



Care of Patients with Pulmonary Disorders

Changes in clinical conversations when providers are informed of asthma patients' beliefs about medication use and integrative medical therapies



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ARTICLE INFO

Article history:

Received 5 May 2015

Received in revised form

12 November 2015

Accepted 15 November 2015

Keywords:

Primary care

Patient-provider communication

Integrative medicine

Asthma

Health beliefs

Decision-making

ABSTRACT

Objectives: To explore whether patient's personal beliefs about inhaled corticosteroid (ICS) and integrative medicine (IM) are discussed at routine primary care visits for asthma.

Background: Negative medication beliefs and preferences for IM can be salient barriers to effective asthma self-management.

Method: A qualitative analysis of transcripts from 33 audio-recorded primary care visits using conventional content analysis techniques.

Results: Four themes emerged when providers had knowledge of patient's beliefs: negative ICS beliefs, IM use for asthma, decision-making and healthy lifestyles. Two themes were identified when providers did not have this knowledge: asthma self-management and healthy lifestyles.

Conclusion: When providers had knowledge of their patient's IM endorsement or negative ICS beliefs, they initiated conversations about these modifiable beliefs. Without training in IM and in effective communication techniques, it is unlikely that providers will be able to effectively engage in shared decision-making aimed at improving asthma self-management.

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Introduction

As many as 82% of adolescents and adults with asthma have uncontrolled disease,¹ defined as an asthma exacerbation requiring a hospitalization or burst of systemic steroids, frequent symptoms, activity limitations, declines in lung function or need for "step-up" therapy. Minorities are disproportionately represented within the asthma population; more than 24 million Americans have asthma and prevalence is higher among non-Hispanic Blacks (11.1%) and those living below the poverty level (11.6%).² Adults die at 6 times the rate of children and Blacks die at nearly twice the rate of

Whites.² Asthma control can be defined as "the extent to which the various manifestations of asthma have been reduced or removed by treatment."³ These include minimal or no symptoms, optimal pulmonary function, few/no exacerbations, and the ability to carry out activities of daily living and achieve optimum quality of life.³ The economic cost of uncontrolled asthma is very high despite asthma control being achievable by adhering to a multifaceted treatment plan that includes trigger remediation and avoidance, self-monitoring guided by asthma action plans, regular follow-up and pharmacologic management, including inhaled corticosteroids (ICS) for persistent disease.^{4,5} Among the many reasons contributing to poorer asthma control, one is more common in Black adults than in other groups: lower rates of inhaled corticosteroid (ICS) adherence.^{6–9}

ICS treatment, part of the multifaceted treatment plan, is largely effective in achieving and maintaining control of persistent asthma

Funding: This study was supported by the National Center for Complementary and Alternative Medicine (National Institute of Health) 1K23AT003907-01A1.

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in the vast majority of individuals with persistent disease.¹⁰ While ICS adherence is estimated at 50% across all populations,¹¹ ICS adherence has been reported as low as 26% in Black adults.⁷ Personal beliefs about asthma and its pharmacologic treatment are among the most significant factors affecting ICS adherence, particularly in the Black community.^{8,12–14} For example, negative ICS beliefs (e.g., skepticism about the need for ICS, concerns about side effects or addiction risk) have been found to partially mediate the association between minority status and ICS use.¹⁵ In addition, lower rates of ICS adherence have also been identified in patients endorsing integrative medicine (IM) for asthma.^{16–18} IM includes “the array of health care approaches with a history of use or origins outside of mainstream medicine”¹⁹ commonly referred to as alternative (*in place of*) or complementary (*in addition to*) medicine. For example, Black adults commonly employ prayer and culturally-relevant home remedies^{20,21} to replace ICS or to augment a patient-directed reduction in ICS dose.^{16–18}

Clinical outcomes might be improved in asthma if providers had knowledge of these important and potentially modifiable beliefs that may contribute to ICS non-adherence. However, most adult asthma care is delivered by primary care providers during visits lasting <15 min²² making it difficult, if not impossible, to identify potential obstacles to the medical plan. This speaks to the pressing need for novel brief interventions that engage patients in their own self-care decision-making.

