Segment 1: Clinical Aspects of Asthma and Long-term Management

Primary Care and Asthma

- Most common chronic disease of childhood.
- Primary care providers are expected to manage most cases of asthma.
- There are disincentives to frequent referrals to specialists.

Modern Paradox

- Understanding of the pathogenesis and treatment of asthma has increased.
- Understanding the steps to control asthma has increased.
- However, morbidity and mortality from asthma around the world is at an alarmingly high level with only recent flattening in some areas around the globe.

Some Possible Explanations

- Patients and families are not recognizing the symptoms of asthma.
- Clinicians are not making the diagnosis.
- Clinicians are either not providing state-of-the-art care, or, if they are, patients are not adhering to the recommended programs.

Barriers to Achieving Optimal Care

- Patients treat asthma as an acute episodic illness rather than a chronic disease.
- Physicians assume that patients will put aside their own beliefs, concerns, and goals to follow the treatment plan.
- When the patient and physician are from different cultures, determining and communicating about the treatment plan can be more complicated.

Key Points

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 written plan.

Key Points

4. Good communication between patient and clinician helps identify patient concerns, makes patient teaching more effective and promotes patient self-confidence to follow the treatment plan.
5. Patient education can be efficiently and effectively accomplished in several standard primary care visits.
6. The patient's culture and social experience must be considered in deciding elements of the treatment plan and providing counseling.

