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"Patient-Provider Communication and the Impact on Medical Outcomes for Patients with HIV"

will begin shortly.

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Kindly enjoy the following informative slides while you wait for the presentation to begin…..

New AETC-NMC Website Launching
www.aetcnmc.org

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What Are Your Cultural Competency Training Needs?

Take our online survey and let us know!

Please use the following link at your leisure. (http://www.surveymonkey.com/s/PFGSZ3V)

Your responses are greatly valued and will be used to help ensure Cultural Competence in HIV/AIDS focused health care delivery nationwide!

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AIDS Education and Training Center
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February 2012
Volume: 2 Issue: 2

AETC-NMC NETWORK e-NEWS

Your Connection to Ensuring Cultural Competence in HIV Focused Healthcare

Regional AETC Focus

New York/New Jersey AETC Participates in the AETC NMC's Regional Cultural Competency Emerging Populations Training Needs Assessment and Reveals Their Findings

The NY/NJ AETC is an interdisciplinary team that provides training and education to health care providers serving the states of New York and New Jersey, one of the regions in the country most impacted by HIV. Translation of the latest practice guidelines and how to provide culturally competent HIV treatment and prevention interventions to community based providers caring for underserved populations is the core of our work. We partner with the leading academic medical centers and clinical sites in our region to provide approximately 1,800 HIV-related trainings to over 19,000 trainees annually.

The content of the education provided by the NY/NJ AETC is driven by national and state policy and guidelines, clinical and behavioral research findings, professional standards of care, in combination with, local epidemiology, provider identified needs and structural factors of clinical practice. Recognition of patient, provider and institutional factors informs all of our educational interventions.

The NY/NJ AETC MAI Capacity building project draws upon the theory of social capital to build community level capacity for HIV treatment in high-need medically underserved minority populations on both the individual and site level with three core components. Core Component one, the ACCESS (AETC Clinical Community Exchange & Support) program is a coordinated regional effort to provide individualized longitudinal clinical training for minority/minority serving providers. The goal of the program is

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Do you know the incidence and prevalence of HIV in the county in which you practice?

Visit our website and access the **HIV/AIDS Atlas** and find out!

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Don't Forget…..

Remember to take your CME post-test evaluation at the end of this webcast to receive your free credits.

….Listen for announcements at the conclusion of the webcast on how to complete your post-test.

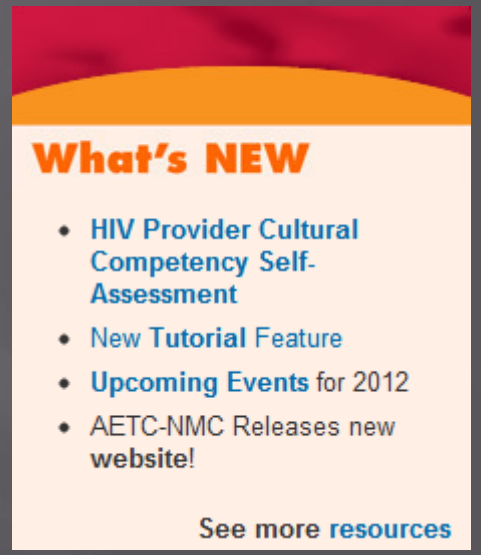
Need help determining which AETC-NMC trainings you will benefit from the most?

Take our new HIV Provider Cultural Competency Self-Assessment and find out!

After completing the assessment:

1) You will learn your cultural competency strengths and areas of improvement, and

2) You will be immediately linked to appropriate AETC-NMC trainings based on your results.



Visit the "What's New" section of our website to get started today!

