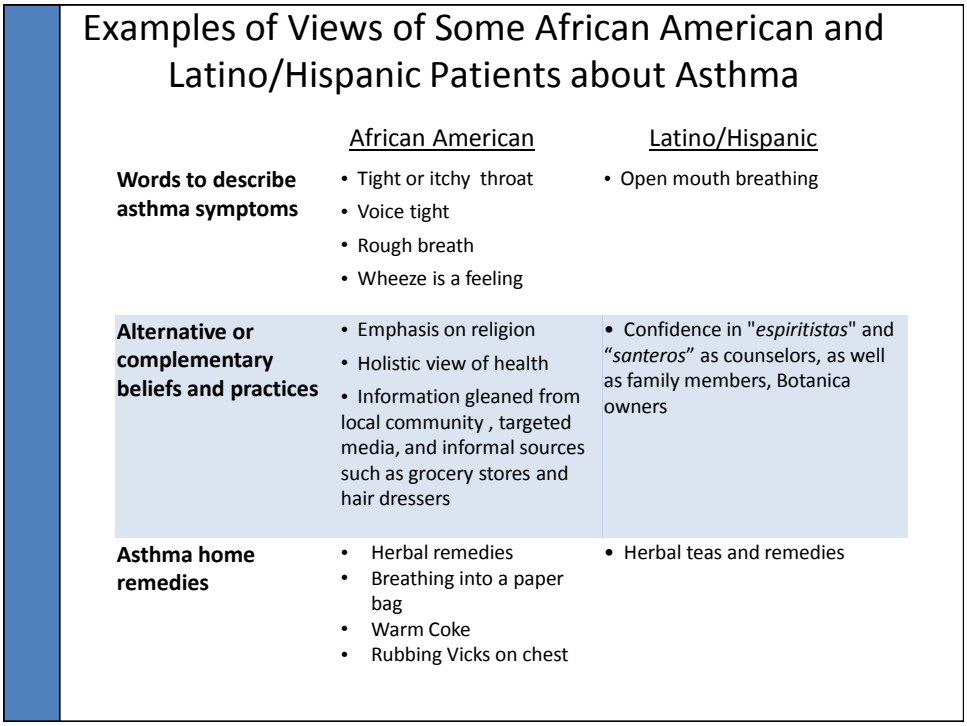
ADDITIONAL COMMENTS

Reference:

Eisenberg, D. M. (2005). The Institute of Medicine report on complementary and alternative medicine in the United States - Personal reflections on its content and implications. *Alternative Therapies in Health and Medicine, 11*(3), 10-15.


Patient Culture
Patients, on the other hand, may not share, to the same degree, this optimism about science and technology. They may have strong beliefs about other influences on their well being, their health care use, and their health status.

Slide 8



Slide 9

ADDITIONAL COMMENTS

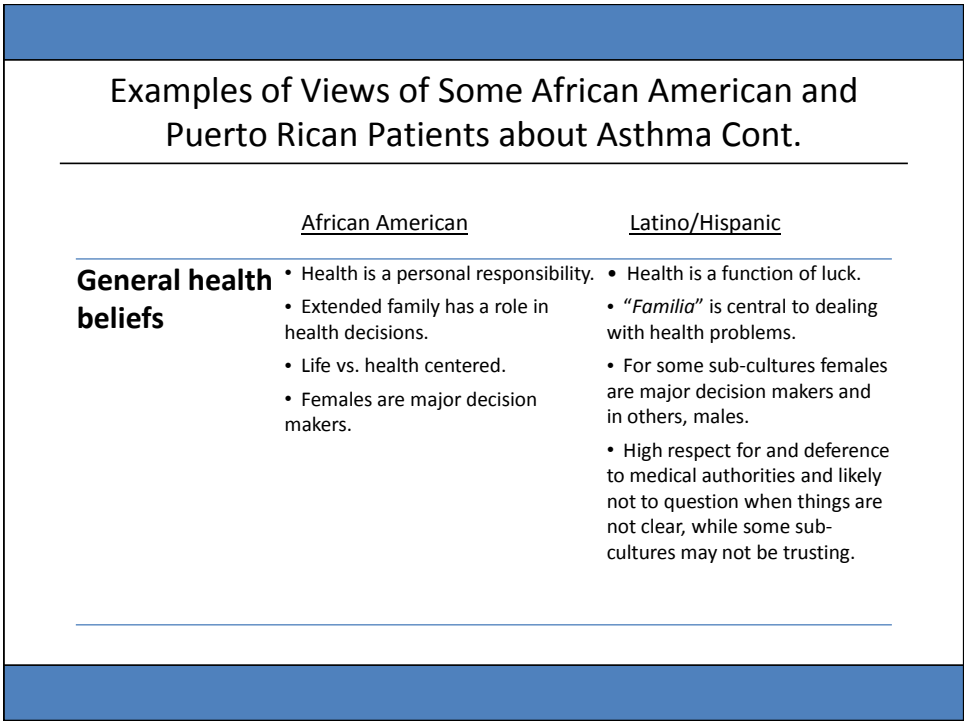
- Here are views observed among a number of African Americans and in Latino/Hispanic people.
- African American and Latino/Hispanic are not monolithic groups and within these populations, there is great diversity.
- Recent studies have shown that words used by patients to describe asthma symptoms are not necessarily synonymous with common clinical terms for symptoms, such as wheeze.
- Influences can be spiritual, social, traditionally accepted, and sometimes are addressed using alternative remedies.
- NOTE TO FACILITATOR: Each of the major points will fade in during the presentation as they are presented. You will need to hit return on the keyboard for the next point to appear.

References:

Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics, 136*(1), 14-23.

George, M. (2001). Culturally-Competent Asthma Education. *Association of Asthma Educators*. Retrieved from: www.asthmaeducators.org

Houle, C. R., et al. (2010). Blowing the whistle: What do African American adolescents with asthma and their caregivers understand by "wheeze?". *The Journal of Asthma : Official Journal of the Association for the Care of Asthma, 47*(1), 26-32.



Slide 10

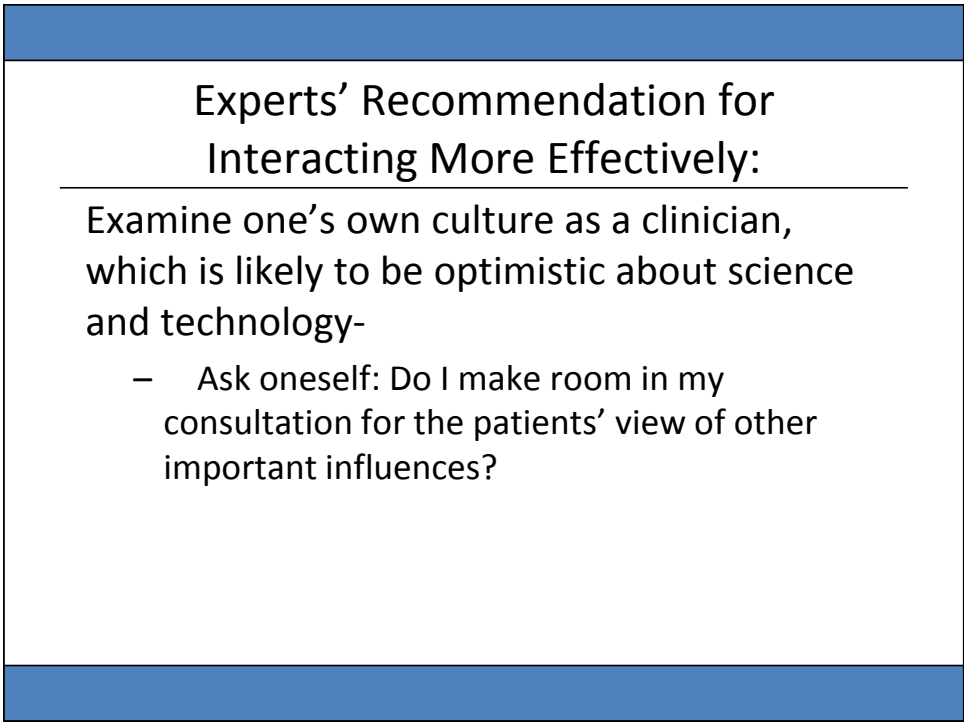
ADDITIONAL COMMENTS

- In Mexican and Dominican cultures, males are considered major decision makers. In Puerto Rican cultures, females are major decision makers.
- As we know, health beliefs will influence what patients do about asthma.
- Are there other examples from the cultures of patients you see?

References:

Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics, 136*(1), 14-23.

George, M. (2001). Culturally-Competent Asthma Education. *Association of Asthma Educators*. Retrieved from: www.asthmaeducators.org



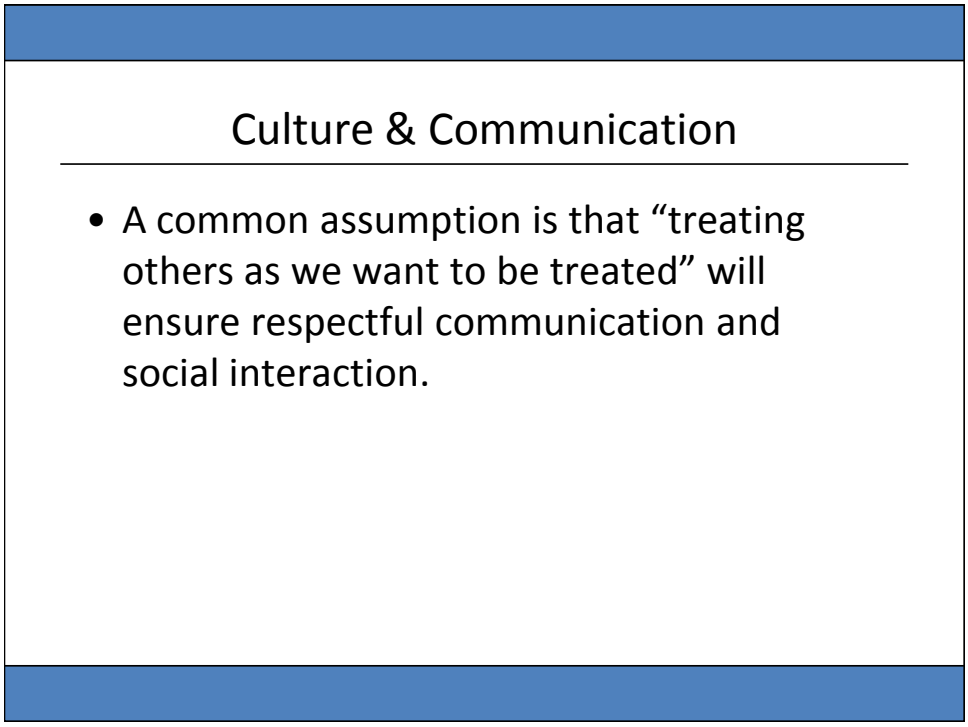
Slide 11

ADDITIONAL COMMENTS

- The task is to engage in a process that makes optimum the opportunity to help the particular patient and the health care provider to achieve their goals.