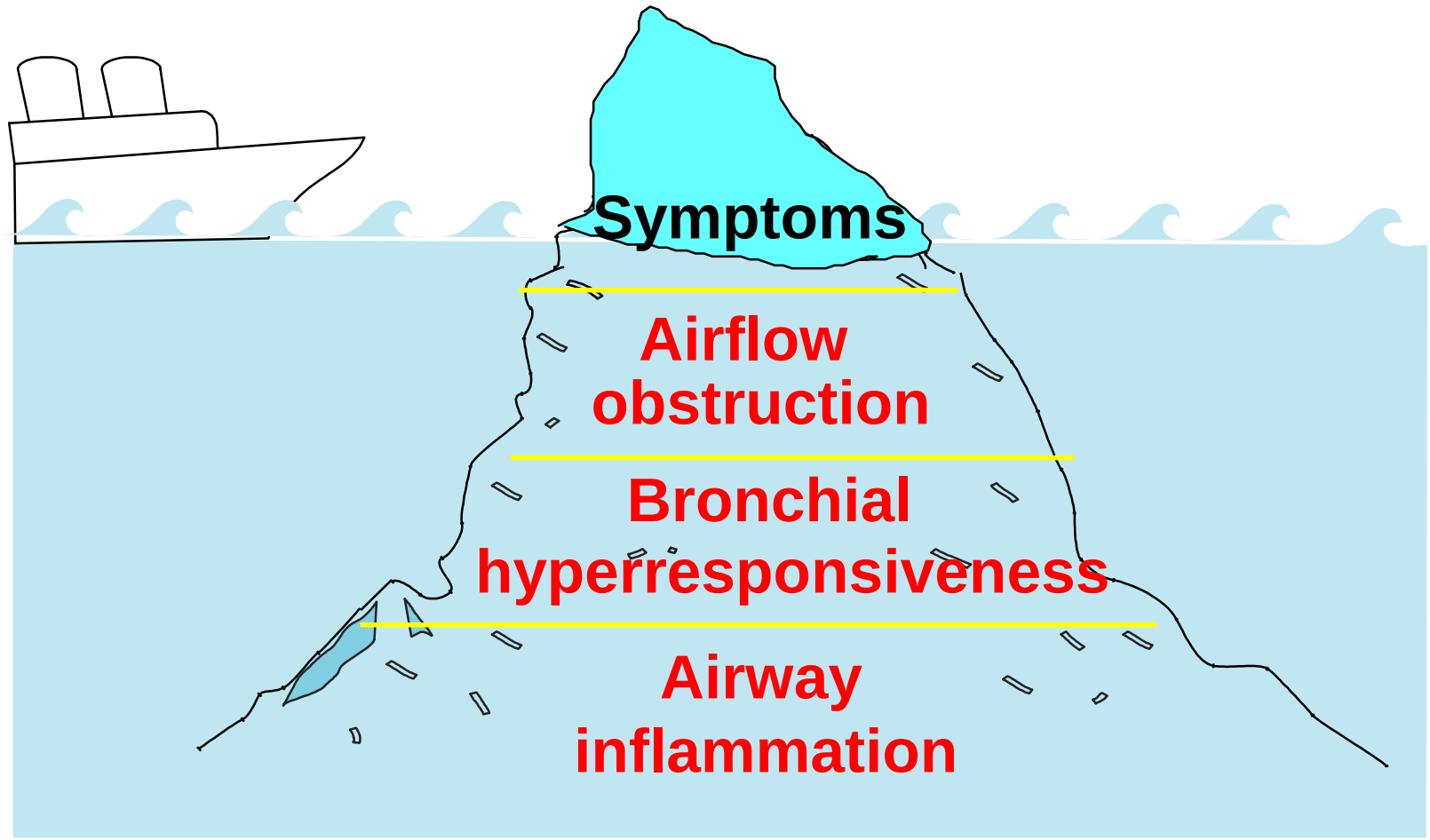
Guidelines


National Heart, Lung,
and Blood Institute
National Asthma Education
and Prevention Program
Expert Panel Report 3:
Guidelines for the Diagnosis and
Management of Asthma
Full Report 2007
U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute
National Asthma Education and Prevention Program
Guidelines Implementation Panel Report for:
Expert Panel Report 3—Guidelines for the
Diagnosis and Management of Asthma
Partners Putting Guidelines
Into Action
U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

Definition of Asthma

- Asthma is a common chronic disorder of the airways that is complex and characterized by variable and recurring symptoms, airflow obstruction, bronchial hyperresponsiveness and underlying inflammation.
- The interaction of these features of asthma determines the clinical manifestations and severity of asthma and the response to treatment.

A Lot Going On Beneath The Surface



Major Indoor Triggers

- Tobacco smoke
- Dust mites
- Animal dander
- Cockroach allergens
- Indoor mold
- Wood smoke
- Formaldehyde
- Volatile organic compounds

Allergen and Irritant Exposure Control

- 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, i.e. that make the patient's asthma worse.

Benchmarks of Good Asthma Control

- No coughing or wheezing
- No shortness of breath or rapid breathing
- No waking up at night
- Normal physical activities
- No school absences due to asthma
- No missed time from work for parent or caregiver

TREATMENT OF ASTHMA

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.

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.

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		
		Mild	Moderate	Severe
	Step 1	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

Asthma Control

- At planned follow-up visits, asthma patients should review level of control with their health care provider based on multiple measures of current impairment and future risk in order to guide clinician decisions to either maintain or adjust therapy.

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

CASE STUDIES OF ASTHMA SEVERITY AND CONTROL

Case Study 1

You meet a 3 year old boy with a long history of recurrent coughing who was recently seen in urgent care due to a severe cough. He was given oral steroids for 3 days and is improving, according to his mother. The child is happy and playful in the room with you. His history is remarkable for several emergency room visits between 6 months and 18 months of age for "bronchitis" during the winter. After further questioning, the mother notes the child has daily cough and she gives him albuterol often.

What is your diagnosis?

At what level of severity is this patient?

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		
		Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

Key: EIB, exercise-induced bronchospasm

Case Study 2

Your 17 year old female patient has just returned home from her first year in college. She is compliant with her controller medication and denies nighttime symptoms. She notes that she is doing well and only having asthma symptoms if she forgets her medication prior to workouts. She is using albuterol for exercise pre-treatment about 3-4 times a week, but not requiring rescue medication. She has not needed recent urgent care or prednisone therapy.

