

Missed Opportunities for Effective Patient Education and Counseling: What the Unannounced Standardized Patient Experience Can Tell Us

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Background: Patient education and counseling skills are critical to patient safety and outcomes, especially for achieving behavior change and managing chronic conditions. The goal of this study was to explore the nature and quality of patient education and counseling skills through in-depth qualitative analysis of resident physician interactions with Unannounced Standardized Patients (USPs) – trained actors integrated incognito into practice. We sought to describe, from the ground up, variation in how resident physicians educate and counsel patients, focusing on aspects that might not be captured through commonly used checklists based on the ASK-TELL-ASK model of patient education.

Methods: Highly trained USPs portrayed two clinical cases, one involving asthma medication education and the other a routine visit requiring both education about a common condition and general preventive recommendations. They were scheduled as new patients and seen by Internal Medicine Residents in two busy, urban primary care clinics. Residents were aware they would see USPs in clinic, but did not know when. USPs completed a comprehensive checklist that assessed communication skills, including those patient education and counseling skills associated with the ASK-TELL-ASK model (assess understanding, provide clear explanations, check understanding), as well as other core clinical skills, after each visit and used a concealed digital recorder to audiotape visits. The 18/37 audible encounters comprise the analysis sample; Asthma case=8 and Routine Visit case=10. Average visit length was 26 minutes (range 12 – 37 minutes). Case portrayal was assessed and found to be consistent. Tapes were transcribed and entered into Atlas TI, a qualitative analysis software program, to facilitate coding and analysis. Major themes were identified by listening to the audio while reading the transcripts so as to include tone, emotion, and other verbal cues.

Results: The qualitative data validated core aspects of the checklist assessment, namely that the clarity of explanations and degree of summarizing/reviewed varied, and that evaluation of patient understanding was rare. Further analysis revealed that checklists may miss some significant aspects of the interaction -critical moments when patients could be more fully educated and engaged. These missed opportunities fell into four categories: 1) failing to orient patients (e.g., not setting an agenda or explaining reasons for actions; mean=4.2 times/visit); 2) failing to engage patients in behavior change (e.g., not reinforcing connections between symptoms and behavior change; postponing decisions until later visits; not making direct recommendations; mean=5.1 times/visit); 3) failing to engage patients in the treatment plan (e.g., not explaining reasons for medication, how to take, what to expect, when to follow-up and why; mean=2.9 times/visit); and 4) failing to help patients navigate the system to obtain recommended services (mean=1.9 times/visit).

Conclusions: While checklists capture critical positive aspects of education and counseling practice during the patient-physician encounter, in-depth qualitative exploration of USP interactions suggests the need to include assessment of missed opportunities to educate and activate patients. These missed opportunities may be essential to achieving intended outcomes of care with enhanced efficiency and therefore not only merit further study but are important targets for education and training.

Perceptions and Barriers to Usage of Generic Medications in a Rural African-American Population

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Background: Usage of generic medications in chronic diseases has been shown to have many benefits, such as similar efficacy for lower price, leading to increased adherence. However, there is significant underuse of generic medicines in African-American communities as well as in communities with low socioeconomic status and low health literacy, such as those found in the rural Southeastern United States. Prior studies have found that such communities have lower trust of generics, particularly for chronic or serious diseases, and increased reluctance to switch from brand to generic. No studies, however, have focused on perceptions of rural, Southern African Americans toward generic medication use.

Methods: To gain insight into causes of low usage of generic medications among African Americans in the rural South, we conducted focus groups in Alabama's underserved and low-income Black Belt area. Inclusion criteria included age of 18 years or older, residence in Alabama's Black Belt region, African-American race, and current use of a daily medication for chronic disease. A total of 30 community members participated in four focus groups. After transcription of the focus group recordings, analysis was performed using NVivo 9. Two authors independently identified themes and then reached a consensus on themes before coding all transcripts. The focus group members were primarily middle-aged women, with over half having only a high school education or less. Most were not employed, and one-fourth had no health insurance.

Results: The general themes that emerged included perceived differences in efficacy and side effects of generic medications versus brand medications; the perception that generics were not "real" medicine; willingness to take generics for minor but not serious illnesses; mistrust in doctors and the health system that affects medication adherence; and the perception that, while generics cost less, people of limited means had to "settle" for less.

Conclusions: Our focus group data showed barriers to generic medication use in disadvantaged communities that include both misinformation about the safety and efficacy of generic medications as well as deeper feelings of mistrust and abuse by the medical system. While education about generics may rectify some of the misinformation, other views, such as mistrust of the health system and the belief that poor people must "settle" for inferior therapies by taking generics, may be more challenging to overcome. Both policy makers and physicians should consider these perspectives when working to increase generic drug usage in these populations.

Motivational Interviewing By HIV Care Providers Is Associated With Patient Commitment to Reduce Unsafe Sexual Behavior?