Patient-provider shared decision-making communication is one critically important component of quality care that may be useful for facilitating mutual understanding and partnering that improve clinical outcomes in chronic conditions, such as asthma.^{23–26} Patients rate communication as one of the most important skills a provider can possess.²⁷ Effective communication enhances providers' understanding of patient preferences and uncovers possible treatment misconceptions. Providers using enhanced communication skills, in which the patient is actively involved in the final decision regarding the course of treatment, saw better patients' outcomes^{28–30} including greater IM disclosure³⁰ and ICS adherence in adults.³¹ Shared decision-making is described as a “deliberation and is interactional in nature” (p.16).³⁰ Unfortunately, patients infrequently discuss their IM use with their providers^{32–34} believing their decision to use IM will be misunderstood³⁴ or that providers are uninterested in IM³⁵ or lack meaningful IM knowledge.^{34,35} In turn, providers may not query patients creating, in essence, a de facto “don't ask, don't tell” policy^{32,34} which leaves the provider inadequately prepared to screen for, or to respond, to patient disclosures. However, identifying negative ICS beliefs or IM use could provide a critical opportunity for a patient-provider interaction that helps align treatment goals.³⁶

Aims

The aim of this study was to explore the content of clinical conversations at routine primary care visits when providers did or did not have knowledge of their patients' use of IM and their personal beliefs about asthma self-management including ICS.

Design

A qualitative descriptive study design using audio recordings of the primary care visits was employed to explore the content of the clinical conversations between the patients and their primary care provider. Qualitative descriptive design is the method of choice when the purpose of the study is description of a phenomenon.³⁷

Setting and sample

We enrolled a convenience sample of 43 participants (patients and providers) from three unrelated primary care sites: two internal medicine group practices and one federally-qualified health center (FQHC). Providers from these sites were recruited from a parent study³⁸ and were considered eligible for enrollment if they were either a medical doctor or a nurse practitioner responsible for the care of a panel of adults with persistent asthma (i.e., those requiring ICS therapy). Patient participants were either identified by their primary care providers or self-referred into the study in response to posted flyers. Inclusion criteria for patients included age ≥ 18 years and prescribed ICS for provider-diagnosed persistent asthma. Exclusion criteria included inability to speak English or to understand the informed consent process. By signing informed consent both providers and patients agreed to provide demographic data and to have their primary care visit audio recorded for the purpose of learning more about how providers and patients talk about asthma self-management. Patients received a \$50.00 cash incentive and transportation tokens to defray travel-related costs and providers received a prepaid debit card after data collection was complete.

Asthma control

Asthma control was calculated by using standard patient-reported outcomes that are recommended by the national guidelines⁴: the number of short-acting β_2 -agonist (SABA) doses in the prior 7 days, the number of night-time awakenings caused by asthma in the prior 30 days, or both. Participants were categorized as having controlled asthma (SABAs ≤ 2 days per week and/or awakenings ≤ 2 times per month), or uncontrolled asthma (SABAs > 2 days per week and/or awakenings 1–3 times per week, or SABAs several times a day and/or awakenings > 4 times per week). Control categorization was determined during analysis and was not available at the time of the visit.

IM endorsement and negative ICS belief assessment

The 17-item *Conventional and Alternative Management for Asthma (CAM-A)* survey is a brief self-administered screening tool with low literacy demands³⁹ that has undergone rigorous psychometric development, testing and refinement.³⁸ The CAM-A identifies two barriers to ICS adherence: negative ICS beliefs and IM use for asthma; the IM endorsement subscale score is significantly associated with uncontrolled asthma.

Procedures

To determine what constituted typical communication between patients and providers during routine primary care visits for asthma, we audio-recorded the visits. In a non-random assignment, patients completed the CAM-A instrument either before or after routine clinic visits. When providers first enrolled, the CAM-A was administered after the visit. This ensured that the conversation was typical of routine visits for asthma. If the provider participated a second time, the CAM-A was administered prior to the visit. When this occurred, trained research assistants (RAs) (pre-med and nursing students) shared a simple written summary of the CAM-A results with the providers in the patient's presence: ‘your patient endorses IM for asthma yes/no’ and ‘your patient has negative ICS beliefs yes/no.’ Additional detailed information was available to the provider although reviewing these details was optional. The RA did not give the provider any instruction as to what to do with this

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