What is her level of control?

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.

Key Point #2

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

Selecting Appropriate Medications

- Quick-relief medications
  - Short-acting beta-agonists
  - Inhaled anticholinergics
  - Systemic corticosteroids
- Long-term control medications
  - Daily inhaled corticosteroids
  - Leukotriene modifiers
  - Long-acting, inhaled β2-agonists (should never be used alone)
  - Cromolyn and nedocromil (not available in some countries)
  - Methylxanthines
- Combination medicines
  - Inhaled Corticosteroid and long acting beta-agonist combination
  - Other anti-asthmatic combination therapies

Inhaled Steroids In Children

- Inhaled corticosteroids are the most effective medications for long-term management of persistent asthma, and should be utilized by patients and clinicians as recommended in the guidelines for control of asthma.

Inhaled Steroids In Children

- Most effective (reduced exacerbations and hospitalizations) long-term anti-inflammatory medications currently available.
- Reduce the need for quick-relief medications.
- Fewer side effects than steroid tablets or syrup.
- Long-term inhibition of growth (mean = ½ inch) may occur with prolonged use of ICS medication in pre-pubertal children.
- Using spacer devices with lowest effective dose and rinsing the mouth after inhaling steroids decrease local side effects and systemic absorption.

Follow-up Visits

- Patients should be scheduled for planned follow-up visits at periodic intervals in order to assess their asthma control and modify treatment if needed.

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.

Key Features of an Asthma Action Plan

- All people who have asthma should receive a written asthma action plan to guide their self-management efforts.
- Written plans should be keyed to symptoms, severity and control and should include:
  - Daily management as well as early recognition and actions for exacerbations
  - Medication names (trade or generic)
  - How much to take and when to take it
  - How to adjust medicines at home as symptoms change
- Plan should be formulated in light of patients' social and cultural experience and expectations.

Asthma Action Plan Examples

Asthma Action Plan

Name	Date
Doctor	Medical Record #
Doctor's Office Phone #: Day	Night/Weekend
Emergency Contact	
Doctor's Signature	

The Colors of a traffic light will help you use your asthma medicines.

Green means **Go Zone!**
Use preventive medicine.

Yellow Means **Caution Zone!**
Add quick-relief medicine.

Red means **Danger Zone!**
Get help from a doctor.

Personal Best Peak Flow _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow from _____ to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR PRIMARY CARE PROVIDER.

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

State of New York, George E. Pataki, Governor
Department of Health, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner

COPY FOR PATIENT

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Plan de Acción para el Asma

Nombre	Fecha
Médico	# Récord médico
Médico Día #	Noche/Fin de semana
En case de emergencia #	
Firma del Médico	

Los colores de un semáforo le ayudarán a usar sus medicinas para el asma.

Verde representa la **¡Zona de Proceder!**
Use medicinas preventivas.

Amarillo representa la **¡Zona de Precaución!**
Añada medicinas para alivio rápido.

Rojo significa la **¡Zona de Peligro!** Busque inmediatamente ayuda de un médico.

Su meor marca en el mejor de capacidad pulmonar_____

PROCEDER

Usted tiene *todos* estos:
- Respira bien
- No hay tos ni adeo con silbido
- Duerme toda la noche
- Puede trabajar y jugar

Medida máxima de _____ a _____

Use estas medicinas ant-inflamatorias preventivas diariamente.

MEDICINA	CUÁNTO	CUÁNTAS VECES/CUÁNDO
Para el asma cuando practica ejercicio, tome:		

PRECAUCIÓN

Usted tiene *cualquiera* de estos:
- Las primeras señales de un resfriado
- Se ha expuesto a algo que provoca el asma
- Tos
- Silbido leve
- Pecho apretado
- Tos por la noche

Medida máxima de _____ a _____

Continúe con su medicina de zona verde, y AÑADA:

MEDICINA	CUÁNTO	CUÁNTAS VECES/CUÁNDO

LLAME A SU PROVEEDOR DE ATENCIÓN PRIMARIA.

