

Physician communication skills training and patient coaching by community health workers

Category	Description
Title of intervention	Physician communication skills training and patient coaching by community health workers
Objectives	<p>Objectives IROHLA taxonomy</p> <ul style="list-style-type: none"> ✓ To inform and educate older adults and professionals ✓ Improving skills of older adults and professionals ✓ To support behaviour change and maintenance (targeted at individuals and professionals) ✓ To customise health literacy interventions or enhance the implementation of these interventions (targeted at individuals and professionals) <p>Short description of the objectives of the intervention</p> <p>Both patients and professionals were trained to enhance their consultation skills in order to improve blood pressure level. These results report on 12 month outcomes; project was due to run for 5 years</p>
Target groups	<ul style="list-style-type: none"> ✓ young seniors: 50-60, ✓ pensioners: 65-80 <p>Short description of the target groups</p> <p>Split across 4 groups:</p> <ul style="list-style-type: none"> • 66% female • Mean age 61.3 years • 70% Relatively low income (below \$35k/yr) • 62% Black Americans, ~34% white Americans. • Language not mentioned, probably all English speakers • Health risk = hypertension • 44% also had diabetes, 24% also had depression, 17% cardiovascular disease • Typical years of education = 12 (not low nationally for this age cohort)
Problem analysis	<p>Consequences for individual and/or society</p> <p>Environment, economic and social factors, behavioural risk factors, and access to care partially explain differences in health status and disparities in healthcare quality for cardiovascular disease. It may also contribute to poorer outcomes</p>

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	<p>among ethnic minorities and the poor. Patient, clinician, and health system factors contribute to disparities in care. Patients' health beliefs and behaviour, low health literacy and involvement in medical decision-making play a role in healthcare disparities and may influence adherence to recommended therapies (Cooper 2011).</p> <p>Several effective quality improvement interventions for hypertension have been identified, but were not able to improve patient adherence, did not include adequate samples of African Americans, relatively few have used culturally and linguistically targeted strategies and focused on ethnic minorities and socioeconomically disadvantaged patients who typically have lower levels of engagement and poorer communication with physicians. Furthermore, few of these studies have simultaneously intervened with patients and their physicians in a comprehensive way — for example, by reinforcing activation and empowerment skills and providing emotional support for patients over time, and by providing individualised feedback to clinicians regarding their communication skills — and few objectively measure intervention effects on health outcomes.</p> <p>Distribution of the problem References are given to substantiate that people with lower SES levels and African Americans have more heart disease than they should.</p> <p>Perception of target groups (of the problem) Not discussed; a condition that people may live with without knowing they have it.</p>
<i>Short description of the modifiable determinants of older adults.</i>	<p>Modifiable determinants of older adults Skills, knowledge, self-efficacy</p>
<i>Short description of the modifiable determinants of professionals.</i>	<p>Modifiable determinants of professionals Skills, awareness, cultural competencies, attitudes</p> <p>The physician communication skills program was designed to provide physicians with personalised feedback based on their videotaped performance with a simulated patient scheduled for an office appointment.</p> <p>The patient intervention was based on a pre-visit coaching model shown to improve patients' communication with clinicians and health outcomes</p>

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Components of the intervention	<p>Components</p> <ul style="list-style-type: none"> ✓ Newsletter (for patients) ✓ Group sessions (training) by professionals ✓ Written information materials (leaflets) ✓ Other: telephone calls, videotaping of consultations <p>Description of components</p> <p>Videotaped consultations to let physicians know how they did.</p> <p>Different levels of coaching of patients to improve their ability to communicate with physicians.</p>
Approach	<p>Theoretical models used</p> <p>Communication Skills Model, no specific reference or break down given of which Model adopted but uses the Roter Interactive Analysis System to measure it and the focus is on patient centered care and on skills such as participants role and contribution in the consultation (verbal dominance), use of open and closed questions.</p> <p>Didactics used</p> <p>Training (physicians) and coaching (patients) in communication skills. Aim is for a form of Shared Decision Making - referred to here as Participatory Decision Making (PDM). This is a patient centred approach centring on the doctor-patient relationship and physician and patient communication behaviours involving:</p> <ul style="list-style-type: none"> • activation and empowerment skills through intervention with both patient and their physician; • emotional support over time for patients; • culturally and linguistically targeted strategies to address poor levels of engagement and communication by ethnic minority patients with their physicians; and, • individualised feedback to clinicians regarding communication skills <p>Techniques used</p> <p>Group sessions, newsletter, written information, telephone calls, videotaping of consultations.</p> <p>Contexts</p> <p>Public/state-operated clinics in urban low SES communities (Washington DC area)</p>