Reference:

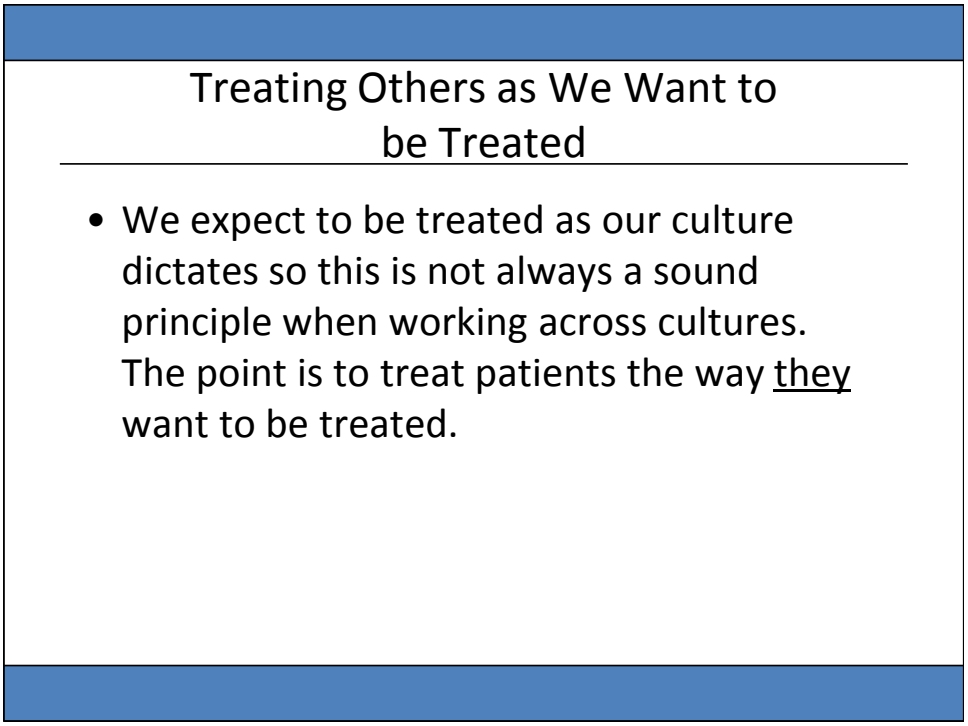
Betancourt, J. R. (2006). Cultural competence and medical education: Many names, many perspectives, one goal. *Academic Medicine: Journal of the Association of American Medical Colleges, 81*(6), 499-501.



Slide 12

ADDITIONAL COMMENTS

- What do you think of this statement?


Treating Others as We Want to be Treated
• We expect to be treated as our culture dictates so this is not always a sound principle when working across cultures. The point is to treat patients the way they want to be treated.

Slide 13

Video Demonstration

SUGGESTED SCRIPT – *BEHAVIORAL SCIENTIST/HEALTH EDUCATOR*

We are now going to watch a video. This video presentation is designed to illustrate physicians working with African American and Latino/Hispanic children with asthma (and their parents) and how they incorporate principles of cross-cultural communication in their delivery of asthma care. The video does not depict the entire proceedings of each visit (i.e., the physical exam). Rather, it provides an overview of techniques that are appropriate and not appropriate when working cross-culturally. It is best to use your judgment about the family's needs or interest to determine the order of the messages.

 **SUGGESTED SCRIPT –** BEHAVIORAL SCIENTIST /HEALTH EDUCATOR

All of the behavioral messages in the video are on a handout in your binder, so you do not need to take notes.

Vignette #1

 **Instructions**

- Show Video vignette #1- "What not to do"
- Pause video after vignette 1 for discussion. Be sure to pause video at **2:28** before the "Points to Remember."
- Discuss vignette 1 **briefly**. Go through the discussion questions below **(suggested time: 5 minutes)**

Discussion Question:

1. What did you like about how the physician counseled the family?

2. In what ways could the interaction have been improved?

    - *The physician appeared too familiar when he slapped the grandfather's back and leg.*

    - *The physician could have taken more time to learn the names of the patient and grandfather (he called the boy Jamal and the grandfather "Fred" when he had actually introduced himself as "Fredrick", and his grandson as "Jamar")*

    - *The physician could have more gently inquired about the family's asthma management practices rather than sternly lecturing the family.*

    - *The physician assumed that the grandfather was responsible for making health care decisions for Jamar. He could have asked the family who should be involved in decision making.*

    - *The physician assumed that Jamar wasn't paying attention because he saw him looking down. In some cultures, it may not be appropriate for children to look directly at adults.*

    - *The physician overestimated the study data that appeared to confuse the family. If scientific information is not relevant to the counseling issues, it can be left out.*

    - *The physician framed Jamar's asthma to be fatal. He could have softened this information by providing encouragement first.*

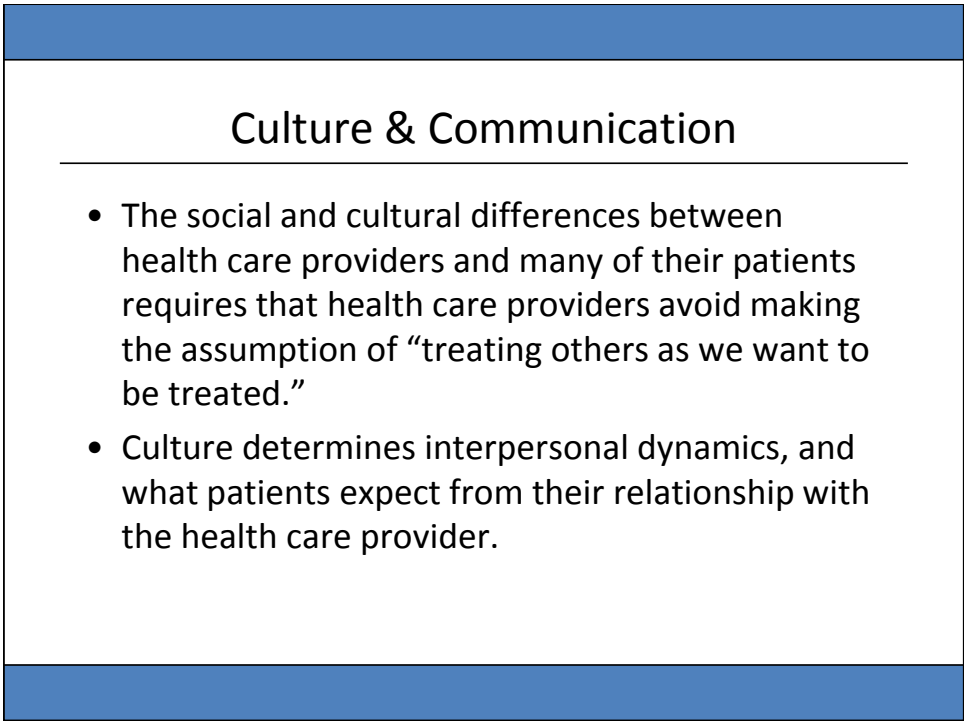
3. Is there a different approach you would have taken?

4. What principles of cross-cultural communication were evident (or not) to you?

    - *Try not to be too familiar.*
    - *Don't neglect to learn the name of the patient (and parent) even if hard to pronounce.*
    - *Don't discount family practices if not harmful.*
    - *Find out who the decision maker is in the family.*
    - *Don't expect same nonverbal responses you'd give.*
    - *Don't over represent study data.*
    - *Don't give a bad news message without a good news message.*

 **Instructions**

- Resume video at **2:30** and show "Points to Remember." (dvd will go back to the main menu)
- Continue presentation with slides 14 and 15



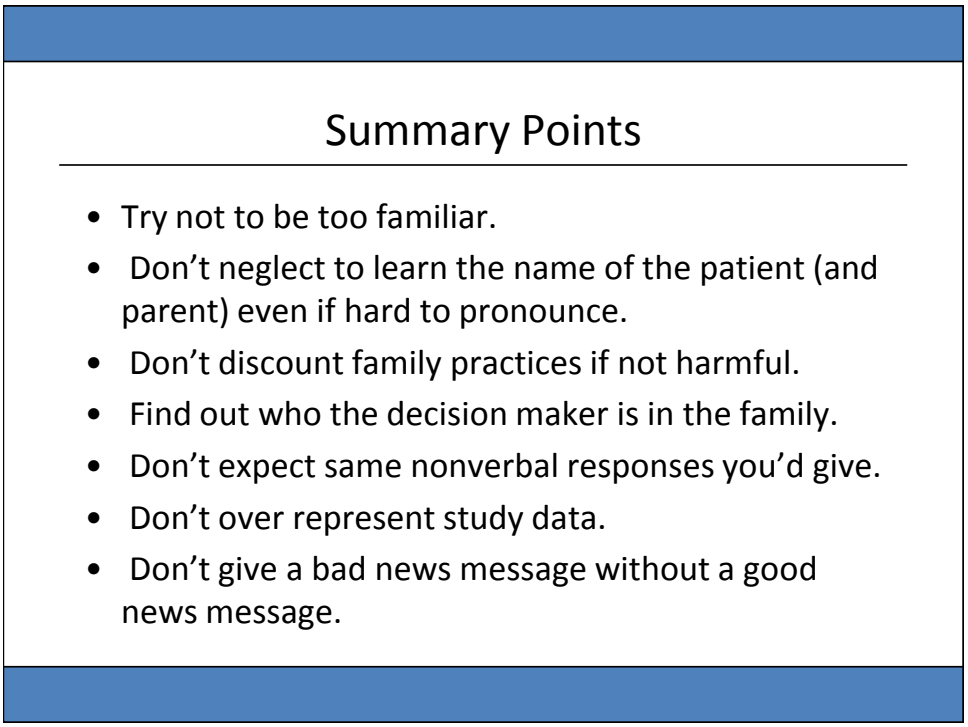
Slide 14

ADDITIONAL COMMENTS

- A number of strategies have been recommended by experts to increase one's ability in cross-cultural communication.

Reference:

Salimbene, S. (2000). *What Language Does Your Patient Hurt in? A Practical Guide to Culturally Competent Patient Care*. St. Paul, MN: Diversity Resources.



Slide 15

ADDITIONAL COMMENTS

Examples:

- Body contact
  - Latino/Hispanic- Common
  - African American- Comfortable with close personal space
  - Native American- Touch is not appropriate until a relationship is established
  - Chinese- Distance is appropriate for personal space
  - Muslim/Arab- Not appropriate across genders

References:

The Manager's Electronic Resource Center. The Provider's Guide to Quality and Culture. Retrieved from http://erc.msh.org/mainpage.cfm?file=5.1.0.htm&module=provider&language=English

Purnell, L. D. (2009). Guide to culturally competent care. F.A. Davis Company.

Rundle, A., Carvalho, M. & Robinson, M. (Eds.) (1999). Cultural competence in health care: A practice guide. San Francisco, CA: John Wiley & Sons, Inc.

