

ASK THE EXPERT

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Question:

What are ways the asthma educator can elicit hidden health beliefs that may impact adherence to asthma medications?

Expert: Maureen, PhD, RN, AE-C FAAN

Answer: Inhaled corticosteroid (ICS) adherence, a primary cause of uncontrolled and/or fatal asthma¹, is lower in minority populations relative to Whites²⁻⁵ due, in part, to higher rates of erroneous personal health beliefs regarding asthma self-care⁶⁻¹² (e.g., coffee is a safe, effective asthma treatment) and negative ICS beliefs^{2-5,7,8,13} (e.g., ICS is addicting). These beliefs have been shown to be associated with ICS non-adherence^{7,13,14}, more asthma attacks^{13,15} and delays in seeking care⁷. Disease control might be improved if asthma educators had knowledge of these important and potentially modifiable beliefs. This means that it is the responsibility of the educator to ask about patients' health beliefs and to ensure a safe environment to promote patients' disclosure of beliefs¹⁶. This will require that the educator deliver patient-centered care which is "respectful of and responsive to individual patient preferences, needs and values and ensures that patient values guide all clinical decisions"¹⁷.

Meet the Expert:



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What does patient-centered care look like? The Institute of Medicine offers the following guidelines that can serve as a template for the delivery of patient-centered asthma education¹⁷.

- 1. Care Is a Continuous Healing Relationship.** A continuous healing relationship is characterized by humility in the face of what science doesn't know. The educator uses horizontal communication, not top-directives that fail to acknowledge the right to self-determination and that devalue patients' beliefs and preferences.
- 2. Care Is Customized According to Patient Needs and Values.** Asthma educators are responsible for their own cultural competency training¹⁶ to insure that they deliver



asthma education in a culturally-respectful nonjudgmental manner that acknowledges the importance of – and accommodates- diverse world views.

3. **The Patient Is in Charge.** The educator accepts and respects patients’ self-determination even when patient goals for asthma self-management do not align with evidence-based guideline-directed care.
4. **Knowledge Is Shared.** The educator solicits the patients’ health beliefs to better understand different worldviews and offers evidence-based recommendations to reduce treatment conflicts. This is best accomplished by initiating a conversation using a “permissive stem”, a statement that acknowledges that there may be an inherent conflict in the medical plan but that this is a safe environment in which differences can be reconciled. “I know that most of my patients don’t take their controller medication as prescribed – either they take fewer doses or stop taking the medicines completely between attacks. I also know that this is sometimes because they have fears about the safety of the medicine or because they don’t believe they need it every day. What kinds of things do you believe to be true about your controller medicines?” Also ask if they have found other effective disease management strategies. “Many of my patients have found ways, other than their asthma medicines, to prevent or relieve their asthma symptoms. This might be exercise, diet, herbs, or things they eat or drink. Can you tell me what you have found to work for your asthma?” Disclosures must be met with respect and evaluated for safety.
5. **Decisions are evidence-based.** Patients may not find the evidence for guideline-directed asthma self-management compelling. While many alternative treatments may not have “proof” that they work, most are not harmful. The educator should therefore support the patients desire to use integrative therapies- that is, to use prescription medicines and alternative therapies together. Once they have agreed to use some prescription medicines, the educator can work to increase the amount of, or consistency of prescription medicine use, as a partnership with the patient is established.
6. **Safety is paramount.** The educator actively dissuades patients from making harmful decisions using persuasive communication techniques, such as motivational interviewing and therapeutic communication.
7. **Needs Are Anticipated.** The educator anticipates patients’ conflicts with evidence-based recommendations and develops a plan to reconcile differences amicably by engaging patients in shared decision-making; such approaches enhance patient-educator partnerships and result in greater alignment of patient values and educator goals.

In summary, what should the educator ask?



1. The educator should solicit patients' beliefs about the need for, and safety of, ICS and other asthma prescriptions.
2. The educator should ask patients about their non-prescription self-management approaches (complementary and alternative medicine, folk care)⁶⁻¹⁵.

How should the educator respond to disclosures?

1. Never express anger or frustration.
2. Never ridicule.
3. Assume responsibility for learning about these approaches; be knowledgeable about what is dangerous and what things are likely harmless, even if they are ineffective. Develop a joint plan that allows for integrative management.
4. Don't make assumptions. Just because a patient in one cultural group holds a certain set of beliefs, do not assume all members of that cultural group believe the same things.

By delivering expert patient-centered care, asthma educators can elicit the hidden beliefs that conflict with evidence-based guideline-directed care; these conflicts can then be reconciled by engaging patients in shared decision-making. To be successful at disease management, the patient's concept of health-- what it is, how it is achieved, and how it is sustained --must be considered in addition to the externally specified targets set by evidence-based guidelines.

