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How to Take a Shared Decision-Making Approach to Asthma Care

Announcer Introduction:
You're listening to Deep Breaths: Updates from CHEST on ReachMD. This non-CME education was brought to you by CHEST and was sponsored by AstraZeneca. Your host is Dr. Demondes Haynes, who's a Professor of Medicine in the Division of Pulmonary and Critical Care at the University of Mississippi Medical Center in Jackson.

Dr. Haynes:
Welcome to *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Demondes Hayes, and joining me to discuss the role of shared decision-making in asthma care are Drs. Njira Lugogo and Neil Skolnik.
Dr. Lugogo is a Clinical Professor of Internal Medicine in the Division of Pulmonary and Critical Care Medicine at the University of Michigan Health. Njira, thanks for being here today.

Dr. Lugogo:
Thank you so much for having me.

Dr. Haynes:
And Dr. Skolnik is a Professor of Family and Community Medicine at the Sidney Kimmel Medical College of Thomas Jefferson University and the Associate Director of the Family Medicine Residency Program at Jefferson Health Abington. Neil, it's great to have you on the program today.

Dr. Skolnik:
Demondes, it is my pleasure to be here.

Dr. Haynes:
Now, we've recently had a shift in our understanding of how to manage acute asthma symptoms and how to reduce the risk for our patients as the focus is now on relief of bronchoconstriction and inflammation as Njira mentioned in our first podcast. So let's start with you, Neil. Can you tell us why that is?

Dr. Skolnik:
Demondes, we've known for a long time that the pathophysiology of asthma has two main components, bronchoconstriction and inflammation, and we've known, with the exception of purely exercise-induced asthma, that bronchoconstriction occurs in the context of airway inflammation. That's why for over 20 years now, inhaled corticosteroids have been foundational therapy for the treatment of asthma. Interestingly, though, we're often blind to what's right in front of us until it's pointed out. And even though we knew that inflammation was critically important as an underlying cause of asthma and even though we had integrated it long ago as a part of our standard controller therapy, we didn't think to apply the same knowledge to the treatment of rescue therapy until the advent of SMART therapy. Now if we go back over 20 years ago, there's a paper by Tattersfield looking at perhaps what might be called the window of opportunity – this time in the ten days before full-blown exacerbation where patients start using their SABA more often, their peak flows decrease, and their symptoms increase. But even after that came out, we didn't quite connect the dots until the studies started coming out beginning around 2005 to 2010 looking at SMART therapy – that stands for Single Maintenance and Reliever Therapy. Combination of budesonide and formoterol was the only ICS/LABA that was studied that showed it's effective at decreasing exacerbations when compared to standard therapy using SABA alone as rescue. Why? Because we were finally addressing inflammation and recognizing inflammation as a core feature of exacerbations, not just a core feature of controller therapy or ongoing asthma.

Dr. Haynes:
Well, thanks, Neil. And as a quick follow-up to that, how do you think this change in thinking has been received by our patients?

Dr. Skolnik:
Well, Demondes, it's not just by our patients, though that is critically important, but it has to start with our patients' primary care physicians because over 80 percent of people with asthma are seen primarily by their primary care physicians. And I can tell you, primary care is a big ship. Now what I mean by a big ship is big ships are powerful, but they turn directions slowly. The evidence supporting the use of an anti-inflammatory as a part of rescue therapy is robust, but even with robust evidence, we don't change our habits on a dime. It takes time to get experience with it, and it will take time to educate primary care, for primary care to change to this new habit of using an anti-inflammatory, an ICS/SABA, as the main approach to rescue therapy, and then in turn, it will take time for patients to feel comfortable with it.

Dr. Haynes:
Well, given this fundamental change in treatment and the lack of awareness among our patients, it seems like new strategies may be necessary in order to get our patients on board. So if we turn to you now, Njira, how have you been managing this in your practice?

Dr. Lugogo:
I think it's been quite a journey in the last few years. I will say that my practice is almost 95 percent asthma, so I talk to asthma patients all the time every week. Many have had asthma for years, if not decades, and they've been indoctrinated from pretty early on to understand that their rescue inhaler is the most important medication that you should have with you all the time. So, I would say there's some fear; there's a lot of hesitation about changing your behavior around a medication you've been told to keep with you all the time, and many of these patients have familial asthma histories. There are multiple members in one family that have had asthma. They've seen grandparents or parents with asthma, and everybody emphasized the importance of SABA therapy for bronchoconstriction, so that's what our patients really believe is important.