University of Michigan Health System. (2010). *Program for Multicultural Health*. Retrieved from http://www.med.umich.edu/multicultural/ccp/culture/culture.htm

SUGGESTED SCRIPT – BEHAVIORAL SCIENTIST/HEALTH EDUCATOR

Now we are going to watch the second vignette.

Vignette #2

Instructions

- Show vignette #2- "What to do"
- Pause video after vignette 2 for discussion. Be sure to pause video at **2:06** before the "Points to Remember."
- Discuss vignette 2 **briefly.** Go through the discussion questions below **(suggest time: 5 minutes).**

Discussion Questions:

1. In what ways was the interaction improved?
    - *The physician asked the family about their preferred language from the start.*
    - *The physician gently inquired about alternative strategies the family is using to manage asthma.*
    - *The physician incorporated the family's alternative practices into the treatment plan.*
    - *The physician asked the family if anyone else should be informed of Marisol's treatment plan.*
    - *The physician offered to accommodate Marisol's grandmother by calling her and speaking to her in the language she is most comfortable with.*
2. Is there a different approach you would have taken?
3. What principles of cross-cultural communication were evident (or not) to you?
    - *Confirm the preferred language- if not your language, ensure a translator is available.*
    - *Invite conversation about alternative methods of treatment.*
    - *Integrate non harmful practices and your treatment recommendations.*
    - *Inquire regarding who else you should communicate with about the treatment plan.*

- *Assuming the family is listening even when usual signs of attention may not be evident.*
    - *Eye contact*
        - *Latino/Hispanic- Typically valued, though more traditional, less acculturated people of Mexican heritage may not maintain eye contact*
        - *African American- Intense eye contact may be seen as aggressive*
        - *Native American- Considered rude*
        - *Muslim/Arab- Eye contact is maintained*

4. What are your reactions to the reference of the decision maker in this family?

 **Instructions**

- Resume video at **2:10** and show "Points to Remember." (dvd will go back to the main menu)
- Continue presentation with slides 16 and 27

SUGGESTED SCRIPT – BEHAVIORAL SCIENTIST/HEALTH EDUCATOR

Let's summarize some strategies to consider.

Strategies

- Begin by being friendly, but formal, when the patient is from another culture (e.g. use surnames).
- Don't wait for the usual signs of attention (eye contact or questions). Present your advice clearly and simply, assuming the person is with you.

Slide 16

ADDITIONAL COMMENTS

Examples:

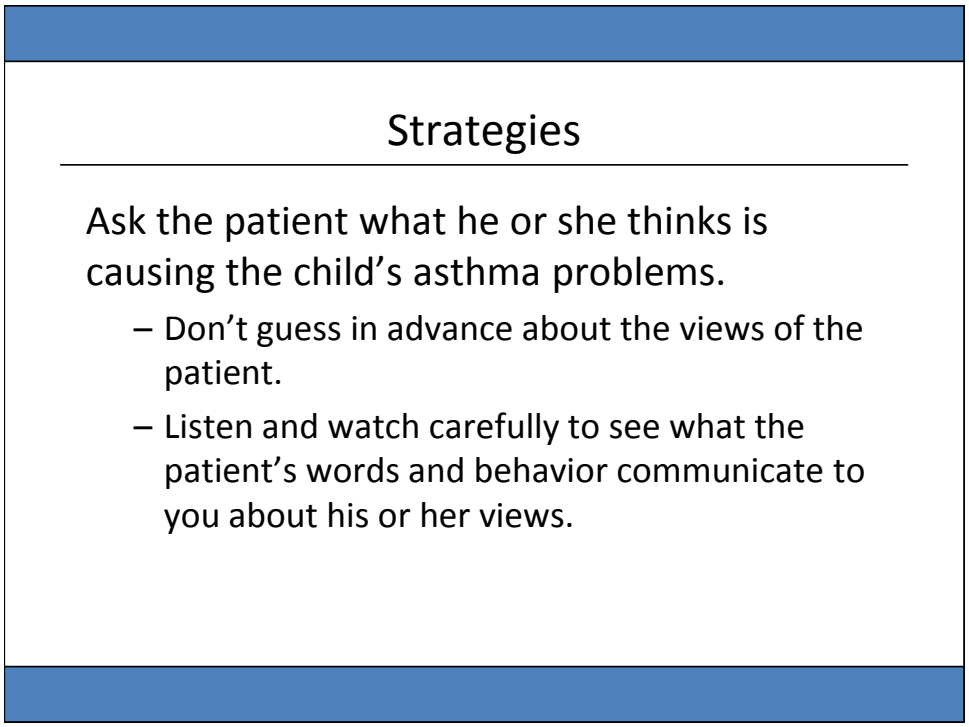
- Signs of attention and communication styles:
  - Latino/Hispanic- Value *simpatía* (sympathy, courtesy, respect) and *personalismo* (personalism, intimacy)
  - African American- Dynamic speech and gestures and/or facial expressions
  - Native American- Attentive listening skills and they expect a period of silence before answering questions to demonstrate consideration and support
  - Chinese: Avoid "yes or no" questions as the typical response is yes, even when the patient may not have understood fully. Active listening is key.
  - Muslim/Arab- Unspoken queues are often as important or more important than what is said (etiquette and body language are important); speech is expressive
- The point is: don't be overly friendly until you understand the patient expectations.

References

Purnell, L. D. (2009). *Guide to culturally competent care.* F.A. Davis Company.

Rundle, A., Carvalho, M. & Robinson, M. (Eds.) (1999). *Cultural competence in health care: A practice guide*. San Francisco, CA: John Wiley & Sons, Inc.

University of Michigan Health System. (2010). *Program for Multicultural Health*. Retrieved from http://www.med.umich.edu/multicultural/ccp/culture/culture.htm

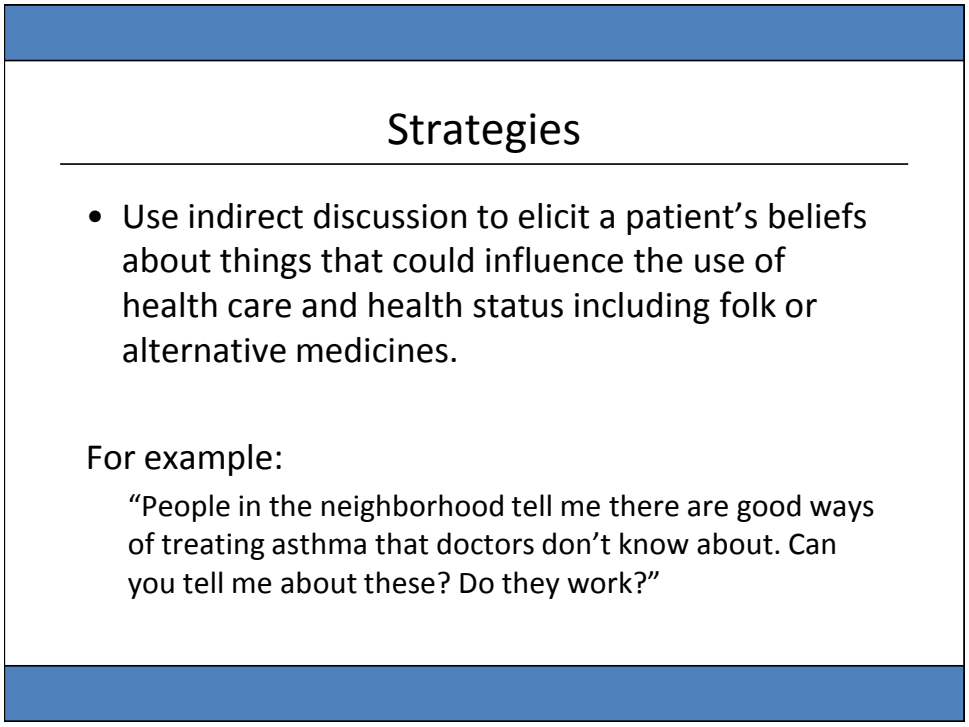


Slide 17

ADDITIONAL COMMENTS

Reference:

Salimbene, S. (2000). *What Language Does Your Patient Hurt in? A Practical Guide to Culturally Competent Patient Care*. St. Paul, MN: Diversity Resources.



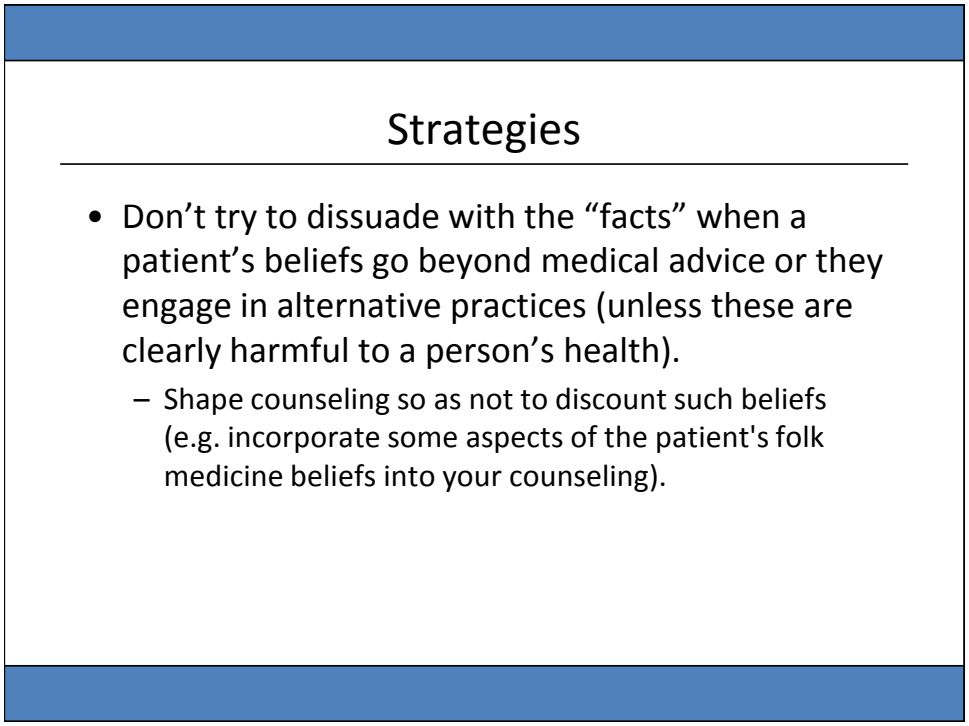
Slide 18

ADDITIONAL COMMENTS

- What are ways you discover health practices of patients from a different culture?

Reference:

Salimbene, S. (2000). *What Language Does Your Patient Hurt in? A Practical Guide to Culturally Competent Patient Care*. St. Paul, MN: Diversity Resources.