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Patient-Provider Communication and the Impact on Medical Outcomes for Patients with HIV

AETC National Multicultural Center
Howard University, College of Medicine

Learning Objectives

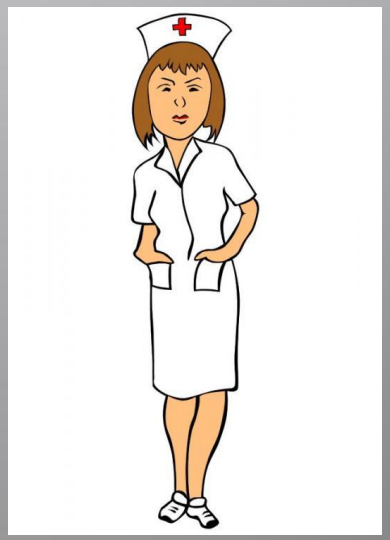
- Describe the history of the patient-provider relationship in the United States
- Define health communication as it relates to the patient-provider interaction and apply IPC as a possible model to improve the interaction
- Explore health literacy as an important foundation to better communication and health outcomes
- Evaluate how knowledge, attitudes and beliefs among health care providers toward patients with HIV impact patient/provider communication
- Identify barriers to successful patient-provider communication and understand their impact on decision-making and apply SDM as a possible model to improve shared decision making

History of the Patient-Provider Relationship in the United States

Patient-Provider Relationships

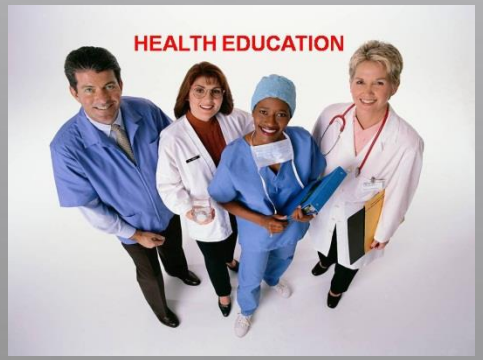
- Historic view of the "gray-haired, white man" and nurses in starched uniforms "nightingales"
  - Patients relied on the physician for medical care, medical information, prevention education, and decision making

The relationship was one-on-one, without the oversight of patient advocates, managed care organizations, or health insurance companies.



Patient-Provider Relationship

In this new age of the empowered patient, where the source of patient empowerment has shifted from the physician to the internet, support groups, medical resources and community-based organization who provide health education, how do provider and patient negotiate the relationship to ensure positive medical outcomes?



Patient Expectation

- Patient expectations extend to more than just a one-on-one relationship with the physician and include other factors, such as waiting time, access to consultations, ability to contact physicians, and time spent with the physician
- Each of these factors either enhances or diminishes trust in a care provider and directly affects the patient-provider relationship
- With the evolution, the physician must stay relevant in the equation by developing a relationship that transcends the control of outside forces

Overcoming Prior Distrust and Suspicion

Minority patient history around health care is laced with distrust and reasonable suspicion.

- Tuskegee, Alabama Syphilis Trials on African American men (1937-1972)
- Forced sterilization of Native American women by the IHS/BIA (1960-80)

feature 4/20/78

Native American denounces Indian bills, sterilization

By Erik Sjobeck

As 400 participants of "The Longest Walk" headed into Wichita, Kan., Lee Brightman, Sioux Indian and a coordinator of the protest march, was in Santa Cruz speaking to a small group of Native Americans.

"The biggest thing we can do now," Brightman, 47, told the local Indians, "is to support 'The Longest Walk.'"

The walk began Feb. 11 in Sacramento with about 200 Indians vowing to walk to Washington, D.C.

Native Americans are alarmed at a recent surge of what they call anti-Indian legislation being introduced inthe U.S. Congress, Brightman said. He specifically cited H.R. 9054, which calls for the termination of the Bureau of Indian Affairs and an end to tribal governments.

In his speech Brightman denounced the Indian Health Services for what he called the forced sterilization of young Indian women.

"They've taken away a God-given right," he said. "They prey on young Indian women."

As Brightman cited statistics showing that approximately 15,000 Indian women had been sterilized from 1973 to 1976, a woman stepped forward from the audience and volunteered that it had happened to her.

"Most of the girls I went to school with had their tubes tied," she said. "The doctors would tell them 'you can always get another operation and have it reversed.' And that's a lie."

The woman, a Chippewa-Cree Indian, was raised on a reservation in Montana.

Brightman called on the Indians gathered there to organize and "stop this murder."

Brightman said "The Longest Walk" is costing $200 to $300 a day for food and clothing.

