XAVIER UNIVERSITY OF LOUISIANA COLLEGE OF PHARMACY
SIXTH HEALTH DISPARITIES CONFERENCE
IMPROVING MEDICAL EFFECTIVENESS AND HEALTH OUTCOMES TO ACHIEVE HEALTH EQUITY THROUGH INTERPROFESSIONAL COLLABORATIONS
NEW ORLEANS, LOUISIANA MARCH 7-9, 2013

Workshop 1

Healthcare Communications and Education

XAVIER UNIVERSITY OF LOUISIANA COLLEGE OF PHARMACY
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Accreditation

UAN 0024-0000-13-004-L04-P

Participation in this activity earns 1.25 contact hours.
To receive credit, participants must complete an evaluation form at the conclusion of this session.

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At the completion of this activity, participants will be able to:

- Identify innovative programs where patient provider communication and health education strategies have improved health outcomes.
- Identify the implication of basic science research on current clinical practices.

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José A. Torres-Ruiz, PhD

OPENING REMARKS

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1. List at least 2 clinician communication skills that have been associated with patient recall of information.
2. List at least 2 clinician communication skills that have been associated with patient satisfaction with care.
3. List at least 2 clinician communication skills that have been associated with patient adherence with medical recommendations.

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Debra L. Roter, MPH, DrPH

SPEAKER

Improving Patient Provider Communication to Enhance Medical Effectiveness

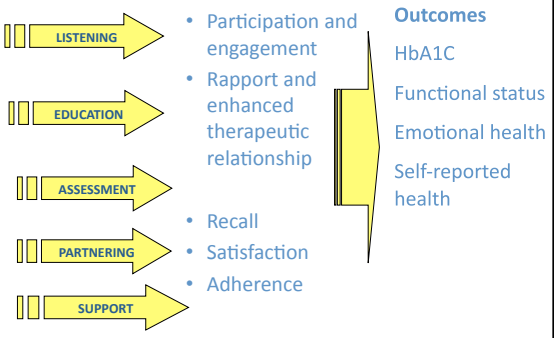
Debra Roter, DrPH
Professor
Johns Hopkins Schools of Public Health, Medicine and Nursing

Objectives of today's presentation

Review evidence that patient-provider communication matters in enhancing the processes and outcomes of care.

Describe an ultra-brief training strategy to enhance patient-provider communication.

Communication is linked to Visit Process and Clinical Outcc



Visit Outcomes: **Predictors of Patient Recall**

Meta-analysis of the communication literature found significant (small to moderate) effect size (ES) relationships between Recall and:

(1) more information-giving
(2) less question-asking
(3) more positive talk
(4) more partnership building

(Hall, Roter, Katz, 198

Visit Outcomes: **Predictors of Patient Satisfaction**

Significant (small to moderate) ES for patient satisfaction were associated with:

(1) more information-giving

(2) more positive talk (both verbal and nonverbal)
(3) less negative talk
(4) more social talk

(5) more partnership building

(6) more talk overall

(Hall, Roter, Katz, 1988)

Predictors of Patient Adherence

Significant (small) ES for patient adherence were associated with:
(1) more information-giving

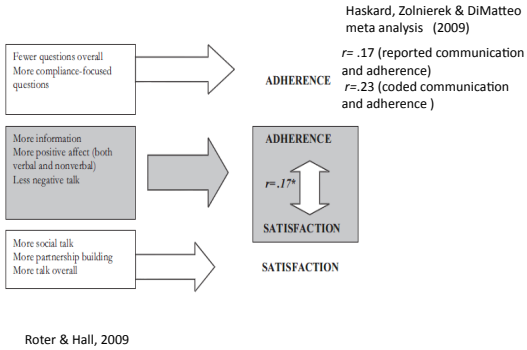
(2) less question-asking overall

(3) more compliance-focused questions

(4) more positive talk (both verbal and nonverbal)

(5) fewer criticisms and disagreements

(Hall, Roter, Katz, 1988)



Haskard, Zolnierek & DiMatteo meta analysis (2009)

r= .17 (reported communication and adherence)
r=.23 (coded communication and adherence)

Roter & Hall, 2009

Communication and Patient Health Outcomes

Communication has been linked to: HPB, HcA1C, pain, anxiety, and functional and quality of life measures.

Griffin et al, "Effect on health related outcomes of interventions to alter the interaction between patients and practitioners." A systematic review of 35 trials. Annals of Family Medicine 2:595-608, 2004.

Communication and Clinician Outcomes

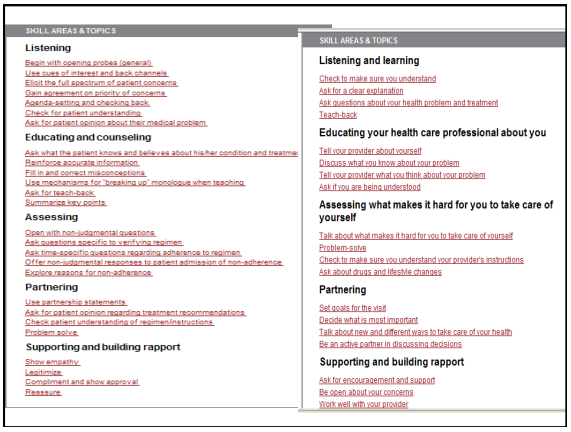
Skilled communication is associated with less burnout and stress, greater self-efficacy, greater professional satisfaction, higher patient satisfaction.

Good communication may also be protective against malpractice litigation.

Roter, DL. (2006). The Patient-Physician Relationship and its Implications for Malpractice Litigation. Journal of Health Care Law & Policy, 9 (2); 304-314.