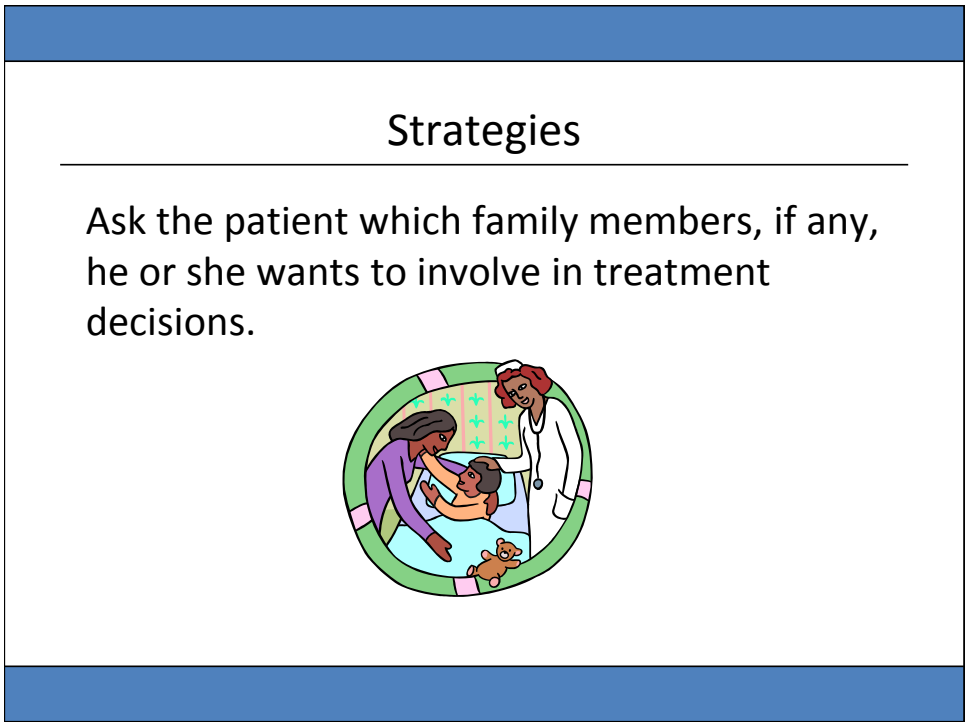
Slide 19

ADDITIONAL COMMENTS

- What are ways you shape counseling to incorporate your patient's beliefs or practices?

Reference:

Salimbene, S. (2000). *What Language Does Your Patient Hurt in? A Practical Guide to Culturally Competent Patient Care*. St. Paul, MN: Diversity Resources.



Slide 20

SUGGESTED SCRIPT

Examples of Decision Makers:

- Latino/Hispanic- Involve entire family
- African American- Women are typically the head of the household

- The point is, a simple question "who should we include in decisions about treatment" can make a difference in patient responsiveness.

References:

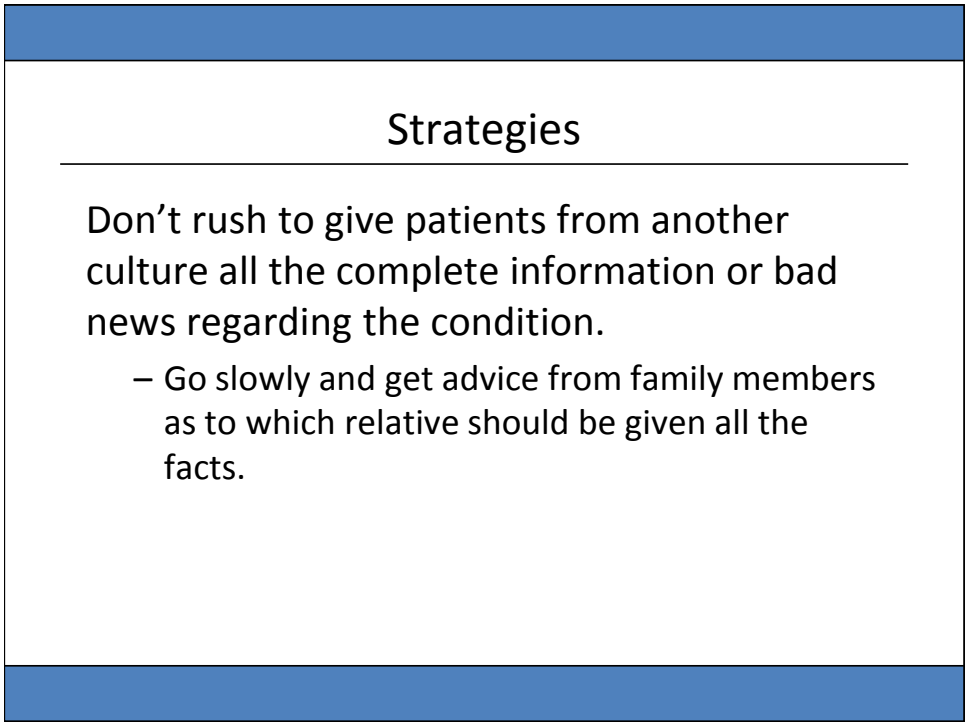
Huff , R., & Kline, M. (1999). *Promoting health in multicultural populations: A handbook for practitioners.* Thousand Oaks, CA: Sage Publications, Inc.

Purnell, L. D. (2009). *Guide to culturally competent care.* F.A. Davis Company.

Salimbene, S. (2000). *What Language Does Your Patient Hurt in? A Practical Guide to Culturally Competent Patient Care*. St. Paul, MN: Diversity Resources.

The Manager's Electronic Resource Center. *The Provider's Guide to Quality and Culture*. Retrieved from http://erc.msh.org/mainpage.cfm?file=5.1.0.htm&module=provider&language=English

University of Michigan Health System. (2010). *Program for Multicultural Health*. Retrieved from http://www.med.umich.edu/multicultural/ccp/culture/culture.htm



Slide 21

ADDITIONAL COMMENTS

Examples of:

- Delivery of bad news
  - Latino/Hispanic- Appropriate to consult entire family when delivering bad news and deciding treatment
  - African American- Involve family and clergy if appropriate and requested
  - Chinese- Death is viewed as a natural part of life
  - Muslim/Arab- Death is accepted as God's will

References:

Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. JAMA, 274(10), 820-825.

Purnell, L. D. (2009). *Guide to culturally competent care.* F.A. Davis Company.

Rundle, A., Carvalho, M. & Robinson, M. (Eds.) (1999). *Cultural competence in health care: A practice guide*. San Francisco, CA: John Wiley & Sons, Inc.

University of Michigan Health System. (2010). *Program for Multicultural Health*. Retrieved from http://www.med.umich.edu/multicultural/ccp/culture/culture.htm

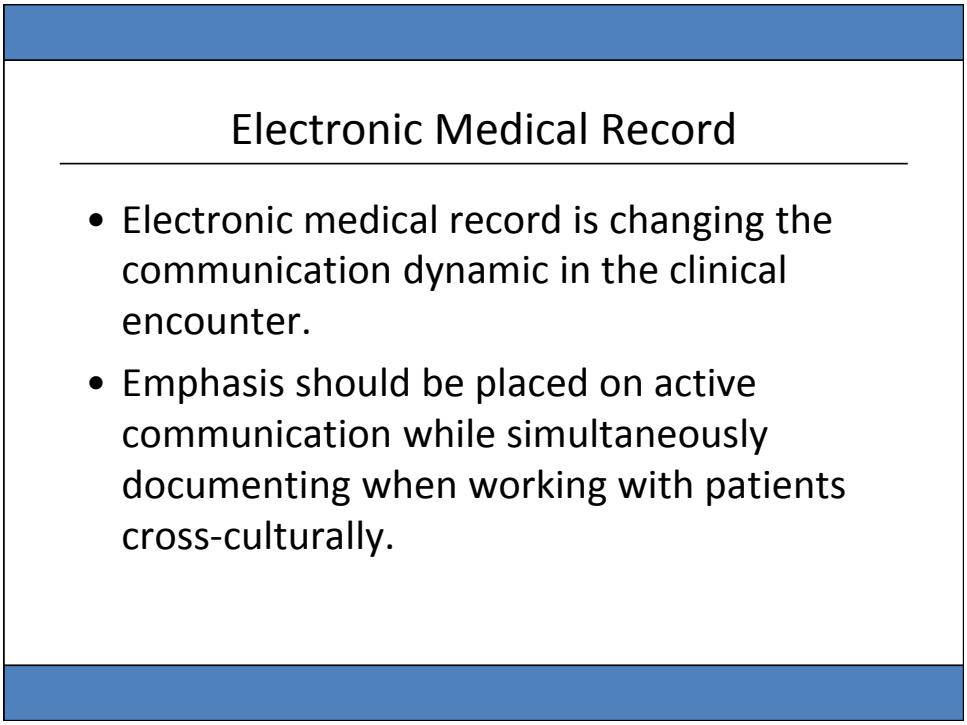
Summary Points

- Confirm the preferred language- if not your language, ensure that an interpreter is available.
- Invite conversation about alternative methods of treatment.
- Integrate non harmful practices into your treatment recommendations.
- Inquire regarding who else you should communicate with about the treatment plan.

Slide 22

SUGGESTED SCRIPT – BEHAVIORAL SCIENTIST/HEALTH EDUCATOR

The interaction between clinicians and patients is made even more complicated when the clinician may need to also focus attention on electronic medical record or interpretative services to guide them through the visit.

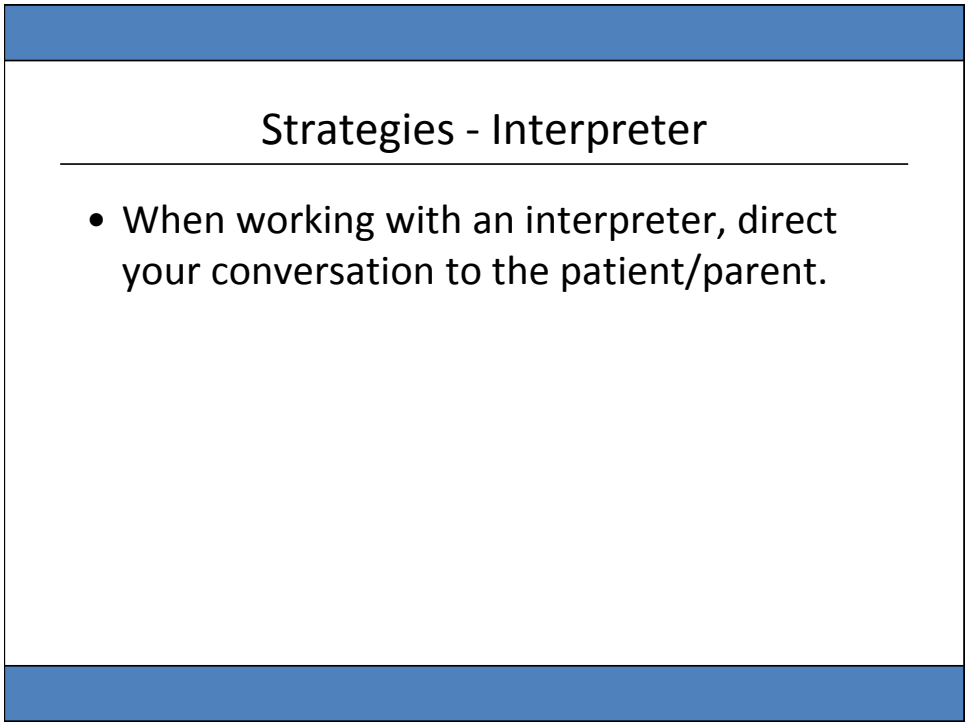


Slide 23

ADDITIONAL COMMENTS

- When using electronic medical record in the clinical visit, special consideration of communication may be particularly important for patients who may get nervous about documentation.