Snow, high altitudes and highway patrols have caused problems for the walkers. Three women have had babies on the walk. Some students in Colorado had actually quit school to join the march, he said.

"People were thrilled that they got to walk with us," Brightman said.

Recording artists John Denver and Country Joe McDonald have made offers to hold benefits for the march.

Case Study 1: Trust & Cultural Competence

A 39 year old African American women presents to her physician after receiving a positive HIV test. During HIV counseling, immediately after the test, she refused to believe she could have contracted the virus in a sexual way, denying any risk behavior and confident that her former husband is not infected, and wondering aloud if immunizations she received as a child or "shots" she remembered getting when she hurt her back at work several years ago could have been "contaminated." Her discussions with the medical assistant have revealed that she cannot think of any other way she could have gotten "it" and that someone has made a big mistake. She laments that he daughter lives so far away and says repeatedly that "if she were here, she would know what to do." She continues to press for answers before she sees the doctor, indicating she cannot afford to be late back from lunch to her job.

Models for Addressing Issues of Cultural Competence

Carrillo, Green & Betancourt (1999)

- Identify the patient's core cultural issues
- Explore the meaning of the illness to the patient
- Explore the patient's social context
- Negotiate across the patient-physician culture to develop a treatment plan that is agreeable to both sides

BESAFE

(www.aids-ed.org)

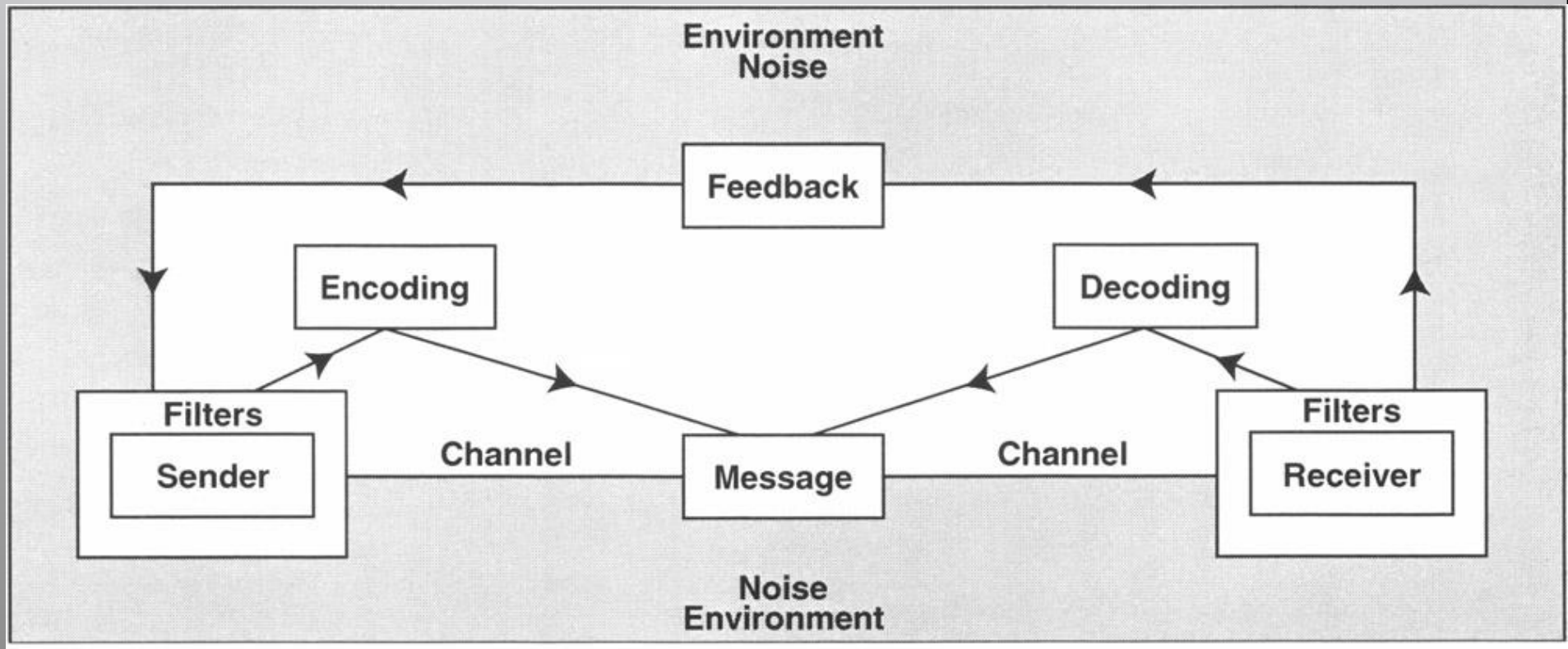
- **Barriers to Care**
- **Ethics**
- **Sensitivity of the Provider**
- **Assessment**
- **Facts**
- **Encounters**
- Nationally recognized model of cultural competence that specifically targets HIV/AIDS-serving clinicians