Parallel patient and clinician skills to enhance patient-centeredness and medical effectiveness

L - LISTEN
E - EDUCATE
A - ASSESS
P - PARTNER
S - SUPPORT



SKILL AREAS & TOPICS

Listening
Begin with opening probes (general).
Use cues of interest and back channels.
Elicit the full spectrum of patient concerns.
Gain agreement on priority of concerns.
Agenda-setting and checking back.
Check for patient understanding.
Ask for patient opinion about their medical problem.

Educating and counseling
Ask what the patient knows and believes about his/her condition and treatment.
Reinforce accurate information.
Fill in and correct misconceptions.
Use mechanisms for "breaking up" monologue when teaching.
Ask for teach-back.
Summarize key points.

Assessing
Open with non-judgmental questions.
Ask questions specific to verifying regimen.
Ask time-specific questions regarding adherence to regimen.
Offer non-judgmental responses to patient admission of non-adherence.
Explore reasons for non-adherence.

Partnering
Use partnership statements.
Ask for patient opinion regarding treatment recommendations.
Check patient understanding of regimen/instructions.
Problem solve.

Supporting and building rapport
Show empathy.
Legitimize.
Compliment and show approval.
Reassure.

SKILL AREAS & TOPICS

Listening and learning
Check to make sure you understand
Ask for a clear explanation
Ask questions about your health problem and treatment
Teach-back

Educating your health care professional about you
Tell your provider about yourself
Discuss what you know about your problem
Tell your provider what you think about your problem
Ask if you are being understood

Assessing what makes it hard for you to take care of yourself
Talk about what makes it hard for you to take care of yourself
Problem-solve
Check to make sure you understand your provider's instructions
Ask about drugs and lifestyle changes

Partnering
Set goals for the visit
Decide what is most important
Talk about new and different ways to take care of your health
Be an active partner in discussing decisions

Supporting and building rapport
Ask for encouragement and support
Be open about your concerns
Work well with your provider

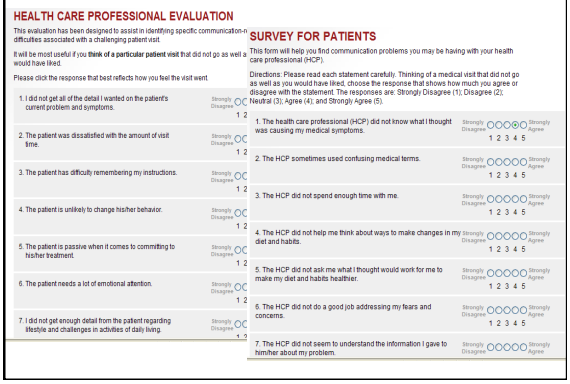
Applying the LEAPS model to the design of patient and physician Web-based communication tools

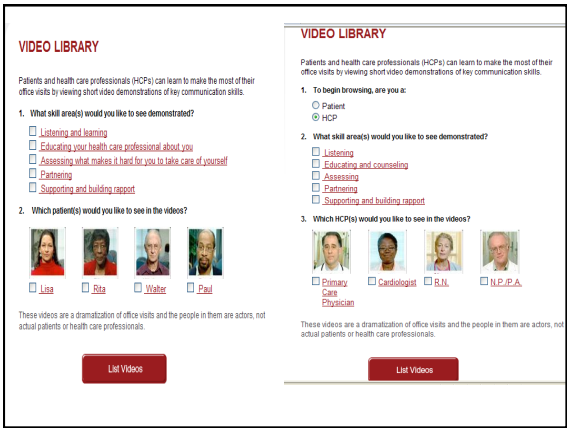
Separate patient and physician video glossaries drawing from an archive of 500 15-second clips modeling key communication skills organized by a complementary heuristic.

Interactive format allowing individual tailoring of skills through the use of a communication-challenge screener.

TIME TO TALK CARDIO
www.timetotalkcardio.com

18 item communication-challenge screener





Evaluation of impact

- METHODS

A randomized trial of 194 patients in four community-based ambulatory care settings in Mississippi, Missouri and North Carolina and New Jersey with pre and post assessments of skill use and satisfaction.

Twenty-nine physicians agreed to use the tool (without randomization) and complete pre and post exposure assessments of routine skill use.

Patients reported greater change in targeted skills across 5 dimensions

GROUP		INTERVENTION	CONTROL GROUP	
Communication Domain (hypothetical score range)		Number of skills used at follow-up visit [a] [change from baseline] (95% CI for number of skills lower bound--upper bound)	Number of skills used at follow-up visit [a] [change from baseline] (95% CI for number of skills lower bound--upper bound)	Overall Wald Chi-square
ALL DOMAINS	(0-18)	12.4 [3.6] (11.7 – 13.1)	9.7 [1.0] (8.0 – 11.5)	5.1; p=.02
Identification problems/ concerns	(0 – 3)	2.3 [.84] (2.2 – 2.3)	1.7 [.28] (1.4 – 2.1)	13.4; p=.0001
Information exchange	(0 – 3)	2.0 [.45] (1.8 – 2.1)	1.6 [.09] (1.4- 1.8)	5.3; p=.02
Time management	(0 – 3)	2.2 [.46] (2.0 – 2.4)	1.9 [.11] (1.5 – 2.2)	1.8; p=.17
Treatment adherence	(0 – 3)	1.9 [.66] (1.8 – 2.1)	1.4 [.11] (0.9 – 1.9)	4.1; p=.04

Patients reported greater change in satisfaction across 5 dimensions

INTERVENTION GROUP		CONTROL GROUP	
	Satisfaction score[a] [change from baseline] (95% CI for score lower bound--upper bound)	Satisfaction score[a] [change from baseline] (95% CI for score lower bound--upper bound)	Overall Wald Chi-square (difference in satisfaction scores between groups)
Overall satisfaction (hypothetical range 1-5)	4.5 [.47] (4.4 –4.7)	4.2 [.16] (4.0–4.4)	7.1 p=.008
Identification of problems and concerns	4.5 [.47] (4.4 –4.6)	4.3 [.30] (4.1 –4.5)	1.2 p=.25
Information exchange	4.5 [.43] (4.4 –4.7)	4.2 [.11] (3.9 –4.5)	6.4, p = .01
Time management	4.6 [.52] (4.4 –4.7)	4.3 [.25] (4.0 –4.5)	3.7, p= .05
Treatment adherence	4.5 [.45] (4.4 –4.7)	4.1 [.06] (4.0 –4.3)	15.1, p = .0001
Shared decision making	4.4 [.47]	4.2 [.24]	4.9, p = .03

What about clinicians?