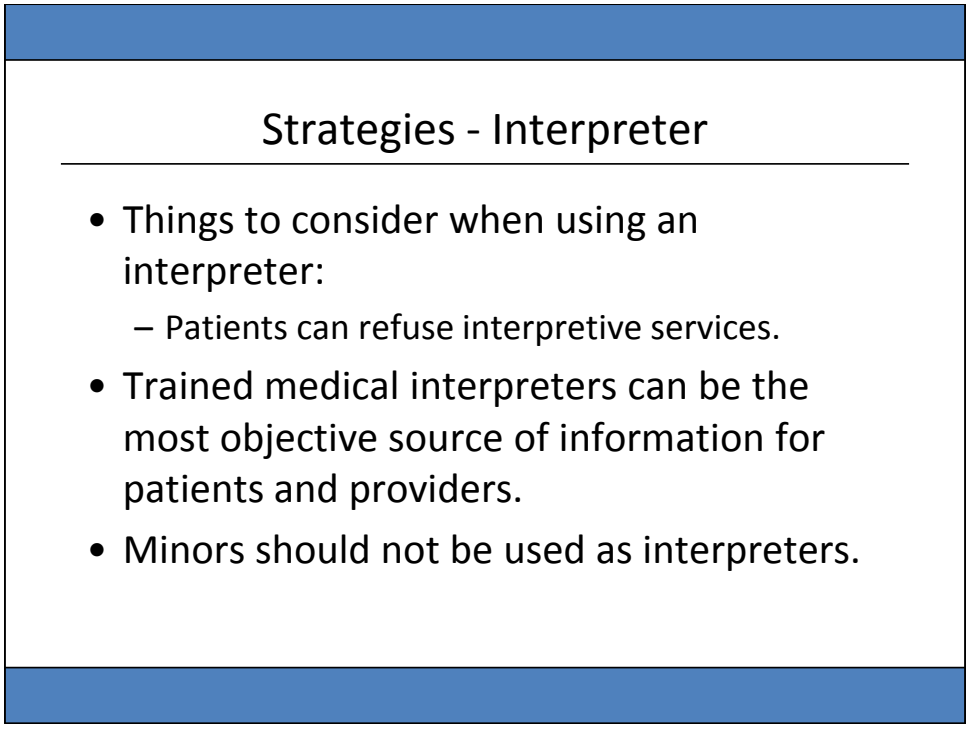
- Most patients want to be able to look at their physician and this may take extra attention on your part when you are using the computer.



Slide 24

SUGGESTED SCRIPT

- There may be times when an interpreter may be required during the clinical visit, which can also affect interactions between clinicians and patients. There are several things to keep in mind when utilizing interpretive services during a clinical visit.

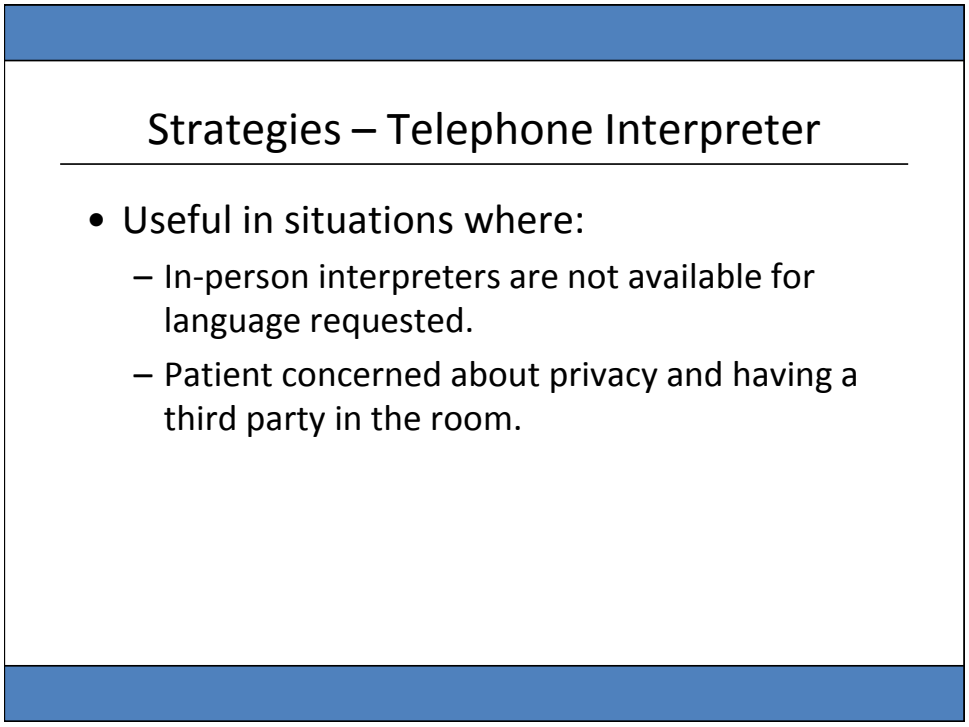


Slide 25

ADDITIONAL COMMENTS

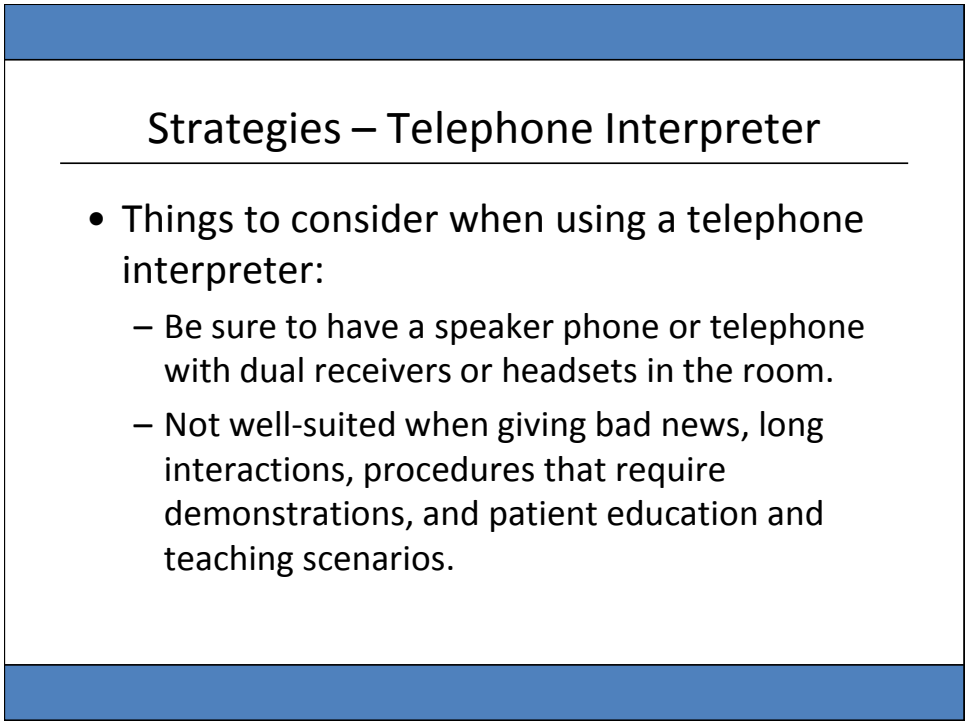
Reference:

U.S. Department of Health and Human Services - Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, D.C.: Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf



Slide 26

Reference:
International Medical Interpreters Association (2008). *A medical interpreter's guide to telephone interpreting.* Retrieved from http://www.imiaweb.org/uploads/pages/380.pdf



Slide 27

ADDITIONAL COMMENTS

- Non-verbal information is not necessarily visual information. With telephone interpreting, body language is not observable by the interpreter. However, if both other parties are in the same room, they can still see each other's body language. A great deal of non-verbal information is reflected in tone of voice, breath patterns, inflection, vocal volume, and other auditory cues. All of these are perceivable to telephone interpreters.

Reference:

International Medical Interpreters Association (2008). *A medical interpreter's guide to telephone interpreting.* Retrieved from http://www.imiaweb.org/uploads/pages/380.pdf

SUGGESTED SCRIPT – HEALTH EDUCATOR

Now we are going to watch the third vignette, which demonstrates how to work effectively with an interpreter.

Vignette #3

Instructions

- Show vignette #3- "How to work effectively with an interpreter"
- Pause video after vignette 3 for discussion. Be sure to pause video at **1:10** before the "Points to Remember."
- Discuss vignette 3 **briefly (suggested time: 5 minutes).**

Discussion Questions:

1. What ways did the physician work effectively with the family and interpreter?

    - *The physician greeted the patient first and then the interpreter.*
    - *The physician directed her attention to the patient.*
    - *The physician paused and allowed the interpreter to translate.*

2. What principles of working with an interpreter were evident (or not) to you?

    - *Direct communication to the patient.*
    - *Don't use minor children as interpreters.*
    - *Speak at an even pace and pause to allow translation.*
    - *Recognize that the interpreter may take longer to translate your original statement.*

3. What are some differences in having a family member interpret versus a trained interpreter?

    Having a family member interpret may pose confidentiality and safety issues for the parent/patient.

Instructions

- Resume video at **1:11**
- Show "Points to Remember."
- End session

Session 2, Segment 5
Case Presentations

INSTRUCTIONS- *ASTHMA SPECIALIST/BEHAVIORAL SCIENTIST* **(30 minutes)**

- This segment requires preparation by the physician instructor. Each of the two cases should be reviewed and salient issues related to each identified to raise with participants in discussion.

- After the two cases have been discussed, ask the physicians if they can describe a cross-cultural case from their experience.

- The behavioral scientist should contribute to the psychosocial, educational, and cultural aspects of the cases to assist the clinician.

SUGGESTED SCRIPT – *ASTHMA SPECIALIST*

We discuss cases for two reasons:

- To help clinicians apply concepts of cross-cultural communication in their own practice.
- To identify and resolve complex asthma situations when working cross-culturally.

Let's discuss some cases that represent common challenges facing clinicians when working with patients of a different race/ethnicity than their own.

SUGGESTED SCRIPT – *ASTHMA SPECIALIST*

Now let's consider some typical asthma cases and together think about how advice and counseling might specifically account for potential cultural influences on patients, that is, what specifically you might say and do to enhance the interactions.