So, in my experience, education has been of critical importance in this situation. It's been really important for us to have shared decision-making, and so shared decision-making is really dependent on a very good relationship with the patient. You have to have good rapport throughout the appointment, making them comfortable sharing with you their thoughts, fears, and feelings about the new way of managing their asthma. And they have to be supported in a deliberate way so that they can think about their options, express preferences, and get answers to their medications and pairing them to make decisions about their treatment. Because, after all, we engage with patients for 20 minutes, but then they go on back to their lives where they have to make choices, and they may continue to use that SABA despite our attempts if they aren't really buying into the fact that they need to embrace a new treatment paradigm. So to accomplish shared decision-making, you have to introduce the choice to the patients, you have to describe the available options to allow patients to really understand why you're doing what you're doing, and then to help them explore those preferences and make decisions and ultimately respect what the patient has to say. And sometimes people aren't ready to embrace this new change from the beginning, and so it's sort of an iterative process over time.

Dr. Haynes:
For those just tuning in, you're listening to *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Demondes Haynes, and I'm speaking with Drs. Njira Lugogo and Neil Skolnik about how we can take a shared decision-making approach to asthma care.

Based on what Njira discussed earlier, it seems that educating patients about this significant change in care is a critical component of shared decision-making and should be a focus of these discussions. So coming back to you, Neil, how have you used shared decision-making to empower patients to embrace change?

Dr. Skolnik:
Demondes, like you said, shared decision-making is critically important, and as Njira said, it is the best way to get buy-in from patients and the best way, therefore, to enhance adherence long-term. Now unlike Njira's practice, my practice is a primary care practice. It's not primarily an asthma practice. In that context, I even more so agree with everything that Njira said. I just agree with it across therapeutic areas. If we don't let the patient have a vote, then the patient leaves feeling unheard and doesn't leave feeling that they're a part of the care team. A critical component of shared decision-making is recognizing that we have information that the patients don't have, and they have information that we don't have. We know the latest in research. They are the only one, though, who knows their comfort with making a change in therapy, who knows their values and preferences. So usually, I'll share with patients that there's a new advance and that here's the way in which it can be beneficial for them, and here is why. I also make it very clear to them that I recommend this new therapy. Then, I ask them for their thoughts. Most importantly at that point, I keep quiet. So I listen, ask them to share any concerns that they have, and then address those concerns.

Dr. Haynes:
And once patients have that understanding through shared decision-making, Njira, what kind of impact can this have on their adherence and outcomes?

Dr. Lugogo:
What I've seen with my patients is a lot more self-advocacy. Their adherence may not change all the time, so these treatment algorithms are meant even for people who are relatively nonadherent because, frankly, they don't want to take medication when they don't feel ill, but they want to take medication when they have symptoms and get relief and good outcomes. They don't want to go to the ER or the hospital or take steroids, but they end up there because our current treatment is not successful, and so what I found is that patients will then tailor their therapy to their symptoms. We'll see improvements in exacerbation risk and less attacks. They'll even say that they feel better. They have better bronchodilation, they feel less short of breath, and they don't have to use inhaled steroids all the time. It's very hard to justify for some patients utilization of inhaled corticosteroids all the time when they're relatively asymptomatic. The more severe patients still have to take their maintenance therapy, but there's less fear because you have a plan. You know based on your action plan what to do when you start getting in trouble, and when you take those therapies ultimately, in many cases it's successful, but if not, you know when to ask for help and reach out in order to get better control over your disease. And so at the end of the day, I feel like patients feel very empowered and activated, and by the way, conversations about pathophysiology, inflammation, and all that can be had with people that are very health literate or people who are rather health illiterate as long as you explain it in a manner that resonates with the patient and they're able to get all their questions answered. They feel like you care, and they are more likely to embrace the treatment plan and have good outcomes.

Dr. Haynes:
Before we close, Njira, would you mind sharing some highlights from our discussion today that our audience should take with them?

Dr. Lugogo:
If I were to take away one thing from today, it's that we need to empower our patients to take better care of themselves, and the way to do that is to provide them with information that enables them to make choices that lead to better outcomes. Now, it does require us as providers to become comfortable with new treatment paradigms, look at the literature, feel like we, ourselves, are ready to embrace change, and then boldly go where you maybe haven't gone before with our patients and talk to them about how we know better now so we want to do better and to really trust that our asthma patients ultimately want good outcomes. And we can get them there by helping them to make the right choices for themselves.

Dr. Haynes:
Well, with those key takeaways in mind, I want to thank our guests, Drs. Njira Lugogo and Neil Skolnik, for sharing their thoughts on how to involve patients in improving their asthma care and reducing risk over time. Dr. Lugogo, Dr. Skolnik, it was great having you both on the program today.

Dr. Skolnik:
Thank you.

Dr. Lugogo
Thank you so much for having me.

Announcer Close:
This has been Deep Breaths: Updates from CHEST on ReachMD. This non-CME education was brought to you by CHEST and was sponsored by AstraZeneca. To access this and other episodes inthis series, visit Deep Breaths: Updates from CHEST on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!