Physicians using the website reported a subsequent significant increase in the use of targeted communication skills.

Impact of Clinician web Tool on Physician Communication

Communication Domain (hypothetical score range)	Pre-Intervention count of always used skills (sd); score range	Post Intervention count of always used skills (sd); score range	Paired T-test value; p value
ALL DOMAINS (0-23)	12.9 (5.5); 0 – 22	16.9 (4.8); 7 – 22	4.6 ; p=.001
Identification of medical problems / concerns (0-4)	2.5 (1.1); 0 – 4	3.0 (1.0); 1 – 4	2.3; p=.03
Information exchange (0-5)	2.4 (1.3); 0 –4	3.5 (1.4); 1 –4	4.0; p=.001
Time management (0-2)	1.1 (0.8); 0 – 2	1.2 (0.8); 0 – 2	1.1; p=.29
Treatment adherence (0-4)	2.5 (1.2); 0 – 4	3.2 (1.3); 1 – 4	3.3 ; p=.003
Shared decision making 0-4)	1.5 (1.3); 0 – 4	2.5 (1.5); 0 – 4	3.7; p=.001
Interpersonal rapport (0-4)	2.9 (1.3); 0 – 4	3.4 (0.9); 1 – 4	3.1; p=.004

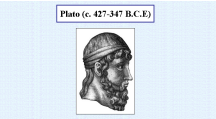
Were we successful?

Yes

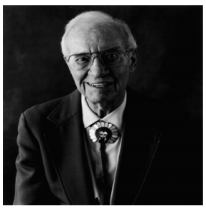
BUT ……..LIMITED TO REPORTED OUTCOMES

In articulating the physician's responsibility to be both teacher and healer, Plato laid the foundation for patient-centered medicine and collaborative models of therapeutic relationship.

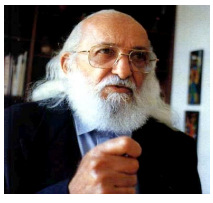
"A physician to slaves never gives his patient any account of his illness…The free physician, who usually cares for free men, treats their diseases first by thoroughly discussing with the patient and his friends his ailment."



When patients are empowered to enter into a full partnership with their doctors and when the expertise of both is recognized and respected, the dynamics and processes of care must change dramatically for the better.



Malcolm Knowles (1913 - 1997)



Paulo Freire (1921 -1997)

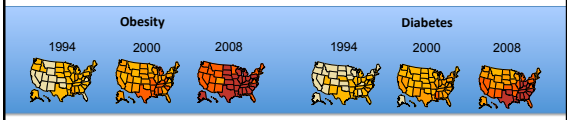
Can mapping brain circuits controlling eating behavior lead to treatments for obesity and diabetes?

Arshad M. Khan, Ellen M. Walker, Anais Martinez, Briana E. Pinales, Nicole Dominguez, Sarah D. Chenausky, Joshua Ortiz-Guzman, Claire E. Wells and Teresia A. Carreon

UTEP Systems Neuroscience Laboratory
Department of Biological Sciences and
Border Biomedical Research Center
University of Texas at El Paso

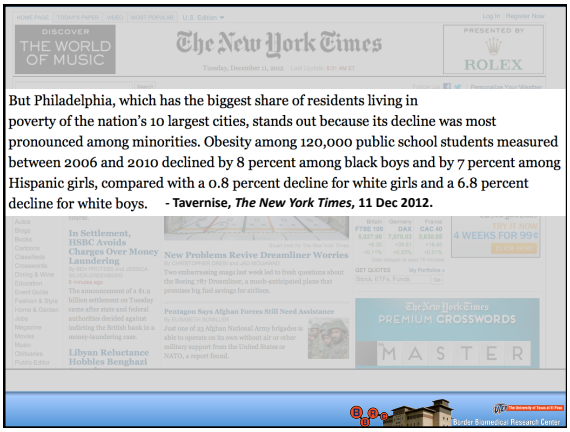
Sixth Annual Health Disparities Conference
Xavier University, New Orleans, LA
7-9 Mar 2013

Obesity and Diabetes are Epidemics with Health Disparities



Data from the United States-Mexico Border Health Commission 2009 White Paper

- Mexican-American males, (12-19 yrs) had the highest prevalence of obesity (22.1%) compared to non-Hispanic white (17.3%) and black males (18.5%)
- Obesity in Mexican-American females increased from 9.2% to 19.9% from 1988-1994 to 2003-2006.
- 31.7% of all U.S. children (10-17 yrs) are overweight or obese; 40.9% of all Hispanic children in this age range are obese.



But Philadelphia, which has the biggest share of residents living in poverty of the nation's 10 largest cities, stands out because its decline was most pronounced among minorities. Obesity among 120,000 public school students measured between 2006 and 2010 declined by 8 percent among black boys and by 7 percent among Hispanic girls, compared with a 0.8 percent decline for white girls and a 6.8 percent decline for white boys. **- Tavernise, *The New York Times*, 11 Dec 2012.**

Metabolic complications can originate from brain circuit dysfunction

Metabolic complications can originate from brain circuit dysfunction

Hyperphagia, Rage, and Dementia Accompanying a Ventromedial Hypothalamic Neoplasm

Alexander G. Reeves, M.D. and Fred Plum, M.D. New York

Arch Neurol—Vol 20, June 1969

Case History

- 20 year old Puerto Rican woman
- Bookkeeper by profession
- First admitted to New York Hospital in Nov. 1962
- Complained of suffering from polydipsia, polyuria, and bulimia for the past year
- No other behavioral deficits; no impaired memory; body x-rays normal; blood panel normal
- Suspected hypothalamic tumor

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- Suspected hypothalamic tumor
- In July 1964, patients' behavior had changed markedly; she "became withdrawn but was given to frequent outbursts of unprovoked laughing, crying, and, at times, rage."
- On 16 Oct 1964 – underwent a second craniotomy and an inoperable tumor at the base of the brain was found
- Although she was managed for metabolic disease, she died and a postmortem study was conducted.

