

Revisiting What We Need to Do to Help Urban Minority Children with Asthma



Bruce G. Bender, PhD *Denver, Colo*

The article by Garbutt et al¹ brings us back once again to the important question of how to help urban minority children with asthma. The lessons from this study are not new, but nonetheless reinforce what providers can do to improve care.

The study is a model of how qualitative research informs our understanding of the experience of asthma and its treatment in families. The investigators conducted 7 focus groups with 48 St Louis parents/caregivers of mostly black children with asthma. Using a focus group guide, meetings were conducted by interviewers of the same race as the participants. Focus groups were audiotaped, transcribed, and coded for major themes. The extracted themes deliver clear and important messages about the families' experience of asthma. Pediatric asthma is often overwhelming psychologically, socially, educationally, and financially. Adherence may be low, the result of a number of barriers: (1) Concerned about the safety and effectiveness of prescribed medications, parents and caregivers may prefer home remedies. (2) Families may receive insufficient information about the child's asthma and its treatment. (3) Trust in the child's physician, essential to treatment adherence, is often absent if the physician has not established a strong connection by showing sincere concern, listening, and taking the time to give sufficient information. The take-home messages underscore the importance of delivering compassionate, patient-centered care that includes solid and repeated asthma education.

The problem of asthma undertreatment in low-income, urban families is well documented. Black children with asthma are at increased risk for morbidity and mortality compared with their white counterparts.^{2,3} Although appropriate guidelines-based care can help level this playing field,⁴ low-income minority children continue to be undertreated for their asthma.^{5,6} Furthermore, even where effective medications are prescribed, adherence may be low; only a third of prescribed medication was actually taken in studies of black children⁷ and those on Medicaid.⁸ Patient-centered care (PCC), which addresses those barriers identified by Garbutt et al, represents at least part of the answer to improve asthma

management. PCC emphasizes the importance of establishing trust by listening to and acknowledging patient's concerns, respecting the patient's cultural background, and helping to ensure that the clinician's goal for treatment matches that of the patient.⁹ Studies that used a randomized controlled trial design to test the impact of training health care providers to communicate effectively and deliver evidence-based, pediatric asthma care in a PCC framework have consistently shown improvement in outcomes including improved family satisfaction and reduced exacerbations and costs.¹⁰⁻¹² Effective communication techniques that were taught in these studies included inquiring about patients' concerns, encouraging patients to be physically active, providing sufficient information, and setting goals for successful treatment. Adults with asthma whose providers were randomized to an intervention that included training in shared decision making were more satisfied with their care, more adherent to their treatment regimen, and had fewer exacerbations requiring urgent care in the ensuing 12 months.¹³ Racial and cultural proximity between provider and patient is helpful but not essential.¹⁴ Just as important to black patients is encountering a caring and empathic health care provider who takes the time to listen while transmitting honesty and the sense that they have the patient's best interests at heart.¹⁵ Once patients have access to health care, the quality of their interaction with the health care system and provider remains a key ingredient to the success of treatment.

REFERENCES

1. Garbutt JM, Patterson D, Gehlert S, Strunk RC. Insights from parents can guide asthma care for urban, minority children. *J Allergy Clin Immunol Pract* 2016;5: 516-8.
2. Berry J, Bloom S, Foley S, Palfrey J. Health inequity in children and youth with chronic health conditions. *Pediatrics* 2010;126:S111-9.
3. Hines A. Asthma: a health disparity among African American children: the impact and implications for pediatric nurses. *J Pediatr Nurs* 2011;26: 25-33.
4. Gergen P, TEach S, Togias A, Busse W. Reducing exacerbations in the inner city: lessons from the Inner-City Asthma Consortium (ICAC). *J Allergy Clin Immunol Pract* 2016;4:22-6.
5. Bryant-Stephens T. Asthma disparities in urban environments. *J Allergy Clin Immunol* 2009;123:1199-206.
6. Piper C, Elder K, Glover S, Baek J. Racial influences associated with asthma management among children in the United States. *Ethn Dis* 2008; 18:225-7.
7. McNally K, Rohan J, Schluchter M, Riekert K, Vavrek P, Schmidt A, et al. Adherence to combined montelukast and fluticasone treatment in economically disadvantaged African-American youth with asthma. *J Asthma* 2009;46: 921-7.
8. Makhinova T, Barner J, Richards K, Rascati K. Asthma controller medication adherence, risk of exacerbation and use of rescue agents among Texas Medicaid patients with persistent asthma. *J Manag Care Spec Pharm* 2015; 21:1124-32.
9. Irwin R. Patient-focused care: using the right tools. *Chest* 2006;130:73-82.

Division of Pediatric Behavioral Health, Department of Pediatrics, National Jewish Health, Denver, Colo

Conflicts of interest: B. G. Bender is on the boards for GlaxoSmithKline, Teva, and Sandoz.

Received for publication November 8, 2016; accepted for publication November 9, 2016.

Corresponding author: Bruce G. Bender, PhD, Center for Health Promotion, National Jewish Health, 1400 Jackson St, Denver, CO 80206. E-mail: benderb@njhealth.org.

J Allergy Clin Immunol Pract 2017;5:519-20.
2213-2198

© 2016 American Academy of Allergy, Asthma & Immunology
<http://dx.doi.org/10.1016/j.jaip.2016.11.031>

10. Patel M, Shah S, Cabana M, Sawyer S, Toelle B, Mellis C, et al. Translation of an evidence-based asthma intervention: Physician Asthma Care Education (PACE) in the United States and Australia. *Prim Care Respir J* 2013;22: 29-36.
11. Cabana M, Slish K, Evans D, Mellins R, Brown R, Lin X, et al. Impact of physician asthma care education on patient outcomes. *Health Educ Behav* 2014; 41:509-17.
12. Clark N, Gong M, Schork M, Evans D, Roloff D, Hurwitz M, et al. Impact of education for physicians on patient outcomes. *Pediatrics* 1998; 101:831-6.
13. Wilson SR, Strub P, Buist AS, Knowles SB, Lavori PW, Lapidus J, et al. Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. *Am J Resp Crit Care Med* 2010;181: 566-77.
14. Meghani S, Brooks J, Gipson-Jones T, Waite R, Whitfield-Harris L, Deatrick J. Patient-provider race-concordance: does it matter in improving minority patients' health outcomes? *Ethn Health* 2009;14:107-30.
15. Jacobs E, Rolle I, Ferrans C, Whitaker E, Warnecke R. Understanding African-Americans' views of the trustworthiness of physicians. *J Gen Intern Med* 2006; 21:642-7.