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	<p>Stakeholders involved Physicians, underserved low SES mostly ethnic minority individuals. General internists and family physicians who saw patients at least 20 hours per week at one of the participating study sites. Physicians were excluded if they intended to leave the practice within 12 months (Cooper 2011)</p> <p>Type of professionals involved Primary care physicians (GPs)</p>
Resources and qualifications	<p>Duration of the intervention Flexible. Evaluated at 12 months, but will run for 5 years in total.</p> <p>Financial costs for the implementing organisation In addition to administrative and recruitment costs (not likely to be unusually high or low):</p> <ul style="list-style-type: none"> • Evaluation & coaching sessions for professionals: videotaping, analysis of interaction on videotape, feedback given to GPs. • Group session reasonable to administer intervention to patients. Individual telephone calls, newsletters and photo novels as coaching reminders (additional costs in design and material production and distribution); (these costs could be very high due to individual feedback & coaching). • Evaluation costs can be variable, too, but ideally a few person months of skilled statistician time. <p>Required competencies of professionals Willingness to embrace cultural competency, consultation skills.</p> <p>General internists and family physicians who saw patients at least 20 hours per week at one of the participating study sites. Physicians were excluded if they intended to leave the practice within 12 months (Cooper 2011).</p>
Implementation	<p>Implementation strategy</p> <ul style="list-style-type: none"> • <i>For health professional:</i> videotaped performance with a simulated patient scheduled for an office appointment; followed by subsequent feedback about consultation skills improvements; • <i>For patients:</i> pre-coaching focused on communication skills related to engagement, activation, and empowerment parallel to skills targeted in the physician intervention. • <i>Intermediaries:</i> Community health workers (CHWs) administered the intervention to enhance its cultural

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	<p>appropriateness, relevance, and effectiveness. CHWs asked patients to think about any changes they wanted to make regarding interactions with their physicians; allowed patients to practice disclosing concerns, asking questions, and stating preferences; provided pocket-sized diaries for patients to record their appointments, medications, and questions; and helped patients identify sources of support for their new behaviours and strategies to overcome anticipated problems. Intensive intervention patients received bimonthly photo novels that reinforced the coaching messages. All patients received a monthly health education newsletter designed to meet the needs of low literate adult readers.</p> <p>Conditions for effective implementation Primary care Health Professionals willing to improve their cultural competency; patients keen to improve their health or consultation outcomes.</p> <p>Stakeholders involved Primary care physicians, community health workers, individuals with hypertension risk, communication skills trainers</p>
Transferability	<ul style="list-style-type: none"> • Professionals need to be videotaped with standardised patients and then coached about their consultation skills deficits. • Individuals need to be counselled (can be done in many ways, including group sessions, role play, different forms of reminders (such as photo novel and encouragement, etc.) about how to assert themselves better and to ask better questions. • No specific manuals are available.
Evaluation	<p>Methods used Changes in physician verbal dominance and patient-centeredness.</p> <p>Physician communication behaviours were obtained from videotapes of the simulated visit and audiotapes of the first patient study visit. All visits were analysed using the Roter Interaction Analysis System (RIAS), a widely used coding system with demonstrated reliability and predictive validity.</p> <p>Patient Ratings of Physicians' Participatory Decision-Making (PDM) Style: aggregate of three items, each rated on a five-point scale from 0=never, to 4=very often:</p> <ol style="list-style-type: none"> 1. If there was a choice between treatments, how often would this doctor ask you to help make the decision? 2. How often does this doctor give you some control over your treatment? and