Metabolic complications can originate from brain circuit dysfunction

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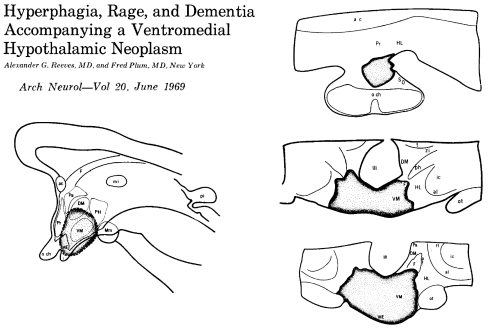
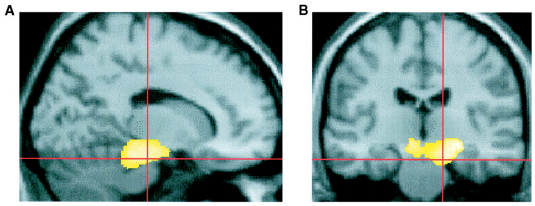


How can we identify the brain regions and circuits that are involved?

Limitations of PET or fMRI



Cranston I. *et al.* (2001) *Diabetes* 50:2329-2366.

Research Goals of the UTEP System Neuroscience Laboratory *(Established 2011)*

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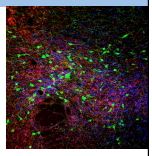
1. Identify feeding & autonomic control circuits at high resolution

- Glucose sensing brain circuits in normal and diabetic animals
- "Hunger circuits" contributing to overeating and obesity
- Create high resolution maps of brain regions activated by hypoglycemia



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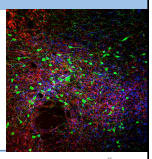
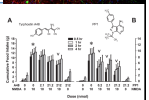


2. Identify pharmacologic targets for therapeutics

- Pharmacologic targets for appetite and glycemic control
- Pharmacologic targets for neural control of autonomic function



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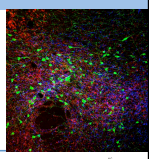

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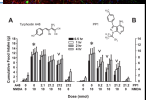

3. Manipulate these circuits to feeding and glycemic control

- Optogenetic tools to control behavior and autonomic function

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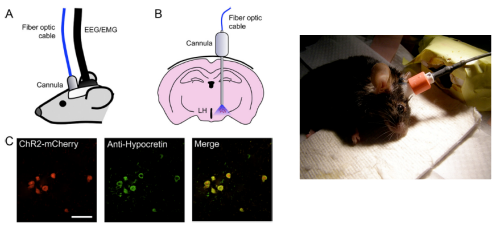
Optogenetic Control of Hypothalamic Neurons



Carter ME et al. (2009*) J. Neurosci.,* 29:10939-10949.

Research Highlight: Creating a High Resolution Atlas of the Mammalian Hypothalamus

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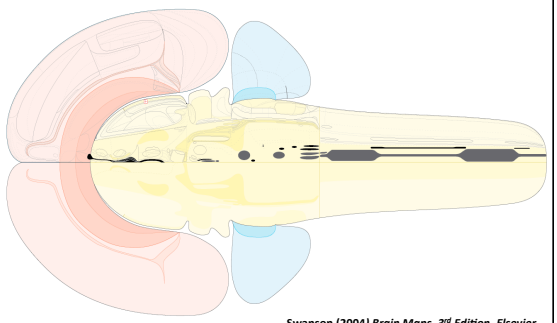

Swanson (2004*) Brain Maps, 3rd Edition. Elsevier*

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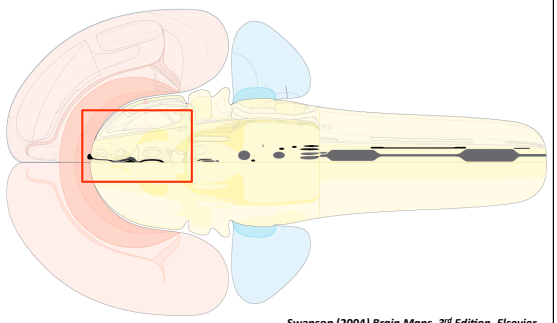

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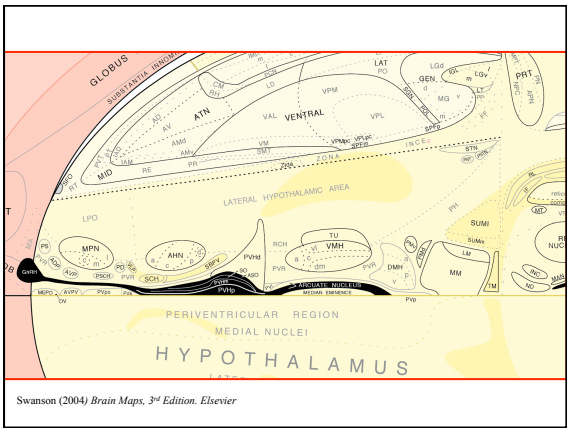