CASE ONE

Mr. Gray is an African American grandfather who brings his 10 year old granddaughter, Tina, to see you. He is very worried that asthma will interrupt her schooling. Mr. Gray describes that Tina frequently complains of an itchy throat for which her mother gives her herbal tea. She also uses albuterol which reduces the itch when it is severe, which another physician recommended. Mr. Gray doesn't think the albuterol is a good idea and thinks the problem is Tina's throat and not asthma.

ADDITIONAL COMMENTS

- Let's focus our attention on social and cultural factors that may influence your interaction given the ethnicity of the family.

DISCUSSION QUESTIONS- *ASTHMA SPECIALIST/BEHAVIORAL SCIENTIST*

1. (BS) The decision maker does not appear to be Mr. Gray. Who should the physician talk to about Tina's asthma?

   The decision maker is likely the mother or grandmother and the physician should communicate in a way that includes them in Tina's treatment.

2. (AS) What does itchy throat mean to the family and to the physician?

   To the family, itchy throat likely means cough, wheeze, or shortness of breath.

3. (AS) How would you communicate to the family how asthma is treated?

   The herbal tea may not be harmful to Tina, therefore advice should probably not dissuade the family from continuing to use it.

   Counseling should include what the family believes helps asthma along with physician recommendations.

SUGGESTED SCRIPT – *ASTHMA SPECIALIST*

CASE TWO

Today you are seeing the Diaz family. Roberto is a 3 year old child of Puerto Rican ethnicity who has been brought by his mother to see you. Roberto has serious asthma. He experiences frequent symptoms and has had several emergency room visits and hospitalizations. The mother expresses frustration with his clinical course and states her family "has lots of home remedies from Puerto Rico for him to use". She requests your input on what to do next for her son.

DISCUSSION QUESTIONS- *ASTHMA SPECIALIST/BEHAVIORAL SCIENTIST*

1. (AS) What treatment plan is Roberto currently on?

   Roberto's treatment plan appears to be unclear and may include home remedies.

2. (BS) Who are the medical decision makers for Roberto?

   Roberto's mother as well as other family members.

3. (BS) How would you include these decision makers in a discussion?

   Ask the mother who the decision makers are and inquire about their availability.

4. (AS) What strategies can be used in considering the Diaz family's culture and beliefs in treating Roberto's asthma?

   Counseling should include what the family believes helps asthma along with physician recommendations.

INSTRUCTIONS- *ASTHMA SPECIALIST*

Ask participants if they have a cross-cultural case from their practice that they would like to discuss (share 2-3 cases).

Summary

SUGGESTED SCRIPT- *PRIMARY CARE PHYSICIAN OR ASTHMA SPECIALIST* **(10 minutes)**

The goal for all of us is to combine effective treatment and communication for our patients and be especially attentive when working cross-culturally. In the cross-cultural communication section in your binder, you will find handouts on communicating across cultures, specifically with African American and Latino/Hispanic patients, and working with interpreters. You will also find a Cross-Cultural Communication Self-Assessment tool that we encourage you to use.

We hope this program has stimulated your thinking and been of help to you.

INSTRUCTIONS- *ASTHMA SPECIALIST*

Before adjournment, complete CME procedures.

Appendix

The Appendix contains all documents included in the physician binder.

Appendix 1: Classification, Assessment, Therapy

- Classification, assessment, and therapy charts, ages 0-4, 5-11, and ≥12

Appendix 2: Sample Action Plans

- Sample asthma action plans
- Sample long-term plan

Appendix 3: Communication Strategies

- Communication strategies
- Key asthma messages for the patient and family
- Review of concepts
- Physician's record: categories of asthma messages provided
- Physician's record and self-rating

Appendix 4: Cross-Cultural Communication

- Cross-cultural communication strategies
- The Cross-Cultural Communication Self-Assessment Scale
- Communicating with your Latino/Hispanic Patients
- Communicating with your African American Patients
- Tips for working with interpreters
- Cross-cultural communication resources

Appendix 5: Master Trainers

Appendix 6: Asthma Resources

Appendix 7: PACE References

APPENDIX 1

See Pocket Guide

APPENDIX 2

SAMPLE LONG TERM TREATMENT PLAN

Name: Daryll Ward Age: 8 years old Weight: 60 lbs

Moderate persistent asthma currently on controller medication

CLINICAL CONDITION	Baseline Plan & When asthma is under control	At the FIRST sign of a cold or mild asthma attack	For rapidly worsening asthma (severe attack)	When there is no cough or wheeze for 3 months	For cough or wheeze with exercise
SYMPTOMS	• Breathing is good with no daily or nighttime symptoms • Able to do usual activities	• Breathing problems and symptoms present or waking up from sleep • Can do some but not all usual activities	• Breathing is hard and fast • Rescue medicines have not helped • Cannot do usual activities	• Breathing is good with no daily or nighttime symptoms • Able to do usual activities	2 puffs 5-10 minutes before exercise
PEAK FLOW (LPM)	200-230	180-200	<180	200-230	
MEDICATION *Reliever:* Albuterol	2 puffs as needed	2 puffs every 4 hr	2-6 puffs every 20 minutes for 3 doses then 2-4 puffs every 4 hr	2 puffs as needed	
Controller: 1) Beclomethasone (ICS), 40 mcg	1-2 puffs 2x/day	1-2 puffs 2x/day	1-2 puffs 2x/day	0-1 puffs 2x/day	
Corticosteroid Tablet or Syrup	0	0	Begin with 1-2 mg/kg/day **NOTIFY MD**	0	

* If patients develops symptoms when corticosteroid discontinued, either resume corticosteroids or try leukotriene modifier

Mellins R.B., Evans D., Clark N., Zimmerman B., Wiesemann S. (2000). Developing and communicating a long-term treatment plan for asthma. *Am Fam Physician*, 61(8), 2419-28.

APPENDIX 3

Communication Strategies

Nonverbal attentiveness

Sit at the same level as patient and family. Avoid having a barrier, such as a desk between you. Make eye contact when listening and speaking. Lean forward slightly.

Eliciting underlying fears

Ask open-ended questions such as:

- "What is your greatest worry about asthma?"
- "What concerns do you have about the medicine?"
- "What things would you like to do that your asthma makes it hard to do?"

Addressing immediate concerns

Patient or family concerns should be addressed right away, even if a complete answer isn't possible at the time. The purpose is to reassure the family by being responsive to the issues that matter to them.

Reassuring messages

Unrealistic fears (of medicines or possible fatality) can block compliance. By conveying accurate information about risks and stressing that following your recommendations will increase the child's safety, the family will be reassured and more likely to follow your advice.

Interactive conversation

Ask open-ended questions that can't be answered "yes" or "no" to encourage the family to convey information about beliefs, concerns, and how they manage asthma at home. Use simple, clear language and avoid medical jargon. Use analogies to ensure that the family grasps new ideas.

Tailoring the regimen

Assess the family's daily routine to learn the best times and places for giving medicines during the day. Reach agreement on a daily plan for taking the medicine, making sure they are willing and able to follow it.

Planning for decision-making

Help the family plan for decision-making by encouraging them to keep a diary and/or develop strategies for handling potential problems or choices that may occur, such as emergencies at school or participation in sports at school or summer camp. Reviewing the written treatment plan with the family helps them know how to decide when medicines should be adjusted to control symptoms, and when the child needs immediate medical attention.

Setting short-term goals for treatment

Should be decided with the family, and tied to the patient's own goals to increase motivation to follow the treatment plan. Provides a benchmark for the family to judge progress.

Setting goals with the long-term treatment plan

Having a long-term treatment plan helps the family know what to expect and what they may be able to achieve through preventive care.

Nonverbal encouragement and verbal praise

Reinforce positive steps the family has taken to control asthma. Use these strategies to increase their confidence that they can manage asthma successfully following your plan.

Key Asthma Messages for the Patient and Family

1. What happens in an asthma attack

In an asthma attack you have trouble breathing because:

- The airway lining swells and produces too much mucus (inflammation).
- The muscles around the airways squeeze them partly shut (bronchospasm).

2. How medicines work

Anti-inflammatories don't give an immediate feeling of relief, but are crucial to reducing inflammation
and preventing its return. Bronchodilators relax the muscles that have tightened around the airways.

Call me if either of the following happen, because it means the medicines need to be adjusted:

- If bronchodilators are needed more than 4 times a day, we will need to increase the amount of anti-inflammatory medicine.
- If there is jitteriness or anxiety, we will need to reduce the amount of bronchodilator.

3. Responding to changes in asthma severity

GIP Message: All people who have asthma should receive a written asthma action plan to guide their self-management efforts.

When symptoms change, use the long term plan to adjust the medicines.

If symptoms worsen rapidly, follow the emergency plan I've given you.

Come immediately for treatment to my office or the hospital if any of the following happens:

- No improvement after following the emergency plan
- So breathless you can't talk or walk
- Blue fingernails or lips

4. How to take medicines

Demonstrate for me how to use the metered dose inhaler and spacer.

Show me how to use the peak flow meter.

Use the step by step instructions at home.

5. Safety of medicines

The medicines I've prescribed are safe when used in the doses I've recommended.

Low doses of inhaled corticosteroids are safe and do not cause serious side effects.

Corticosteroids are not the same as the muscle-building steroids some athletes use.

6. Goals of therapy

Your child should be symptom free.

This control should be achieved with as little medicine as possible. The long-term plan can get us to the point of decreasing or stopping the medicines.

Some people with asthma have been sports champions and Olympic gold medalists.

7. Criteria of successful treatment

Your child should sleep through the night, have no wheeze or cough even during exercise or colds, and be fully active.

If you continue to have symptoms, call me and we'll fine tune the plan.

If your child has asthma symptoms more than once every two months, daily medicines will be needed
until there are no symptoms for 3 or 4 months even during exercise or colds.

8. Managing asthma at school

Key school personnel need to be informed about the child's asthma.

Important points to inform the school about are:

- How to minimize exposure to triggers
- When to use medicine at school
- Encouraging participation in physical activities
- What to do in an emergency

Only keep your child home if the wheezing is bad or she has a fever or sore throat.

9. Identifying and avoiding triggers

GIP Message: Clinicians should review each patient's exposure to allergens and irritants and provide a multipronged strategy to reduce exposure to those allergens and irritants to which a patient is sensitive and exposed.

Sometimes triggers to symptoms can be identified, so see if you can discover what yours are.

Triggers may include respiratory infections, allergens (dust, roach, and animal dander), irritants (smoke), and exercise.

Use bronchodilator and cromolyn preventively when you may be exposed to a trigger.

10. Referral to further education and review of goals

Take part in a comprehensive asthma self-management program.

Remember our goal for your child is to be symptom free and fully active.

REFERENCES

Clark NM, Gong M, Schork MA, Evans D, Roloff D, Hurwitz M, Maiman L, Mellins RB. Impact of education for physicians on patient outcomes. Pediatrics 1998;101:831-36.