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Background: Commitment to behavior change, when expressed by patients during clinical encounters, is associated with better patient outcomes. Motivational interviewing (MI) is a counseling style with the potential to elicit this commitment. The extent to which HIV providers use MI when counseling patients about safe sex, and whether its use is associated with patient commitment to safer sex practices, is unknown. We hypothesized that more MI-adherent provider counseling would be associated with patient expressions of commitment to safer sex.

Methods: Routine follow-up visits between 426 HIV-infected patients and 45 healthcare providers collected as part of the Enhancing Communication and HIV Outcomes (ECHO) Study were audio-recorded, transcribed and searched for sexual risk counseling. Our study outcome was the presence of expressed patient commitment to reduce high-risk sexual behavior, coded using the Client Language Assessment in Motivational Interviewing. The independent variable was the extent to which providers used communication behaviors consistent with MI, coded by the Motivational Interviewing Treatment Integrity (MITI). Using the MITI, we calculated an overall summary score reflecting the balance of MI adherent minus non-adherent provider talk. We used logistic regression analysis, with generalized estimating equations accounting for clustering of patients within providers, to investigate whether more provider MI-adherence was associated with patient commitment to sexual behavior change.

Results: Of the 426 total audio-recorded encounters, 27 contained provider counseling regarding unsafe sexual practices. Six of the 27 dialogues included patient commitment talk to reduce unsafe sexual practices. The most common provider behaviors within the 27 dialogues were giving information (e.g. "The higher the viral load, the more likely the risk of infection" n=114 utterances), and asking closed questions (e.g. "Do you always use protection?" n=95). The most common MI-adherent behaviors were reflections (e.g. "You always use condoms then" n=56) and patient affirmation (e.g. "That is a very smart decision" n=19). Less common MI-adherent behaviors were emphasizing patient control (e.g. "You're the one who would say yes or no" n=7) and support (e.g. "You know we are here for you" n=1). The most common MI-nonadherent behaviors were advising without permission (e.g. "If you're gonna have sex with him, just use a condom" n=16), directing the patient ("Don't give it to anybody" n=12) and confronting the patient ("It's not okay for you to have sex without a condom" n=6). The summary score of MI balance was higher in dialogues in which patients expressed commitment than in dialogues in which they did not (mean 4.0 vs. 1.2). The odds of expressed patient commitment were higher when providers used more MI adherent than non-adherent behaviors, OR: 1.17 (1.01-1.38).

Conclusions: Patients were more likely to express commitment to safer sex during clinical encounters in which their healthcare providers used communication behaviors consistent with the principles of motivational interviewing. With 1.2 million HIV-infected individuals in the United States, and 84% of new HIV infections caused by sexual transmission, MI holds promise as one strategy to help reduce the spread of HIV. More research is urgently needed to determine the most effective communication strategies to influence patient sexual risk behavior.

Decreasing Disparities in Breast Cancer Screening in Refugee Women Using Culturally Tailored Patient Navigation

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Background: Refugee and recent immigrant women have low breast cancer screening rates. Patient navigation can improve breast cancer screening in low income, ethnic/racial minorities, but little information is available for refugee women. The objective of this study was to evaluate the effect of a culturally tailored patient navigator program on decreasing disparities in breast cancer screening in refugee women from Africa, the Middle East and Bosnia.

Methods: Since April 2009, all women who self-identified as speaking Arabic, Somali or Serbo-Croatian (Bosnian) and were eligible for breast cancer screening at an urban community health center, were enrolled in a patient navigator program. Patient navigators were women from the same community who spoke the same language as the patients they served. Patient navigators educated women about breast cancer screening, explored their barriers to screening, and tailored interventions to individual women to help them complete mammography screening. We compared breast cancer screening rates in refugee women to English and Spanish speaking patients receiving care at the same health center over a four year period, starting 1 year prior to the navigator program (2008), using Chi-square tests.

Results: Over the 4 year period, there were on average 147 refugee women eligible for breast cancer screening. Among these women, 19% were Somali speaking, 25% were Arabic speaking, and 56% were Serbo-Croatian speaking. Over the same period, there were on average 1555 English and 1494 Spanish speaking women eligible for breast cancer screening at the same health center. In 2008, prior to the start of the navigator program for refugee women, there were marked disparities in mammography screening rates: 35.5% for refugee women compared to 58.3% for English and 62.4 % for Spanish speaking patients ($p < 0.001$). Over the three years of the patient navigator program, mammography rates increased among all patients, showing an increase of 3.4% for English, and 5.4% for Spanish speaking women and 29.3% for refugee women. As of October 31, 2011, mammography screening rates were similar in all groups, with 64.8% of refugee women screened compared to 61.7% in English and 67.8% in Spanish speaking patients (both $p = 0.47$) (Table 1).

Conclusions: A culturally tailored patient navigator program can decrease disparities in breast cancer screening that are present in women refugees from Somalia, the Middle East, and Bosnia.