Definition of Communication and Health Communication

Communication and Health Communication

"The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community."

Communication and Health Communication



Source: Lucas, R. W., *Effective Interpersonal Relationships,* Irwin/McGraw-Hill, 1994, p. 16.

Case Study 2: Communication

A statuesque white female doctor in her early 30s provides information on HIV prevention (in English) to a 19 year old overweight Spanish-speaking Latina, whose second language is English. The doctor provides pamphlets about safe sex, having just diagnosed and treated the patient for Chlamydia. The patient doesn't look at the doctor and only slightly nods as she takes the pamphlets and tucks them into her back pocket. The doctor is careful to acknowledgement the patient's challenge of bringing up the subject with her on-and-off boyfriend, especially in light of a known volatile relationship between the two. The doctor is most concerned about the risk of HIV and opens up to the patient about her concerns. The patient continues to nod, but does not make eye contact with the doctor or provide any feedback. After several minutes of receiving no verbal communication from the patient, the doctor ends the encounter and the patient leaves with the educational pamphlets, written treatment instructions, a prescription for antibiotics, and a gentle reminder to abstain from sex until a week after she takes the azythromycin.

Interpersonal Communication (IPC)

- The patient discloses enough information about the illness to lead to an accurate diagnosis;
- The provider, in consultation with the client, selects a medically appropriate treatment acceptable to the client;
- The client understands her condition and the prescribed treatment regimen;
- The provider and the client establish a positive rapport; and
- The client and the provider are both committed to fulfilling their responsibilities during treatment and follow-up care

Effective Communication

- Because of the limited patient-provider face-to-face time, the training of medical support and administrative staff in IPC cannot be overstated, but not just in medical school and not just for providers
  - Medical assistant's recognition that words, speech acts, metaphors, or other cues are being misunderstood or missed can assist the provider in altering communication strategies
    - "The culture of an individual has a profound effect on the perspective from which they deal with health and illness." (Todd and Baldwin, 2006)
  - "Patients who understand the nature of their illness and its treatment and who believe the provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimens." (Negri, Brown, Hernandez, Rosenbaum, and Roter, 2009)
  - Mastery of IPC should be a greater emphasis during medical training and staff orientation and training.

Case Study 3: "They make me sick"

A 17 year old gay Black male, who dropped out of high school after being rejected by his parents and left homeless, has a T-cell count of 112 and a viral load of 870,000 copies/mL after six months of Highly Active AntiRetroviral Treatment (HAART). The patient confirms that he often forgets to take his medications and shows the physician he has them in his backpack. The physician has a quick discussion about treatment adherence using personal stories of other young gay males he treats (who are homeless) to demonstrate how they maintain treatment adherence. The patient shrugs and says "I just know they make me sick." He provides the patient with a punch out strip that is attached to a dog tag necklace, which has a punch hole for each day of the week. He shows the patient how to use it, punching out the day as he takes his one-day regimen of Atripla. He tells the patient he will arrange for the outreach worker, who has always been able to locate the patient, to check in on him and that he should keep the strips on the necklace until he returns for his next visit in three months.