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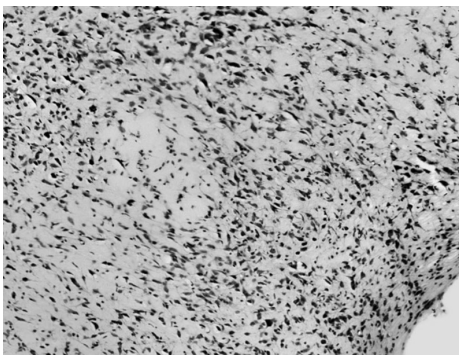

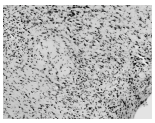

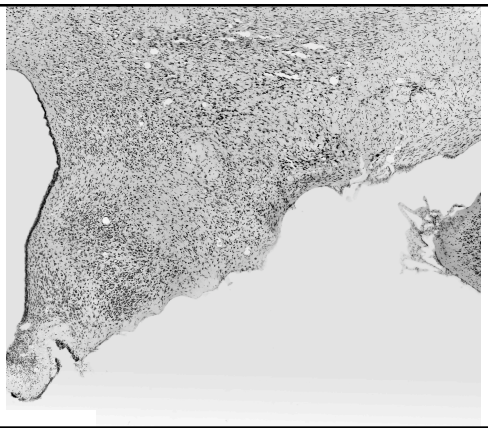

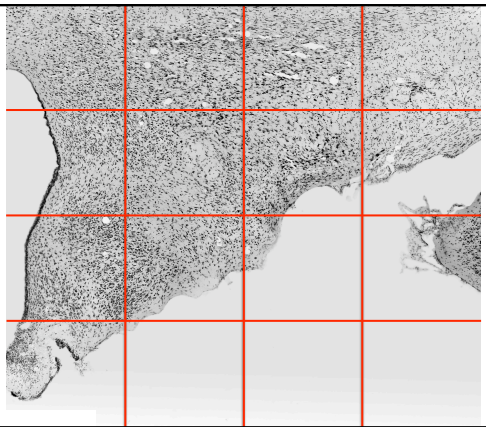

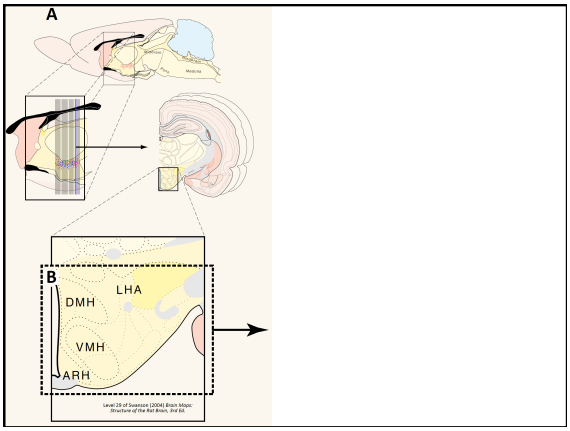

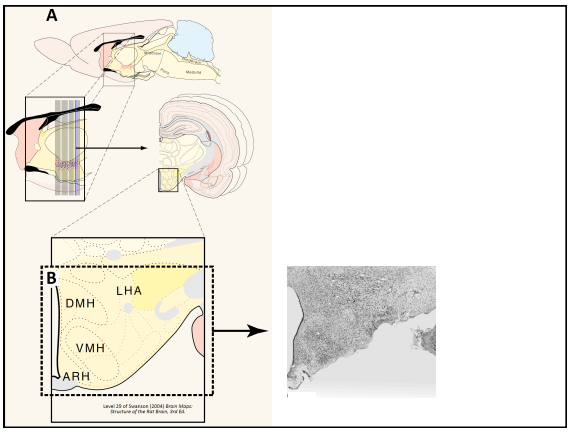

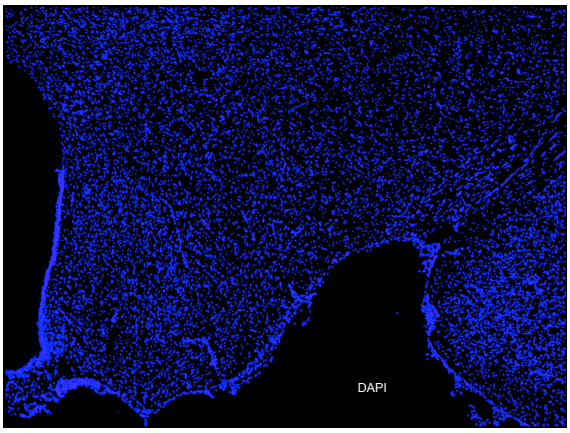

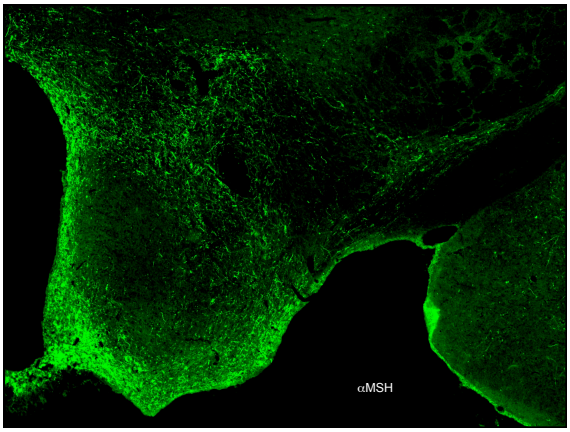

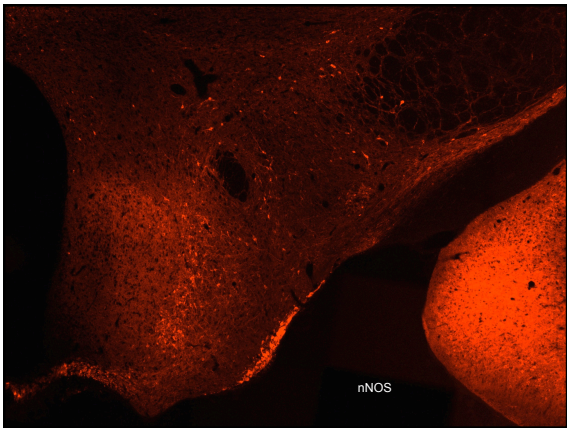

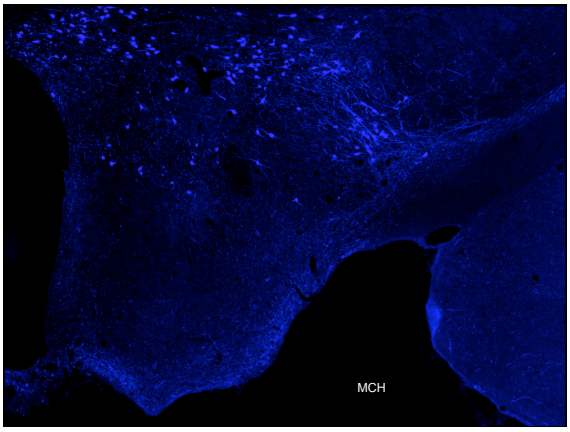

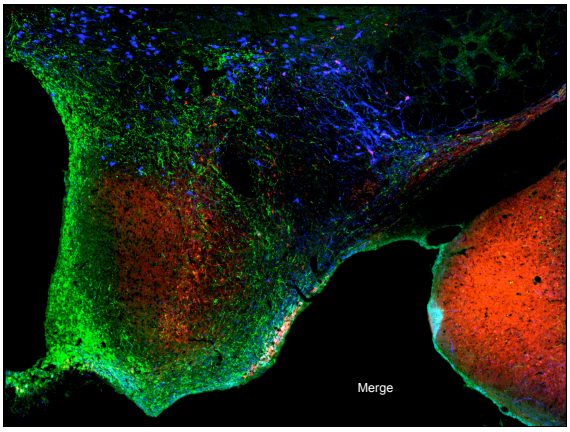

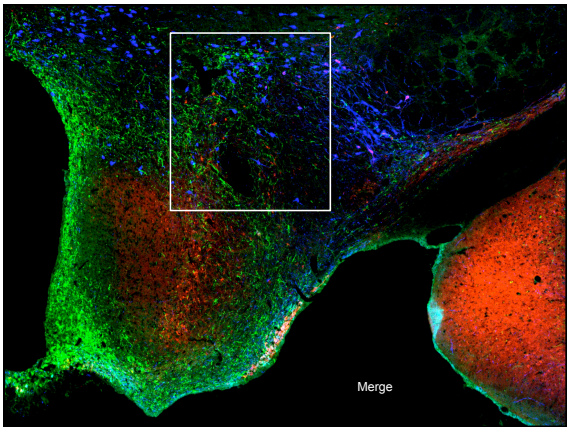

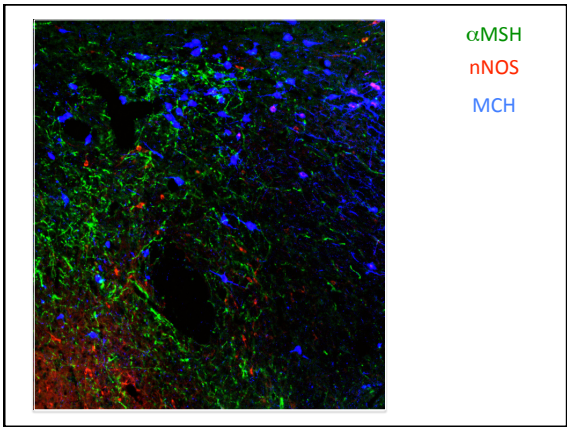

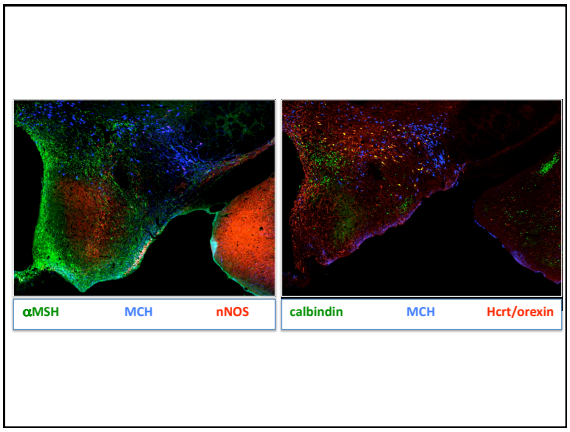