Exploring Challenges and Preferences At Hospital Discharge In a Low Health Literacy Population

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Background: Health literacy is a set of skills, including the ability to perform basic reading and numerical tasks, required to function in the health environment. Low health literacy (LHL) contributes to health disparities. Patients with LHL have a poorer understanding of prescription medication names, indications for use, instructions and more unreconciled medications. Evidence suggests that poor communication plays a role in many medication errors after hospital discharge, and is exacerbated by LHL. The objective of this study was to ascertain the challenges and preferences of patients at risk for LHL when providers are communicating with them about their medications at the time of hospital discharge.

Methods: Patients were selected by convenience sampling from the medicine service at a university hospital in Bronx, NY. Informed consent was obtained and semi-structured interviews (in English or Spanish) were conducted regarding current or previous hospital discharge. Two investigators independently reviewed the transcribed data to generate a codebook using grounded theory. A third researcher reviewed any data where disagreement in coding arose. Saturation of themes was reached after 14 interviews.

Results: Three major themes emerged from analysis of the interview data: challenges to asking questions, patient's preferences for delivery of medication instructions, and the effect of trust on patient's perceptions of the discharge process. Most patients acknowledged that at times they wanted to ask questions and did not. Frequently a barrier to question asking could not be identified, with patients merely stating: "It didn't occur to me to ask." Patients preferred instructions to contain pictures of pills. Most patients organized their medications with a pillbox and identified pills by color; in contrast to the delivery of medication instructions by name, dosage and indication. They preferred explicit, simple language, with careful attention to any dangers. "Don't take the medicine you got at home because you could get real sick. I remember that one. It's important." "She just kept emphasizing what he shouldn't have." Low trust in the medical system challenged patient's ability to solve problems after discharge. Patients with regular follow-up stated they would call their doctor or pharmacist if they had a problem. Without a trusted provider, problem solving suffered. "If I can't get it [medication] that day, I'll have to wait the next day, sometimes two days." Patients worried when they could not get their medications. Regarding pill color changes, "I really don't know what I would do" was a common response. "I wanted to know what I'm taking and why...it never happened. Then I refused to take the medication." Some mistrust stemmed from a misconception of standard residency program practice. "So many different doctors and they come and ask different questions so many times." "They don't know too much." "You have a young doctor, they don't know what they're doing. So they [patients] won't tell them."

Conclusions: The results of this analysis suggest providers need a mechanism to uncover patient's questions and that medication instructions are not currently delivered in a way to minimize post-discharge medication errors. Additionally, efforts to enhance trust may increase patient problem solving abilities after discharge. Further research is needed to develop and evaluate methods for patient-centered discharge planning that account for low health literacy.

Factors That Sustain Humanism in Teachers of Internal Medicine Residents

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Background: The humanistic care of patients has been shown to improve patient satisfaction and patients' trust in their doctors. Humanism is often taught by example; teaching faculty are thus charged with modeling humanistic behavior to learners. Residents are vulnerable to declining empathy during their training and therefore can especially benefit from humanistic teachers. However, with many demands and pressures on teaching faculty, it can be hard to sustain humanism, much less to model humanistic behavior to learners. The goal of this study was to identify factors that exemplary humanistic teachers believe help them to maintain their caring attitudes.

Methods: A survey was administered to all internal medicine residents at the University of Pennsylvania in June 2011, asking them to nominate up to three teaching attending physicians who served as excellent role models for the humanistic care of patients. Faculty members who received the most nominations were invited to participate in a one-on-one interview to identify factors that sustain humanism in their teaching and patient care. Interviews were conducted until themes reached saturation. The interviews were transcribed anonymously and coded with NVivo software by an independent coder; codes were verified by one of the investigators (CC).

Results: 119 of the 150 internal medicine residents at the University of Pennsylvania responded to the survey (71% participation). 92 of the 591 internal medicine teaching faculty (15.5%) received one or more votes. The range of votes per faculty member was 1 to 21. The top sixteen nominees, with votes ranging from 5 to 21, were invited to be interviewed; response rate was 100%. Demographics describing interviewees are as follows: mean age was 43.2 years. Nine interviewees were women (56%) and seven (43.7%) were general internists. Other specialties included pulmonary/critical care (25%), hematology/oncology (12.5%), infectious disease (12.5%), and GI (6.25%).

Factors that sustain humanism for these interviewees include: engaging in ongoing self-reflection (68.7%); deriving sustenance for humanism from the patient interaction itself, including a desire to find a connection with the patient (62.5%); being humble to receiving feedback and striving to improve one's practice (50%); and being conscious of living up to a standard of being a "good doctor," as well as treating others as one would want to be treated (37.5%). 15 of the 16 interviewees identified role models within medicine that had positively influenced them; the sixteenth cited negative role models in medicine that were a reminder of how not to act. 8/16 (50%) had had personal experiences with illness or close family members with illness which inform their current humanistic tendencies.

Conclusions: These findings have implications for producing future generations of humanistic internal medicine physicians. Identifying teachable factors that help to sustain exemplary humanistic physicians may allow us to replicate those factors and create an environment in which those factors are fostered. Faculty development programs based on these factors may improve the teaching and delivery of humanistic care.