Profile of Health Literacy in the United States

Health Literacy

- "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (IOM, 2004).
  - Nearly half the adult population, or *90 million* people in the US had difficulty comprehending and utilizing health information.
  - The individuals referenced, however are not just the patients, but also individuals in the entire health care system (physicians, physician assistants, nurses, case managers, health educators, specialists, etc.).
  - Each discipline must understand its own health information to a degree that it can be communicated to a diverse population, which includes those of different culture, language, education, and socio-economic backgrounds.

National Plan to Improve Health Literacy

- IOM highlighted the difficulty of vulnerable populations to understand and act on health issues because of low health literacy, especially:
  - Adults over 65
  - Non-native English speakers
  - People with incomes at or below the poverty level
  - People with less than a high school degree
  - Recent refugees and immigrants
  - Racial and ethnic groups other than White

Estimating Health Literacy Levels

- Low health literacy is associated with worse health outcomes and higher health care costs
- Overestimating health literacy in patients:
  - Providers overestimated the degree to which persons living with HIV were health literate; misidentifying 53% of the sample population as having adequate health literacy when in fact their literacy level was low.
  - African American patients are equally as effected as providers also overestimated the population's health literacy
    - A devastating combination considering the epidemiology of HIV in the US

Suggestions for Health Care Professionals

- The National Plan calls for:
  - Using different types of communication tools, including pictures and models/scorecards
  - AHRQ's *Questions are the Answers*
  - Use proven methods of checking patient understanding, such as the teach-back method
  - Ensure that pharmacists provide the necessary counseling to consumers in language they understand
  - Use technology, including social media to expand access to health care information
  - Participate in ongoing training in health literacy, plain language, and culturally and linguistically appropriate services (CLAS)
  - Advocate for requirements in continuing education for health care providers who work in the field with no CLAS training
  - Refer patients to public and medical libraries to get more information
  - Refer patients to adult education and English language programs, when appropriate

Knowledge, Attitudes and Beliefs among HIV Health Care Providers

Attitudes and Beliefs of Providers

- Health care providers are human
  - They have personal attitudes and beliefs that may or may not be in sync with the attitudes and beliefs of the patients they serve.
  - Conscientious objector laws
  - Obligations to treat anyone who comes into the office
  - "Innocent Victim" versus "someone who deserves what they get"