PELIGRO

Su asma empeora rápidamente:
- Las medicinas no ayudan
- Sus respiratión es fuerte y rápido
- La nariz se abre ampliamente
- Puede ver sus costillas
- No puede hablar bien

Alcance el máximo leer de flujo abajo _____

Tome estas medicinas y llame a su médico inmediatamente.

MEDICINA	CUÁNTO	CUÁNTAS VECES/CUÁNDO

¡OBTENGA AYUDA DE UN MÉDICO AHORA MISMO! No tenga miedo de causar un alboroto. Su médico querrá verle inmediatamente. ¡Es importante! Si no se puede poner en contacto con su médico, vaya directamente a la sala de emergencia. NO ESPERE.

Haga una cita con su médico dentro de dos días a partir de una visita a la sala de emergencia o de una hospitalización.

State of New York, George E. Pataki, Governor
Department of Health, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner

COPIA PARA EL PACIENTE

48s1

Long-Term Treatment Plan

- Patients need to know your long-term treatment plan for them.
- This information is significantly associated with positive asthma outcomes.
- The asthma action plan shows them what to do now.
- An overview of how you plan to manage the asthma over the longer term (the bigger picture is needed).
  - It shows that you have thought through the child's problem.
  - It shows your benchmark of progress.
  - It shows the "light at the end of the tunnel" (it is possible to reduce the amount of medicines needed).

Long-Term Treatment Plan Cont'd

- For example, you might tell patients:
  - Follow the action plan.
  - If the symptoms get worse, we will step up the medicines.
  - If there are no symptoms for three months, we will step down the medicines.
  - The long-term plan is to reach the point where the asthma is under control with as little medicine as possible.

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.

Segment 2: Communication Strategies

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.

Background

- Excellence in medical treatment is worthless if the patient doesn't take the medicine.
- Compliance is closely linked to clinician communication and patient education.
- Most clinicians believe they are good communicators, but most patients feel clinician communication and education is inadequate.
- This diversity of opinion can be even greater when clinician and patient are from different cultures.

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.

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.

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.

Health Belief Model

These beliefs influence willingness to follow preventive or therapeutic recommendations:

- I am **susceptible** to this health problem.
- The threat to my health is **serious**.
- The **benefits** of the recommended action outweigh the costs.
- I am **confident** that I can carry out the recommended actions successfully.

Beliefs About Susceptibility

Some families resist accepting the diagnosis because they believe that:

- Because an older relative was “crippled” by asthma, their child will also be “crippled.”
- Asthma is psychologically caused or feigned by the child.

Resisting the diagnosis reduces the likelihood that the family will follow the treatment plan.

Beliefs About Seriousness

- If the family thinks asthma is not serious, they are less likely to follow the treatment plan.
- If the family overestimates the seriousness of asthma, they may follow the plan, but prevent the child from taking part in normal physical activities.

Beliefs About Benefits and Costs

- The benefits of therapy, obvious to the clinician, are often unclear to patients or irrelevant to their personal goals.
- Perceived costs of therapy include:
  - Financial burden of care
  - Fear that medicines will harm the child
  - Regimen seen as time-consuming and hard to carry out

Fears About Asthma Medicines

39% believe medicines are addictive.

36% believe medicines are not safe to take over a long period.

58% believe regular use will reduce effectiveness.

Beliefs About Ability to Carry Out Recommendations

- Research in psychology shows that when you are confident that you can do something successfully:
  - You do it more often.
  - You are more persistent in the face of difficulty.
- Many families lack confidence that they can manage an asthma attack at home.

Implications

- Therefore, the clinician must establish open communication that permits these health beliefs to be identified and discussed.
- Beliefs may differ according to the patient's social/cultural experience.