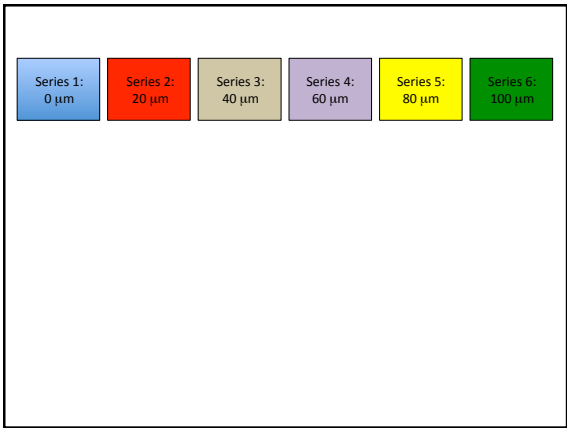

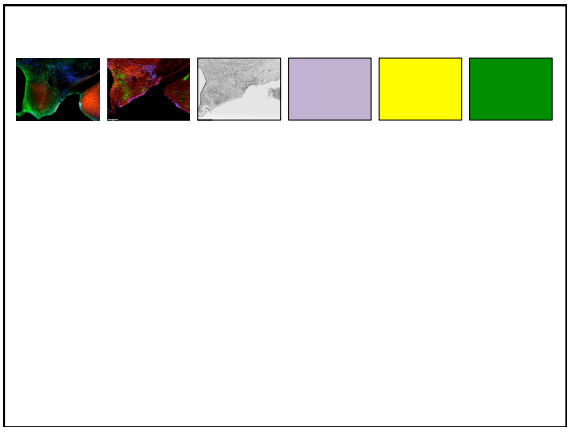

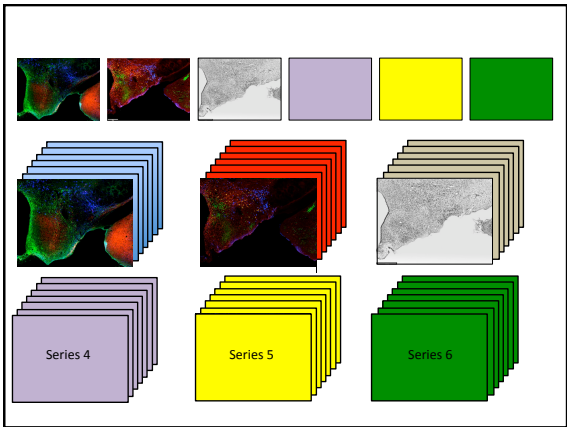

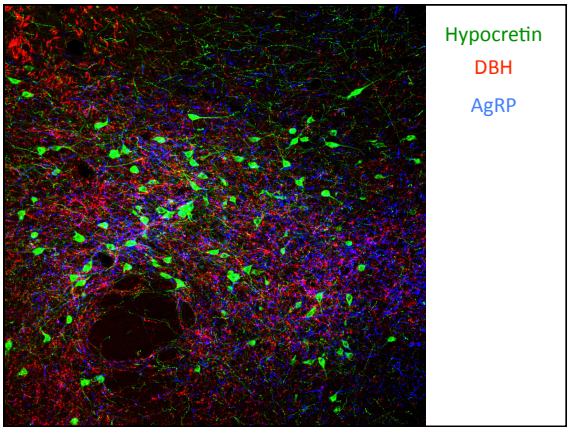

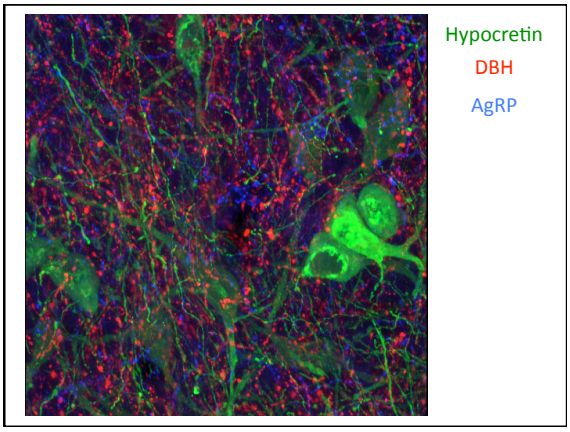

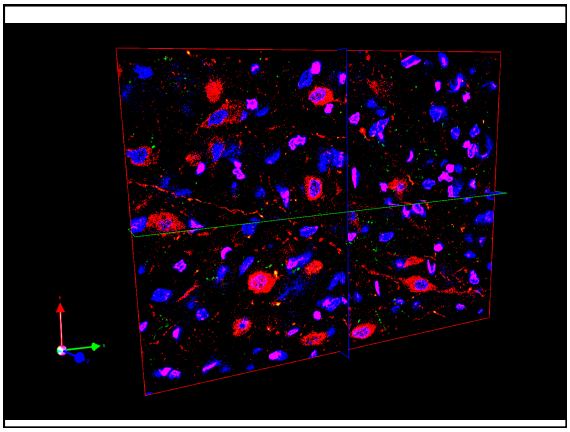

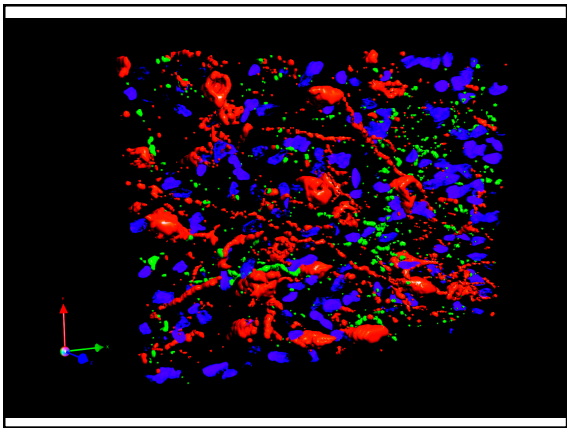

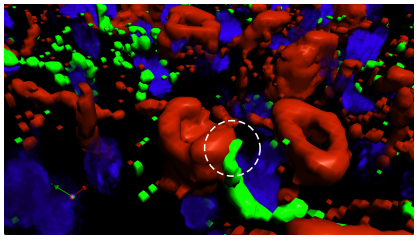

Conclusions

- Our initial goal is to map nerve cell populations involved in feeding and glycemic control.
- The long-term use of these maps will help us target brain cells for pharmacology and optogenetics.
- These maps will provide greater anatomical resolution of brain regions implicated clinically in patient fMRI and PET studies.
- Functional brain imaging data can be brought into anatomical register with our high resolution maps of the hypothalamus.

Border Biomedical Research Center

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Renato Aguilera (director), Armando Varela, Gladys Almodovar

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NEW ORLEANS, LOUISIANA MARCH 7-9, 2013

1. Does effective patient navigation reduce average time to resolution of cancer screening abnormal findings?
2. What are the essential components to a successful patient navigation program?