Measuring Provider Attitudes

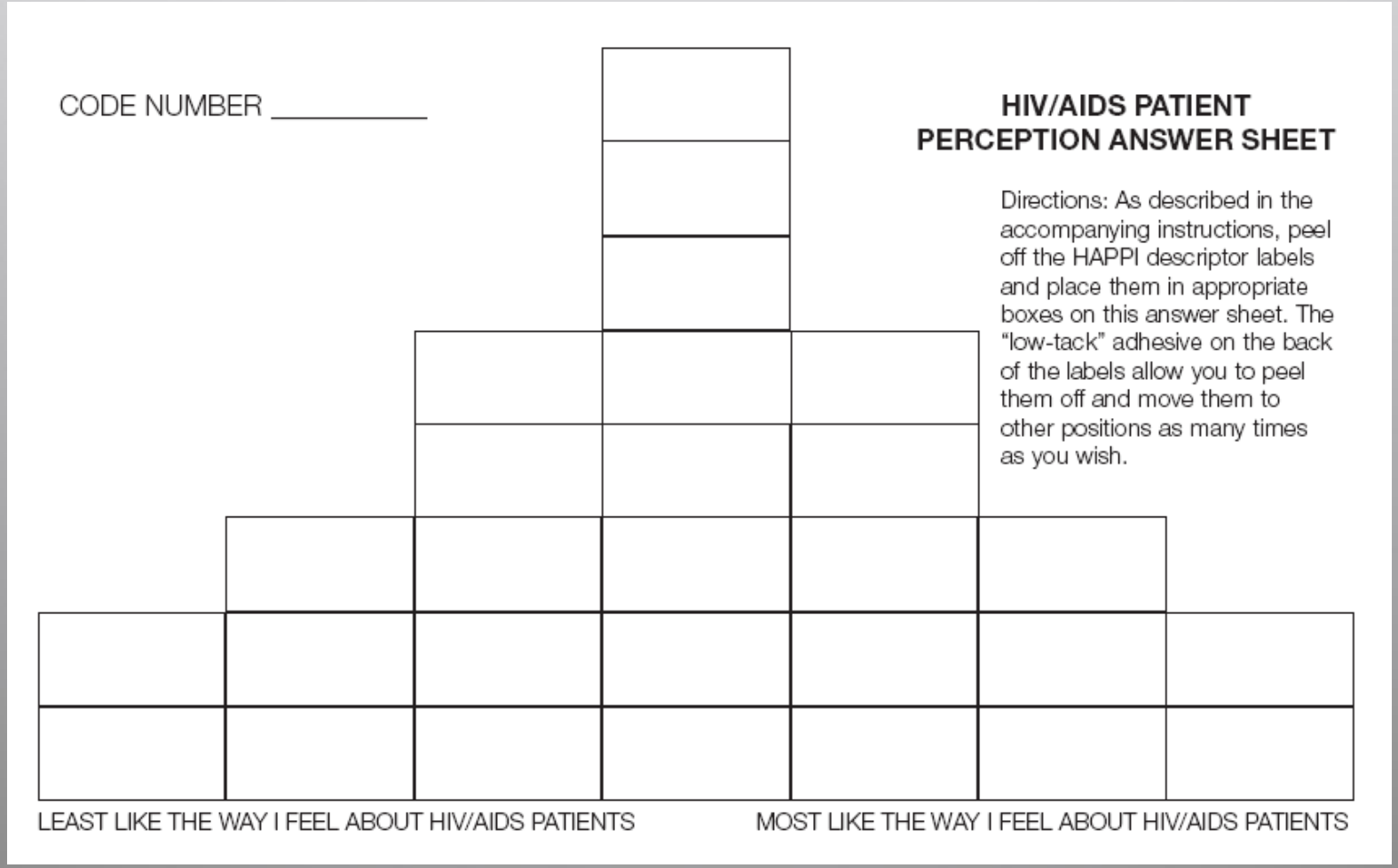
- Attitudes may not change, but an open discussion could help the provider better understand the patient and could help the patient better understand the concerns of the provider
  - Younger and married and male were less supportive than those older and single and female
  - Findings illustrate that attitudes have changed over the last decade, but providers must still check their own attitudes toward patients with HIV

Haas D W et al. J Infect Dis. 2005;192:1931-1942

Q-Sort: Measure of Provider Attitudes

- Q-sort uses self-assigned descriptors to describe emotionality, ability, and reluctance in treating people with HIV
  - Compassionate, caring, accepting, open-minded, gratifying, rewarding, capable, comfortable, stimulated
  - Pity, duty-bound, angry, aversion, dislike, uncomfortable, disapproval, rejection, offended
  - Author's study found lower than expected results in all three categories; room for education

Q-Sort Tool



Developed by: Dr. Raghavend S. Prasad

Q-Sort Data Analysis

Descriptor	Positive or Negative Load	Variance	Mean	Median
Factor 1 - EMOTIONALITY				
Accepting	+	1.69	5.82	6.00
Angry	-	2.35	5.44	6.00
Caring	+	0.86	5.97	6.00
Compassionate	+	1.03	5.60	6.00
Disapproval	-	1.36	5.23	5.00
Dislike	-	1.11	5.44	6.00
Empathetic	+	1.68	4.81	5.00
Helpless	+	2.03	3.72	3.50
Offended	-	1.17	5.24	5.00
Open-Minded	+	1.49	5.43	5.00
Rejection	-	0.88	5.06	5.00
Unsympathetic	-	1.43	5.09	5.00
AVERAGE		1.42	5.24	

Q-Sort Data Analysis

Factor 2 - ABILITY				
Anxious	-	1.83	4.63	4.00
Aversion	-	1.42	5.03	5.00
Capable	+	1.55	4.77	5.00
Comfortable	+	1.40	4.99	5.00
Complicated	-	1.52	4.19	5.00
Inadequate	-	0.81	4.53	4.00
Sad	-	1.99	3.31	3.00
Uncomfortable	-	1.63	5.03	5.00
AVERAGE		1.52	4.56	