Clark NM, Gong M, Schork MA, Kaciroti N, Evans D, Roloff D, Hurwitz M, Maiman LA, Mellins RB. Long-term effects of asthma education for physicians on patient satisfaction and use of health services. Eur Respir J 2000;16:15-21.

Review of Concepts- Management & Treatment

Message		What the Message Addresses
Airway lining swells and mucous forms Muscles tighten around airways		Asthma severity (bad news)
Anti-inflammatories reduce inflammation Bronchodilators relax muscles		Benefits of medicine (good news)
Bronchodilators not to be used more than four times per day Watch for jitteriness and anxiety		Side effects can be limited
Follow the long-term plan Follow the treatment plan		Shows that medicines are adjusted according to the level of control a patient can achieve Shows how benefits of using medicines can outweigh costs
Demonstrate use of medicines Use written instructions		Builds self confidence and level of skills
Need daily anti-inflammatories		Reduces susceptibility to asthma episodes
Long-term goal to control asthma with as little medicine as necessary		Shows how benefits of following regimen over time outweigh costs
Medicines safe when used as instructed Inhaled steroids safe in low doses Corticosteroids differ from anabolic		Builds confidence in the regimen Reduces fear associated with use of medicine
Expect to exercise without symptoms Expect to sleep through the night		Shows benefits of therapy
Plan can be fine-tuned if problems arise		Shows that ongoing partnership with clinician is needed

Be physically active Sports champs have asthma in control		Shows benefits of therapy Builds self-confidence
School personnel need to be informed about triggers, medications, physical exercise, emergencies		Need for support in the social environment
Triggers can be identified		Increases feelings of control Reduces susceptibility to episodes
Use medicines preventively when your child may be exposed to triggers		Shows benefits of therapy Increases feeling of control
The goal is to be symptom-free		Shows benefits of staying with therapy
Take part in additional asthma education		Builds self-confidence

Physician's Record: Categories of Asthma Messages Provided

Patient's Name: _____

Check if topic covered.

VISIT ONE

- ☐ What happens to the airways in an asthma attack
- ☐ How medicines work (rescue/control)
- ☐ Responding at home to changes in asthma severity (long-term plan and emergency plan)
- ☐ How to take medicines (child/parent demonstrate)

VISIT TWO

- ☐ Safety of medicines when used as directed
- ☐ Goals of therapy (no symptoms with as little medicine as necessary)
- ☐ Criteria of successful treatment (sleep through the night, no asthma symptoms even with exercise or colds)

VISIT THREE

- ☐ Managing asthma at school
- ☐ Identifying triggers
- ☐ Referral to additional asthma education
- ☐ Review of goals of therapy

Physician's Self-Rating Scale on Interactions with the Family

Patient's Name: _____ Date:_____

PHYSICIAN GOALS FOR THE INTERACTION:

- Have parent and child specify his/her concerns and get questions onto the table.
- Reach agreement on being partners.
- Ensure that in achieving a short-term treatment goal, parents see the necessity of a long-term treatment plan.
- Agree on the steps of self-management at home.

Rate your behavior in the interaction with the family: 1=low rating, 5=high rating

WERE YOU ABLE TO:

1. Use appropriate non-verbal attentiveness (e.g. eye contact, closing social distance, etc.)?

1 2 3 4 5

_____

2. Elicit the parents' and child's underlying concern about the child's asthma?

1 2 3 4 5

_____

3. Construct reassuring messages regarding the parents' and child's fears?

1 2 3 4 5

_____

4. Address immediately the concerns the family expressed?

1 2 3 4 5

_____

5. Engage the family in interactive conversation (e.g. used open-ended questions, simple language, analogies, etc.)?

1 2 3 4 5

_____

6. Tailor the regimen by eliciting and addressing potential problems in the timing, dosage, or side effects of the medicines recommended?

1 2 3 4 5

_____

7. Use appropriate non-verbal encouragement and verbal praise when the family reported using correct management strategies?

1 2 3 4 5

_____

8. Elicit the family's immediate objective related to asthma control and agree on a short-term goal?

1 2 3 4 5

_____

9. Review the long-term plan?

1 2 3 4 5

_____

10. Help the family plan for decision-making by encouraging them to keep a diary and/or develop strategies for handling potential problems (e.g. emergencies, participation at school, sports, etc.)?

1 2 3 4 5

_____

APPENDIX 4

Cross-Cultural Communication Strategies

1. Be formal but friendly.

- Smiling and nodding conveys friendliness, but restraint is called with most patients.
- Try to refrain from using first names or nicknames with adults unless specifically given permission.
- Use surnames.
- It is ideal to know cultural preference before touching either an adult or child other than for the physical exam.
- Generally cross-culturally, gestures such as slapping the back are not welcome.

2. Assume the patient is with you even if usual signs of attention aren't evident.

- In many cultures it's rude for a child to look directly at an adult. Even adults may express respect by not making direct eye contact
- Present your advice clearly and simply, assuming the person is with you.

3. Avoid pre-judging what the family believes about the causes of asthma and asthma symptoms.

- Ask the patient what he or she thinks is causing the child's asthma problems.

4. Recognize and consider ways to respect non-science-based beliefs of the family before giving advice.

5. Refrain from overloading the interaction with scientific "facts" to discount unscientific beliefs.

- If the practice isn't harmful, the facts aren't needed; if the practice is harmful, personal persuasion is likely to be more effective than abstract information.

6. Use informal conversation (as opposed to direct questions) to learn about the family's beliefs about conventional and non traditional forms of asthma care.

- These practices may vary widely among individuals within and between different cultures.
- Listen and watch carefully to see what the patient's words and behavior communicate to you about his or her views.

7. Incorporate potential family beliefs about folk or alternative medicine into your counseling.

8. Discover which family members the parent and child wish to involve in treatment decisions.

- Find ways to involve the family decision-maker.

9. Tread softly and go slowly when delivering bad news and determine who in the family should be given all the facts.

10. When using a translator, direct conversation to the patient and parent.

- Greet the patient first then the interpreter.
- Focus on and speak to the patient or parent, not the interpreter.
- Speak at an even pace and pause to allow translation.
- Get the patient to focus on you, not the interpreter. For example, use the patient's name, move your chair closer to the patient, and use facial expressions and body language that communicate your interest.
- If you and the interpreter must clarify something, let the parent or patient know that this is what you're discussing.
- Recognize that the interpreter may need to "paint word pictures" for some terms you use and this may take longer than your original statement. Many concepts have no linguistic equivalent in another language.

The Cross-Cultural Communication Self-Assessment Tool

Think about your most recent interactions with an African-American or Latino/Hispanic family.
How well would you rate yourself on the following?

	In this section, please rate the following statements:	Poor	Below Average	Average	Above Average	Excellent	N/A
1.	Thought initially about likely patient *cultural* preferences for interactions with me and proceeded based on these	1	2	3	4	5	n/a
2.	Was formal but friendly	1	2	3	4	5	n/a
3.	Assumed the patient was with me even though usual signs of attention weren't evident	1	2	3	4	5	n/a
4.	Avoided pre-judging what the family believed about the causes of asthma and asthma symptoms	1	2	3	4	5	n/a
5.	Recognized and considered ways to respect non-science-based beliefs of the family before giving advice	1	2	3	4	5	n/a
6.	Refrained from overloading the interaction with scientific "facts" to discount unscientific beliefs	1	2	3	4	5	n/a
7.	Used informal conversation (as opposed to direct questions) to learn about the family's beliefs about conventional and non-traditional forms of asthma care	1	2	3	4	5	n/a
8.	Incorporated potential family beliefs about folk or alternative medicine into my counseling	1	2	3	4	5	n/a
9.	Discovered which family members the parent and child wished to be involved in treatment decisions	1	2	3	4	5	n/a
10.	Trod softly and went slowly when delivering bad news and determined who in the family should be given all the facts	1	2	3	4	5	n/a
11.	When using an interpreter, directed conversation to the patient and parent	1	2	3	4	5	n/a
	TOTALS						

Culture Considerations (adapted from Cultural Clues™) [1]: Communicating with Your Latino Patient

Be aware that there is variability in all ethnic groups in their health care seeking and health promotion behaviors.

There is some information about this patient and family that you will not learn from tips or information about their culture.

- Country of origin, education, and income level make a difference about how your patient perceives illness and makes health decisions. Ask questions to learn more about this patient and their family.

HOW DOES THE LATINO CULTURE COPE WITH ILLNESS?

1. Explaining the Causes of Illness and Disease

- Your patient may see illness as an imbalance. The imbalance may be between internal and external sources (for example, hot and cold, natural vs. supernatural, the soul is separate from the body).
- ***Ask your patient "Can you tell me what caused your illness?"***
- There are folk-defined diseases such as *empacho* (Stomach ailment) and standard Western medically defined diseases such as measles, asthma, and TB.

2. Helping Your Patient Take an Active Role in Care and Recovery

- Your patient may believe that God determines the outcome of illness.
  Consider the impact religion will have in your patient's active participation in health care recovery. You can validate your patient's belief by asking "Will God be served by taking the best care of yourself?"
- Many patients seek medical care from *curanderos* or other folk healers.
  Ask about use of pharmaceuticals or home therapies such as herbal remedies or certain foods. Screen for possible patient use of injectables, especially antibiotics or vitamins. Ask if you can see the home treatment if your patient cannot identify the substance.
- The patient may be seen as an innocent victim, and be expected to be passive when ill.
  Help your patient take an active role in his or her recovery.

3. Helping Your Patient Feel Comfortable At Their Place Of Medical Care

- Remember to find out if this is your patient's first visit to the medical facility.
- If so, inform them of the medical care process so they understand what to expect.

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[1] *Culture Clues*™ was designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. ©University of Washington Medical Center 12/3/99.
http://depts.washington.edu/pfes/cultureclues.html

Keep in mind that patients who are new to the system may not be aware of the role of the Primary Care Team or the process for getting a referral to a specialist.

4. Understanding Concerns about Depression

- Depression may not be seen as an illness. It is often seen as a weakness and an embarrassment to family.
  Treat these issues with respect. You may want to also offer the services of a clergy member.

HOW ARE MEDICAL DECISIONS MADE IN THE LATINO CULTURE?

1. Making Decisions about Health Care

- Determine who makes medical decisions and who should be communicated with directly (individual or family).
- The mother usually determines when a family member requires medical care; the male head of the household usually gives permission to go to the medical center.
- Head of the household is often the oldest adult male, who is the decision-maker, but important decisions often involve the whole family. The family spokesperson is usually the father or oldest male.
  Ask your patient about whom they want to be included in medical decisions. If the patient does not want to make medical decisions for themselves, let them know they need to prepare a Durable Power of Attorney for health care.
  When possible, engage the whole family in discussions that involve decisions about care.

2. Managing Medical News

- The family may prefer to hear about bad medical news before the patient is informed. The family spokesperson may be best to deliver information about the severity of illness. The family may want to shield the patient from the bad news.
  If your patient consents, meet with the identified persons to strategize how to communicate medical news.