Barriers To Effective Communication

Studies show that patients often:

- Feel they are wasting the clinician's valuable time
- Omit details they deem unimportant
- Are embarrassed to mention things they think will make them look bad
- Don't understand medical terms
- May believe the clinician has not really listened and therefore doesn't have the information needed to make a good treatment decision
- Believe the clinician doesn't understand their social and cultural experience

Video Demonstration:
Communication Strategies

Strategies

- Non-verbal attentiveness
- Addressing immediate concerns
- Reassuring messages

GOAL/PURPOSE

- *Relaxing and reassuring patients so they pay attention to what is being said.*

Strategies

- Interactive conversation
- Eliciting underlying fears

GOAL/PURPOSE

- *Improve the exchange of ideas and feelings and gather information needed for diagnosis and treatment decisions*.

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.*

Strategies

- Non-verbal encouragement
- Verbal praise

GOAL/PURPOSE

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

Key Point #5

Good communication and patient education can be efficiently and effectively accomplished in several standard primary care visits.

Evidence

Randomized controlled trials have shown that good communication and patient education can positively impact patient outcomes.

Results from Parents & Patient, and Pediatrician Outcomes

Both studies showed:

- •Pediatricians were more confident in:
  - developing short-term goals
  - reviewing long-term plans
- •Parents reported that the intervention pediatrician:
  - tried to find out about parents' biggest concerns
  - was more likely to encourage child to be active
  - was more likely ask if child was achieving their own goals.

- •Compared with controls, physicians who received the intervention showed:
  - Increased use of written plans
  - Increased use of inhaled anti-inflammatory therapy
  - More attention to patient fears
  - No additional time for patient visit

Patients whose physicians participated in the PACE seminar had:

- Reduced emergency room visits
- Reduced days of daytime symptoms in the Fall
- Reduced days with decreased activity due to asthma in all seasons (Spring, Summer, Winter, & Fall)

In Summary

- Good communication between patient and clinician helps identify patient concerns that may block adherence, makes patient teaching more effective and promotes patient self-confidence to follow the treatment plan. It is directly related to reductions in symptoms and health care use.
- Good communication and patient education can be efficiently and effectively accomplished in several standard primary care visits.
- Patient culture and social experience influence the interaction with the clinician.

Wrap-up of PACE Plus Day 1 Session

PACE Plus Day 2 Session

Segment 1: Review of Communication Skills and Self-Rating Scale

Key Points

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 written plan.

Key Points

4. Good communication between patients and clinician helps identify patient concerns, makes patient teaching more effective and promotes patient self-confidence to follow the treatment plan.
5. Patients' education can be efficiently and effectively accomplished in several standard primary care visits.
6. The patient's culture and social experience must be considered in deciding elements of communication about the treatment plan and counseling.

Segment 2: Video Demonstration: Patient Asthma Education Messages

Segment 3: Tricky Case

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.

Segment 5: Cross-Cultural Communication

Objectives of Discussion

- To review recommendations from experts regarding effective cross-cultural communication with emphasis on needs in the African American and Latino/Hispanic communities.
- To introduce concepts clinicians can consider to enhance their cross-cultural communications.

Background

In the United States, the groups conventionally termed “minorities” will comprise 38% of the population in 2025 and over 50% of the population by 2065.

Background Cont'd

- Studies have shown that racial/ethnic minorities do not report improved health status despite access to care.

- Patients and providers have different priorities regarding the patient's health.

Background Cont'd

The two subgroups of the population experiencing the greatest prevalence and problems with asthma are African Americans and Latino/Hispanic patients.

Background Cont'd

It has been stated that physicians need to recognize that all individuals operate with some level of bias and stereotyping of cultures different than their own. A self check can help decrease these tendencies.

Cross-Cultural Communication

Cross-cultural communication in health care refers to the ability of health care providers to account for the needs, beliefs, behaviors, and expectations of a multicultural patient population.

Medical Culture

In developing such skills, the culturally aware practitioner can't ignore the "culture" of the U.S. medical care system. This culture believes that it is medical science and technology that can overcome disease.