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Renea A. Duffin, MPA

SPEAKER

Utilizing Patient Navigators to Improve Health Outcomes

Renea A. Duffin, MPA
Vice-President, Cancer Support & Outreach
rduffin@marybird.com

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Presentation Objectives

- Discuss how the effective intervention of a patient navigator affects the uninsured/under-insured in reaching resolution of abnormal cancer screening findings.
- Describe the essential elements of a successful patient navigation program.

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Mary Bird Perkins Cancer Center

- Mary Bird Perkins Cancer Center (MBP) is a nonprofit cancer treatment, education and research system focused on reducing the burden of cancer through treatment, community outreach services, public and professional education, and research.
- Our mission is to improve survivorship and lessen the burden of cancer.

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Outreach Commitment to the Community

- In 2002, Mary Bird Perkins began planning and implementing services and programs for cancer patients, health care professionals and the general public including no costs cancer screenings.
- Since the inception of the outreach program in 2002, approximately **1,500 screening events** have been conducted and **over 47,000 people** have been screened for cancer – at no cost to the screening participant.

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Community Partnerships

- Woman's Hospital – Digital Mammography
- YWCA EncorePlus – Breast Health Education
- LSU Health Sciences Division – Medical Residents
- Numerous community based organizations

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Early Bird Mobile Medical Clinic

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Need for Patient Navigation

- Limited follow-up services were available due to lack of staff dedicated to provide this service
- Population served is primarily uninsured with limited education and knowledge of how to maneuver the health care system
- Number of persons being screened were increasing annually with the launch of the mobile clinic in 2006

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Patient Navigation Pilot

- Two persons completed training at the Harold Freeman Patient Navigation Training Institute in February 2008
- Pilot for breast screening patients began June 1, 2008 through August 31, 2008 utilizing two sites visited monthly
- Pilot completed to develop the protocol for the navigation program as well as establish baseline average time to resolution
- Hired full-time nurse navigator in January 2009

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Role of Patient Navigator

- Remove barriers to care
- Serves as patients main point of contact
- Improve timeliness of care
- Connects patients to support services and community resources
- Patient education

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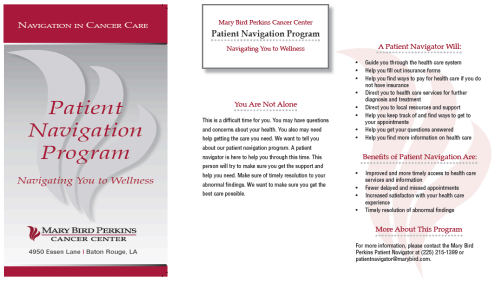
Communications Tools



Common Barriers to Timely Resolution

- Race
- Insurance
- Language
- Transportation
- Lack of trust in healthcare providers

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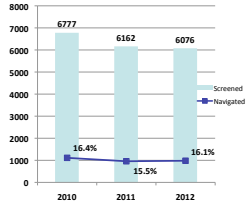
Metrics and Outcomes 2010-2012

- 658 screening events
- 19,015 persons screened
- 3,052 persons navigated
- 120 cancers diagnosed



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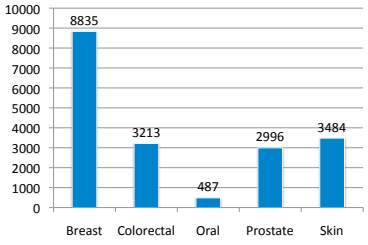
Number of Persons Screened 2010-2012



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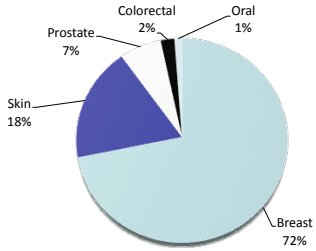
Navigated by Disease Site 2010-2012



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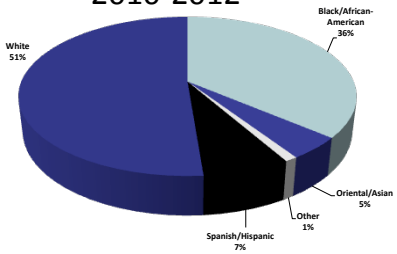
Navigated by Race 2010-2012



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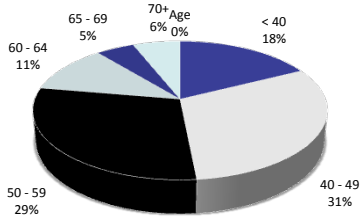
Navigated by Age 2010-2012



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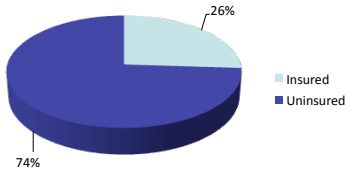
Insurance Status of those Navigated 2010-2012



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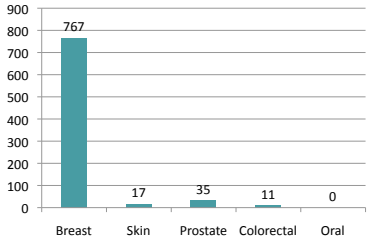
Family History of those Navigated 2010-2012



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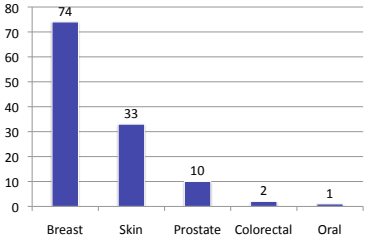
Diagnosis of Cancer



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Metrics and Outcomes 2010-2012

- Average time to resolution of abnormal findings:
  - Breast
    - Abnormal CBE = 7 days
    - Abnormal Screening Mammogram = 12 days
  - Colorectal = 33 days
  - Oral = 56 days
  - Prostate = 29 days
  - Skin = 27 days

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Essential Elements of a Navigation Program

- Support and commitment from leadership
- Funding
- Strong community partnerships
- Data collection and analysis tools
- Compassionate and caring staff

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QUESTIONS

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Panel Discussion

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Closing Remarks