3. Gaining Family Support

- *La Familia* – the family is an important source of emotional support during recovery. Patients like to be able to see and embrace their family members.
  Be aware of the importance of this and consider extending visiting hours. Explain the visitation policy at the time the patient is admitted or before a surgery, so that the family knows what to expect.
- The family may want to allow the patient to remain passive during recovery while they provide complete support for activities of daily living.
  Educate family members about the importance of the patient's active participation during recovery.

WHAT ARE THE LATINO CULTURE'S NORMS ABOUT TOUCH?

1. Understanding Relationships

- Patients value relationships. A polite and friendly encounter before a therapeutic relation is beneficial to medical communication.
  Take time to develop relationships. Shake hands and greet your patient by name, or ask the patient what they prefer to be called. An older patient may prefer to be called Señor (Mr.) or Señora (Mrs.).

2. Understanding Norms about Eye Contact and Body Language

- Eye contact with health care professionals or people of authority may be avoided as a sign of respect.
- For some patients, eye contact may be related to evil spirits. An illness may be attributed to receiving an evil eye or *mal ojo*.
- Another example of evil eye is the belief that if you admire a child by looking without actually touching him or her, the child can become very ill.
- When your patient nods his or her head, it does not necessarily signify agreement, but that he or she is listening to you. Silence is more likely a sign of not understanding or disagreement.
  To ensure understanding, ask open-ended questions and encourage the patient to ask questions.

3. Understanding Norms about Touch, Modesty, and Body Language

- Consider the modesty of women and girls; having a female provider may be helpful.
  Ask your patient about her gender preference for providers. Consider having a female attendant present when a male provider is examining a female patient.

Culture Considerations (adapted from Cultural Clues™): Communicating with Your African American Patient

Be aware that there is variability in all ethnic groups in their health care seeking and health promotion behaviors. There are differences based on age, education, and place of birth. For African Americans, sources of these varying beliefs may include: beliefs brought from Africa which survived the slave trade, carryovers of Western explanations of illness current during slavery, and modern medical theories and practices.

The African American experience in America has left many African Americans mistrustful of mainstream institutions and providers who are members of the dominant culture. To many African Americans, the bad faith and abuses of the Tuskegee Syphilis Study are not isolated lessons learned in history books, but an example of the experiences African Americans endure in health care settings.

HOW DOES THE AFRICAN AMERICAN CULTURE COPE WITH ILLNESS?

1. Explaining the Cause of Illness

- Your patients may believe illness is a result of: natural causes, improper diet and eating habits, exposure to cold air or wind, and the will of God for improper behavior.
- Religion, spirituality and kinship ties may have an important role in your patients' understanding and treatment of illness. Any type of illness, physical or mental, may be seen as a lack of spiritual balance.

HOW ARE MEDICAL DECISIONS MADE IN THE AFRICAN AMERICAN CULTURE?

1. Making Decisions about Health Care

- Your patients' decision process to seek health care often has three phases: 1) Wait and see how illness/symptoms progress while coping using available home or folk remedies, 2) Discuss treatment alternatives and plans with key people within their family, community, or church, 3) Seek medical care from a doctor or health care provider.
- You may be surprised about how long it takes before your patients seek health care. Some patients may prefer self-treatment as giving God a chance to heal.
  Let patients know when it is important to see a physician.
- Some of your older patients may seek care from folk healers, lay advice, home remedies, and prayer to treat illness as well as Western medical treatments. Patients from southern states may also use spiritual elders, herbs, and rituals. Look for ways to combine folk remedies with Western medicine by encouraging treatment that promotes self-care. Determine when the remedies are beneficial, neutral, or harmful. Incorporate beneficial and neutral remedies into the plan of care. Consider potential drug interactions.

2. Participation in Clinical Trials

- Your patients may have a significant mistrust or fear about entering clinical trials because of notable historical injustices in medical care research.
  Discuss the research in detail with patients and family. Spell out the safeguards that are in place to prevent abuse of research participants.

3. Managing Medical News

- Assess and acknowledge the significance of spirituality; avoid dominating the content of the discussion and offer choices for treatment options.
- Spend time with you patients and ask about their health beliefs.
  Ask your patients about key individuals in their community who might be available to assist in supporting/supplementing key recommended medical regimens.
- Be available to consult with your patients' family, minister, and/or friends in cases of serious or terminal illness, especially at the time the illness is being explained.
- Determine if there is a match between your explanation of the causes and likely course of the illness and that of your patients. If there is a mismatch, many patients from this culture will rely on their own explanations before those of medical professionals.
- Even during adversity, many African Americans find solace in a good laugh or playful kidding. Occasional bursts of laughter may seem out of character to the severity of the situation if you are not used to African American culture.

4. Understanding Relationships

- Show respectful behavior (as understood within African American culture) towards your patients.
  Until invited to do otherwise, greet your patient by using formal titles, such as, Mr., Mrs., or Ms. Take special care to have congruent verbal and non-verbal patterns. Especially communicate that you are listening and paying full attention to what your patient may be telling you.
- Your patients may include many people as part of their extended family, some related while the others may be friends of the family or part of the patients' wider social network.

5. Improving Communication with Your African American Patient

- To improve communication, which enhances the building of a trusting relationship, acknowledge and respect your patients' meaning for their illness. Listen carefully.
  Ask: "What are the chief problems your illness has caused you? What do you fear most about your illness? What kind of treatment would you like to have?"
- Making one medically neutral suggestion that fits your patients' belief system builds rapport fast.
  Ask your patients about religious beliefs and, as appropriate, encourage your patients to pray or read scripture.

- Include your patients in the decision-making process. Answer your patients' questions and concerns about diagnosis and treatment plans.
- Enlarge the decision-making process to include social decisions.
- Some patients may call diabetes mellitus "sugar" or "sugar diabetes," pain may be called "miseries," and anemia may be referred to as "low blood." Be alert that there may be divergent meanings and expectations for treatment for such terms as "high blood pressure," "high blood," and "hypertension."
  Use open-ended questions to ensure that you and your patents have a common meaning.

WHAT ARE THE AFRICAN AMERICAN CULTURE'S NORMS ABOUT TOUCH?

1. Explaining Touching

- Before touching your patients, always explain what will be done and why.
- Your gender as the health care provider is not likely to be an issue for your patients. Your patents may prefer that family members of the other gender leave the room.
  Talk to your patients to learn more about their preferences.

2. Understanding Concerns about Hygiene and Health

- Hair care products used by many African Americans leave their hair oily to the touch.
  Offhand comments like "Your hair is oily," from health care providers may offend some African American patients and prevent the building of a therapeutic relationship.

Tips for Working with Interpreters[2]

An **interpreter** *is a person that renders orally into one language a message spoken in a different language.*

In a health care setting, he or she must be an **adult** that is:

- a fluent speaker of both languages in question
- not a relative of the patient
- professionally trained

Determining the need for an interpreter

1. Did the **patient request an interpreter**?
2. Do you as a provider believe that **language or cultural differences** may be **causing a barrier to clear communication** between you and your patient?
   - Legally, language assistance for limited-English speakers is required if you receive federal funds of any kind; no recipient of federal funding may run its programs in a manner that would discriminate on the basis of race, color, or country of national origin, according to Title VI of the 1964 Civil Rights Act.
   - Ineffective methods of communication between English-speaking staff and limited-English-speaking patients are considered to be a common form of discrimination.

Identifying an appropriate interpreter

1. Are they **fluent**?
   - Language screening is needed to establish the degree of fluency.
2. **What type of training have they received?**
   - Being bilingual does not suffice; special skills are involved in interpreting. Professional training is absolutely necessary.
   - Untrained interpreters are at extremely high risk for adding or omitting material, changing the message, giving opinions, and entering into long discussions with the patient or provider from which the other is excluded.
3. Are they **external to the family?**
   - Family members often edit messages heavily, add their own opinions, answer for the patient and impede the development of the patient-provider relationship.
   - Confidentiality becomes a concern with family members.
   - They are often unfamiliar with medical terminology.
   - Family members should be used only for interviews where:
     - Confidentiality is not a concern;

[2] Adapted from "Guidelines for Providing Health Care Services through an Interpreter" – Copyright: The Cross Cultural Health Care Program (CCHCP); www.xculture.org

    - Nothing of a delicate nature will be discussed;
    - Medical terminology will not be used.
4. Are they an **adult**?
    - ***Important**:* The interpreter should never be a child because it affects the power dynamics in the family. Children also lack vocabulary in both languages, and may be traumatized if they are required to pass on bad news or be held accountable for negative health outcomes.

Working effectively with the patient and interpreter

Direct primary attention to the patient.

- Greet the patient first, then the interpreter.
- Establish the interpreter's level of English skills and professional training.
- Request that the interpreter use first person while translating.
- Focus on and speak to the patient, not the interpreter, during the medical interview.
- Cultivate clear and smooth communication.
- Speak at an even pace.
- Pause often to allow the interpreter to translate.
- Ask one question at a time.
- Use plain English; avoid slang, jargon, technical/medical terms, and acronyms, as well as sentence fragments, complicated sentence structure, or changing an idea in the middle of a sentence.
- Provide context or reframe the conversation periodically.
- If you need to talk directly to the interpreter about an issue of communication or culture, tell the patient first what you are going to address with the interpreter.
- Do not hold the interpreter responsible for what the patient says or doesn't say; the interpreter is the medium, not the source, of the message.

Things to keep in mind:

- Avoid patronizing or infantilizing the patient.
    - A lack of English language skills does not reflect low cognitive function or a lack of education.
- Be aware that many expressed concepts may not have linguistic or conceptual equivalent in other languages.
    - This may take longer to translate than your original speech – patience is needed.
- Communicate with the interpreter as a professional.
- Respect his or her judgment and encourage them to ask questions or address potential cultural misunderstandings that may arise.
- Rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.

Cross-Cultural Communication Resources

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APPENDIX 6

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(800) 458-1158
www.nyhealth.gov

Allergy and Asthma Network/Mothers of Asthmatics, Inc.
(800) 878-4403
www.aanma.org

Allergy and Asthma Foundation of America
(800) 7-ASTHMA
www.aafa.org

American Academy of Allergy, Asthma & Immunology
(800) 822-2762
www.aaaai.org/patients/publicedmat/tips/asthmaallergymedications.stm

American Academy of Pediatrics
(800) 433-9016
www.aap.org

American College of Allergy, Asthma and Immunology
(800) 842-7777
www.acaai.org

American Lung Association
(800) LUNG-USA
www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=22581

Institute For Health Care Communication, Inc.
(800) 800-5907
www.healthcare.com

U.S. Environmental Protection Agency
(212) 637-3660
www.epa.gov

National Jewish Medical and Research Center
(800) 222-LUNG
www.asthma.nationaljewish.org/disease-info/diseases/asthma/living/tools/index.aspx

National Institute of Allergy and Infectious Diseases
(301) 496-5717
www.niaid.nih.gov

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APPENDIX 7

PACE Program Bibliography

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