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	<p>3. How often does this doctor ask you to take some of the responsibility for your treatment? The raw score is converted to a percent. A higher score means the visit was more participatory. PDM style is an important measure of patient-centred care; it distinguishes race-concordant from discordant visits and has been linked to satisfaction and continuity of care over time</p> <p>Patients' Perceived Involvement in Care Scale (PICS), a patient self-report measure reflecting level of agreement with: doctor facilitation of patient involvement during the visit; information exchange between patient and physicians; and patient participation in medical decision making Scores on each subscale range from 1 to 5, and higher scores reflect more involvement in care.</p>
Effectiveness	<p>Main results</p> <p>In declining order of improvements seen:</p> <p><i>Patient perception of physician-style-in-promoting-joint-decision-making (PDM in previous) showed significantly greater improvements among patient+ physician intensive group than the patient + physician minimal group ($\beta=+6.2$ vs. -5.2, $p=0.03$).</i></p> <p><i>During consultations, Physicians had less verbal dominance in intervention arms.</i></p> <p>Similarly, two aspects of the PICS, <i>physician facilitation</i> ($\beta=+0.22$ vs. -0.17, $p=0.03$) and <i>information exchange</i> ($\beta=+0.32$ vs. -0.22, $p=0.005$), <i>showed improvements</i> for intensive relative to minimal groups.</p> <p>The improvements in blood pressure did not reach statistical significance, but the direction was consistent across groups and suggestive in the intervention group with the largest systolic BP reduction. Reductions in systolic BP—as small as 5 mmHg—have been associated with significant reductions in mortality.</p> <p><i>Visits of trained versus control group physicians demonstrated more positive communication change scores from baseline (-0.52 vs. -0.82, $p=0.04$). At 12 months, the patient + physician intensive group compared to the minimal intervention group showed significantly greater improvements in patient report of physicians' joined decision making ($\beta=+6.20$ vs. -5.24, $p=0.03$) and Patient involvement dimensions related to doctor facilitation ($\beta=+0.22$ vs. -0.17, $p=0.03$) and information exchange ($\beta=+0.32$ vs. -0.22, $p=0.005$). Improvements in patient adherence and BP control did not differ across groups for the overall patient sample. However, among patients with uncontrolled hypertension at baseline, non-significant reductions in systolic BP were observed among patients in all intervention groups—the patient + physician intensive (-13.2 mmHg), physician intensive/patient minimal (-10.6 mmHg), and the patient intensive/physician minimal (-16.8 mmHg), compared to the patient +physician minimal group (-2.0 mmHg). (Cooper et al 2011)</i></p>

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	<p>Interventions that enhance physicians' communication skills and activate patients to participate in their care positively affect patient-centred communication, patient perceptions of engagement in care, and may improve systolic BP among urban African-American and low SES patients with uncontrolled hypertension. (Cooper et al 2011)</p> <p>The greatest improvements were seen among patients who received coaching by a CHW and whose physicians also received patient-centred communication skills training. (Cooper 2011)</p>
<i>Key elements/components of the intervention that must stay intact in order to have an effective intervention</i>	<p>Key elements</p> <ul style="list-style-type: none"> • Individual and highly specific feedback to willing physicians about how to improve their decision making & participatory styles. • Willingness by patients to adopt more empowered stances; repeated reminders and encouragement to patients. • Community health workers who are culturally competent to interact with cultural minority target patients. • Physician and patient interventions were designed in tandem to support the therapeutic partnership from both perspectives. <p>Recommendations for future changes in intervention:</p> <ul style="list-style-type: none"> • Future work should identify factors associated with successful implementation of evidence-based patient-centred strategies for hypertension in real-world settings. • Efforts are needed to identify levels of intensity and particular intervention components that contribute to improved outcomes, as well as sub-groups of clinicians and patients most likely to benefit from these approaches. • Future interventions might be strengthened by including health system-level strategies and further emphasis on patients' social and environmental context.
Level of evidence	✓ Quasi-experimental: was planned as an RCT, but found to be impossible in practice and may have been other failures of blinding. There was randomisation and partial blinding between participants and controls.
Sector	Health sector
Country	USA
Provider	<p><i>Name:</i> Lisa A. Cooper <i>Organisation:</i> Johns Hopkins Bloomberg School of Public Health <i>Type of organisation:</i> University research dept. <i>Post address:</i> Welch Centre for Prevention, Epidemiology, and Clinical Research, Johns Hopkins University, 2024 E.</p>

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Relevant documents/links	<p>Relevant documents</p> <ul style="list-style-type: none"> • Cooper LA, Roter DL, Bone LR, et al. A randomised controlled trial of interventions to enhance Patient–Physician Partnership, patient adherence and high blood pressure control among ethnic minorities and poor persons: study protocol NCT00123045. <i>Implement Sci.</i> 2009;4:7. • A randomised trial to improve patient-centered care and hypertension control in underserved primary care patients, Cooper et al 2011 <i>JGIM</i>