

Shared Decision-Making in Addressing Asthma Health Disparities



Akilah A. Jefferson, MD, MSc^{a,b} Little Rock, Ark

Despite advances in asthma management, racial disparities persist in asthma prevalence, morbidity, and mortality. Akenroye et al¹ examine an important issue in asthma management and highlight an underappreciated asthma disparity, differences in asthma medication use across patient populations. Their analysis focuses on insurance payers and finds a lower use of asthma biologics in publicly insured individuals compared with privately insured individuals. Although asthma prevalence is known to be higher in Black and Hispanic populations, the analysis finds that white people account for most asthma treatment visits overall (64%), the majority of asthma treatment visits among publicly insured patients (60%), and most asthma biologic treatment visits among publicly insured people (80%). What drives this disparity in asthma management among minority patients? The reasons are likely multifactorial, and both upstream (eg, health system issues, costs) and downstream factors (eg, socioeconomic, education, psychosocial issues) likely underlie them. In addition, the authors prominently cite several considerations at the intersection of the provider–patient–provider access barriers, such as communication difficulties, discordance in cultural beliefs, and cultural competency.¹ Such factors related to provider–patient interactions are well-studied and known to influence asthma health disparities.² What, then, is the best approach to asthma disparities with roots at the provider–patient level?

Shared decision-making (SDM), a key component of patient-centered care, is a collaborative process between providers and patients where medical management options are discussed with the goal of meeting each patient's priorities and health care needs. Shared decision-making requires the elements of (1) information sharing, (2) expression of preferences, (3) deliberation, and (4) decision making.³ Decision aids are the most commonly used SDM tool; several decision aids are available for clinical use by allergists/immunologists.^{3,4} Shared decision-making has been shown to be important in reducing decisional conflict, a common problem where there may be more than one medically reasonable option.³ Importantly, SDM can also improve asthma outcomes, medication adherence, patient and parent satisfaction,

and quality of life.^{5–7} Akenroye¹ notes that underappreciation of disease severity by providers, as well as problems with uptake of medical innovations in minority patients and health literacy, may have contributed to the observed asthma biologic treatment disparity. Use of SDM decision aids in diverse populations has been shown to improve patient decision quality and provider–patient communication.⁸ Furthermore, in studies,⁹ Black patients with asthma wanted patient-centered care and to be "heard and respected," in accordance with SDM.

When considering asthma biologics, SDM can have a particularly important role in providing patients with evidence-based information about innovative therapies. This should include provider explanation of specific biologic choice (eg, by patient phenotype) and biologic therapy response goals (eg, steroid-sparing, exacerbation reduction), while adequately explaining risks, benefits, and alternatives. Better information sharing with patients about asthma medication options and adherence is still sorely needed. Asthma management misconceptions among patients, especially regarding issues of medication safety and when asthma medications should be used, are pervasive.¹⁰ In addition, SDM can incorporate social, cultural, and environment considerations leading to more inclusive, effective, and culturally appropriate care.^{3,8}

Akenroye's¹ finding of lower asthma biologic use in publicly insured patients and in publicly insured minority patients highlights health disparities in asthma medication use by insurance payer and race. These findings underscore the need for improved approaches that address asthma disparities at the provider–patient level, such as SDM. Despite the promise of SDM, however, it has not been well-implemented in clinical practice generally, and studies show even slower adoption of SDM in the care of minority patients.⁸ Although SDM has many challenges—a lack of clinician knowledge and skills, underappreciation of patient interest in shared decision-making, lack of time and resources—its potential benefits are clear.^{3,4} Shared decision-making holds great promise for improving the health of all patients with asthma and, important, for addressing asthma health disparities impacting minority populations.

^aDivision of Allergy and Immunology, Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Ark

^bArkansas Children's Research Institute, Little Rock, Ark

Conflicts of interest: The authors declare that they have no relevant conflicts of interest.

Received for publication August 13, 2021; accepted for publication August 13, 2021.

Corresponding author: Akilah A. Jefferson, MD, MSc, Division of Allergy and Immunology, Department of Pediatrics, University of Arkansas for Medical Sciences, 13 Children's Way, Slot 512-13, Little Rock, Ark 72202-3591. E-mail: aaajefferson@uams.edu.

J Allergy Clin Immunol Pract 2021;9:3977-8.
2213-2198

© 2021 American Academy of Allergy, Asthma & Immunology
<https://doi.org/10.1016/j.jaip.2021.08.013>

REFERENCES

1. Akenroye AT, Heyward J, Keet C, Alexander GC. Lower use of biologics for the treatment of asthma in publicly insured individuals. *J Allergy Clin Immunol Pract* 2021;9:3969-76.
2. Smedley BD, Stith AY, Nelson AR, editors. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press; 2003.
3. Légaré F, Witteman HO. Shared decision making: examining key elements and barriers to adoption into routine clinical practice. *Health Aff (Millwood)* 2013; 32:276-84.
4. Blaiss MS, Steven GC, Bender B, Bukstein DA, Meltzer EO, Winders T. Shared decision making for the allergist. *Ann Allergy Asthma Immunol* 2019;122: 463-70.

5. Kew KM, Malik P, Aniruddhan K, Normansell R. Shared decision-making for people with asthma. *Cochrane Database Syst Rev* 2017;10:CD012330.
6. 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 Respir Crit Care Med* 2010;181:566-77.
7. George M, Bruzzese JM, Sommers MLS, Pantaloni MV, Jia H, Rhodes J, et al. Group-randomized trial of tailored brief shared decision-making to improve asthma control in urban black adults. *J Adv Nurs* 2021;77:1501-7.
8. Nathan AG, Marshall IM, Cooper JM, Huang ES. Use of decision aids with minority patients: a systematic review. *J Gen Intern Med* 2016;31:663-76.
9. George M, Arcia A, Chung A, Coleman D, Bruzzese JM. African Americans want a focus on shared decision-making in asthma adherence interventions. *Patient* 2020;13:71-81.
10. Tam-Williams JB, Jones BL. Closing the gap: understanding African American asthma knowledge and beliefs. *Ann Allergy Asthma Immunol* 2018;121:458-63.