Q-Sort Data Analysis

Factor 3 - RELUCTANCE				
At Risk	+	2.18	4.57	5.00
Cautious	+	2.37	4.57	4.00
Challenged	-	1.44	3.57	4.00
Gratifying	-	1.44	3.74	4.00
Rewarding	+	1.20	4.32	4.00
Stimulated	-	1.28	4.25	4.00
AVERAGE		1.65	4.17	

Barriers to Successful Patient-Provider Communication and Their Impact on Medical Decision-Making

Barriers to Successful Communication

- Communication barriers in the patient-provider relationship can include:
  - Language differences
  - Cultural difference
  - Health literacy
  - Socioeconomic factors
  - Others

Outcomes of Communication Barriers

- Communication barriers significantly reduce:
  - Understanding of treatment,
  - Treatment adherence,
  - Trust in the patient-provider relationship; and
  - Fosters distrust in the health care system

Top Communication Barriers

- Providers identify the top communication barriers with patients include:
  - **Patient does not follow through with treatment or make lifestyle changes**
  - Insufficient time
  - Difficulty getting patient to understand diagnosis
  - Difficulty getting patient to understand implications of diagnosis
  - Interpreter does not adequately translate
  - Patient presents too many problems
  - Patient history is rambling and disorganized

Top Communication Barriers

- Patient does not buy into treatment plan
- Patient provides inconsistent information
- Patient is uninterested in self-car or health maintenance
- Difficulty establishing rapport with patient
- Difficulty reconciling patient's self-diagnosis with physician's diagnosis
- Patient does not want to participate in a partnership with physician

Top Communication Barriers

- Interpreter is a child or inappropriate
- Patient's cultural beliefs about illness interfere with diagnosis and treatment
- Patient talks too much to interpreter
- Patient does not trust the physician
- Patient uses culturally based alternative therapies that the physician in unfamiliar with or disagrees with.

Shared Decision-Making (SDM)

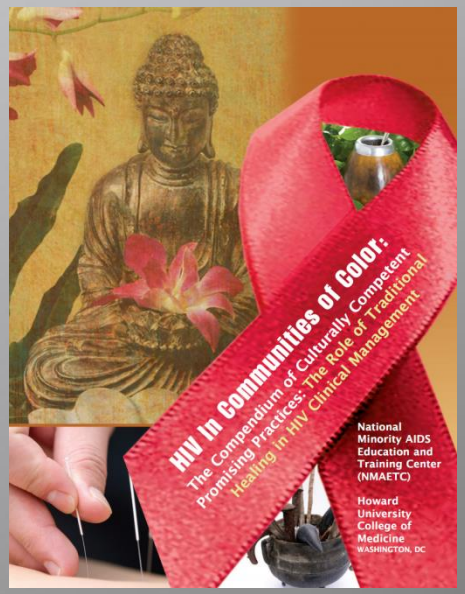
- SDM is an approach that values the contribution of the patient and provider equally when it comes to making decisions about medical treatment, including to:
  - Develop a partnership with the patient.
  - Establish or review the patient's preference for information, e.g. amount and format.
  - Establish or review the patient's preferences for role in decision-making.
  - Ascertain and respond to patients' ideas, concerns, and expectations.

Shared Decision-Making (SDM)

- Identify choices and evaluate the research evidence in relation to the individual patient.
- Present (or direct to) evidence, taking into account the above steps, and help the patient reflect upon and assess the impact of alternative decisions with regard to their values and lifestyles.
- Make or negotiate a decision in partnership, manage conflict.
- Agree upon an action plan and complete arrangements for follow-up.

Resources from the AETC-NMC

- Check out materials for Patient-Provider Communication and HIV in our e-Library at www.aetcnmc.org/elibrary
- Read our Patient-Provider Communication Case Studies at www.aetcnmc.org/studies
- Read our new publication, HIV in Communities of Color: The Compendium of Culturally Competent Promising Practices: The Role of Traditional Healing in HIV Clinical Management on our website: www.aetcnmc.org



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