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.

Examples of Views of Some African American and Latino/Hispanic Patients about Asthma

	African American	Latino/Hispanic
Words to describe asthma symptoms	• Tight or itchy throat • Voice tight • Rough breath • Wheeze is a feeling	• Open mouth breathing
Alternative or complementary beliefs and practices	• Emphasis on religion • Holistic view of health • Information gleaned from local community , targeted media, and informal sources such as grocery stores and hair dressers	• Confidence in "*espiritistas*" and "*santeros*" as counselors, as well as family members, Botanica owners
Asthma home remedies	• Herbal remedies • Breathing into a paper bag • Warm Coke • Rubbing Vicks on chest	• Herbal teas and remedies

Examples of Views of Some African American and Puerto Rican Patients about Asthma Cont.

	African American	Latino/Hispanic
General health beliefs	• Health is a personal responsibility. • Extended family has a role in health decisions. • Life vs. health centered. • Females are major decision makers.	• Health is a function of luck. • "*Familia*" is central to dealing with health problems. • For some sub-cultures females are major decision makers and in others, males. • High respect for and deference to medical authorities and likely not to question when things are not clear, while some sub-cultures may not be trusting.

Experts' Recommendation for Interacting More Effectively:

Examine one's own culture as a clinician, which is likely to be optimistic about science and technology-

- Ask oneself: Do I make room in my consultation for the patients' view of other important influences?

Culture & Communication

- A common assumption is that “treating others as we want to be treated” will ensure respectful communication and social interaction.

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.

Video Demonstration #1:
Communicating Across Cultures

Culture & Communication

- The social and cultural differences between health care providers and many of their patients requires that health care providers avoid making the assumption of “treating others as we want to be treated.”
- Culture determines interpersonal dynamics, and what patients expect from their relationship with the health care provider.

Summary Points

- 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.

Video Demonstration #2:
Communicating Across Cultures

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.

Strategies

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

- Don't guess in advance about the views of the patient.
- Listen and watch carefully to see what the patient's words and behavior communicate to you about his or her views.

Strategies

- Use indirect discussion to elicit a patient's beliefs about things that could influence the use of health care and health status including folk or alternative medicines.

For example:

"People in the neighborhood tell me there are good ways of treating asthma that doctors don't know about. Can you tell me about these? Do they work?"

Strategies

- Don’t try to dissuade with the “facts” when a patient’s beliefs go beyond medical advice or they engage in alternative practices (unless these are clearly harmful to a person’s health).
  - Shape counseling so as not to discount such beliefs (e.g. incorporate some aspects of the patient's folk medicine beliefs into your counseling).

Strategies

Ask the patient which family members, if any, he or she wants to involve in treatment decisions.

Strategies

Don’t rush to give patients from another culture all the complete information or bad news regarding the condition.

- Go slowly and get advice from family members as to which relative should be given all the facts.

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.

Electronic Medical Record

- Electronic medical record is changing the communication dynamic in the clinical encounter.
- Emphasis should be placed on active communication while simultaneously documenting when working with patients cross-culturally.

Strategies - Interpreter

- When working with an interpreter, direct your conversation to the patient/parent.

Strategies - Interpreter

- Things to consider when using an interpreter:
  - Patients can refuse interpretive services.
- Trained medical interpreters can be the most objective source of information for patients and providers.
- Minors should not be used as interpreters.

Strategies – Telephone Interpreter

- Useful in situations where:
  - In-person interpreters are not available for language requested.
  - Patient concerned about privacy and having a third party in the room.

Strategies – Telephone Interpreter

- Things to consider when using a telephone interpreter:
  - Be sure to have a speaker phone or telephone with dual receivers or headsets in the room.
  - Not well-suited when giving bad news, long interactions, procedures that require demonstrations, and patient education and teaching scenarios.

Video Demonstration #3:
Communicating Across Cultures

Segment 5: Clinical Case Discussions

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.

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.

Wrap-up