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The ABCs of Empowered Communication: A Community-Based Intervention for Patients

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Health disparities continue to exist despite improvements in health care delivery and access. Even when access to care, diagnosis, and severity of disease are the same, members of different racial and ethnic groups tend to use preventive and diagnostic services at different rates. This suggests that the emerging disparities are occurring within the context of the medical interaction between physician and patient. Given that patient-physician communication is a significant part of the medical interaction and has been shown to affect health outcomes, patient satisfaction, and adherence to treatment recommendations, evidence suggests that noted disparities might largely be a result of communication difficulties within the medical interaction.¹

Based on these findings, researchers from the Houston Center for Quality of Care and Utilization Studies designed a communication intervention to improve the patient-physician interaction. The results of these efforts yielded a patient-centered community education intervention, the *How to Talk to Your Doctor* (HTTTYD) program. Grounded in effective communication theory, this educational forum empowers patients to become their own best advocates in the medical interaction by teaching them the skills necessary to successfully negotiate optimal medical care through proactive participation with their physicians and other caregivers.

The program is structured around 3 central premises: (1) patients who are active communicators achieve better health outcomes; (2) it is less resource-intensive to effectuate change in a patient's communication style than in a physician's; and (3) ethnically diverse populations often have a more pronounced need for effective communication interventions. Purposefully developing the program as a community-education intervention rather than a clinical-education intervention facilitates a broader reach. For this reason, it is able to encompass diverse patient populations who routinely need medical care, including disease-specific support groups (breast cancer survivors), the elderly, and various community health center patients.

The program is a 2-hour community education forum, intended for small audiences, ranging from 20 to 40 participants. To ensure that both sides of the patient-physician interaction are presented, 2 trainers, typically a physician and a non-

physician, staff each forum. The forum is organized along 4 main learning objectives or discussion topics: (1) recognition of barriers to good patient-physician communication; (2) recognition of examples of effective patient-physician communication styles; (3) application of strategies presented in the forum for improving communication in the medical interaction; and (4) recall of good patient-physician communication strategies.² To promote participants' understanding and active participation in the forum, each participant is given a 20-page, fully illustrated HTTYD guidebook (available in English and Spanish) organized along the 4 main learning objectives outlined above.

After completion of the consent process and a pre-intervention survey, the co-trainers lead the participants through the 4 main learning objectives. As a means of facilitating an understanding of barriers to good communication, participants are asked to share out loud some of the difficulties that they have encountered in communicating with their physician(s). These responses are recorded on a flip-chart and bring about a lively discussion as participants quickly realize that they are not alone in their difficulties and that their concerns are the same or similar to those experienced by the participants at-large. A recognition of communication barriers facilitates a simultaneous recognition of effective communication styles and naturally segues into the second learning objective, that of understanding different communication styles and identifying good communication strategies in the medical interaction. In this section, trainers lead a discussion on patient and physician roles in the medical interaction and help the participants to translate this information into an understanding of the potential impact of these roles on their respective communication styles. Mediated by an understanding of the context of these communication styles, participants are guided through the third learning objective; that of strategizing and applying communication techniques learned during the forum. Specifically, the 3 *ABC* tips suggested are: (a) *Ask* questions in order to receive information, (b) *Be* prepared for the appointment, and (c) *Communicate* and express health concerns. The fourth and final learning objective presented is that of practicing tips for good patient-physician communication. This objective is accomplished by the trainers role-playing a patient-physician interaction, which the participants are then asked to evaluate in light of the previous 3 learning objectives. The script is then reenacted using the suggestions of the participants. After a brief review of the main points of the HTTYD program, the trainers entertain participant questions. The forum concludes with a post-survey.

Using a pre-post survey format to determine the effectiveness of the HTTYD program, researchers collected data from 7 different sites in the greater Houston metropolitan area over a 9-month period (June 2001 – February 2002). The pre-survey comprises demographic questions including age, education, gender, income, race/ethnicity, and current employment status. The pre-survey also includes questions from The Patient Confidence in Communication Scale³ (Table 1). The post-survey includes questions relating to the quality of the forum, materials used, and participants' sense of self-efficacy following the forum.

Descriptive statistics were compiled on the demographics of 110 participants who consented for inclusion in our study. Of the 110 participants 75 percent were women. The age range was 20 to 91 years, with an average age of 51 (± 18.3). The majority of the participants were African American (52 percent), followed by White (24 percent), Hispanic (20 percent), Asian Indian (<1 percent), and Vietnamese (<1 percent). Sixty-one percent of the participants reported some college education, 55 percent reported full-time employment, and 35 percent reported their general health as "very good" or "excellent."⁴

An exploratory factor analysis was conducted on the Patient Confidence in Communication Scale (PCCS) items. The analysis provided evidence that 1 factor formed the basis for the 7 items. The item variance, accounted for by this single factor, at pre- and post-intervention, was 53 percent and 52 percent, respectively. Also, communalities ranged from .59 to .83 at pre- and post-intervention, respectively. The internal consistency of the items at pre- and post-intervention was .84 and .83, respectively.⁴

Results of the repeated measures ANOVA for the effect of time revealed statistical significance ($p = .001$) in participants' mean confidence levels from pre- to post-intervention. Testing for the effect of group also revealed statistical significance ($p = .001$) in mean pre- and post-intervention PCCS scores of the participants. However, testing for the group by time interaction was not statistically significant ($p = .09$). More specifically, the mean pre-post intervention improvement was not statistically different for participants at the 7 sites.⁴

Table 1
Patient Confidence in Communication Scale (PCCS)

No.	Item
1.	I can easily list problems or barriers that get in the way of good patient-doctor communication.
2.	I can easily list the reasons why I need to communicate effectively with my doctor.
3.	I can easily give examples of what my role, as a patient, should be when I talk to my doctor.
4.	I can easily list goals I want to achieve when talking to my doctor.
5.	I can easily give examples of what a good doctor's role should be when he/she interacts with me.
6.	I know ways to improve my communication with my doctor.
7.	I use good communication skills when talking to my doctor.

Note: Response categories for all items were (1) Strongly Disagree, (2) Disagree, (3) Slightly Disagree, (4) Slightly Agree, (5) Agree, and (6) Strongly Agree.

Overall, the findings indicate that although the participants at the centers reported different levels of confidence in communication at both pre- and post-intervention and the level of confidence increased from before to after the intervention, in the final analysis, the change in communication confidence levels was similar for all 7 sites despite the diverse nature of the audience. Also of interest was that self-reported improvement in confidence level was the same regardless of the co-trainer pairs. Thus, effectiveness of the forum was not only site-independent but facilitator-independent, as well.

One of the major strengths of the HTTYD community education forum is its applicability to diverse audiences – from disease-specific cohorts to healthy individuals to senior citizens; all groups have been found to benefit equally. Its adaptability to a "train the trainer" format significantly broadens dissemination capabilities, extending it to varied audiences. In addition, the limited 2-hour format has been found to be greatly conducive to participant attendance.

One of the major limitations of the program is that findings were based on self-reported data. Likewise, an inability to follow up with participants precludes a determination of whether skills taught in the program are actually being incorporated into participants' repertoire of skills in their navigation through the medical interaction. Importantly, inability to follow up also precludes a determination of whether participants' adherence to the learning objectives actually leads to better health outcomes.

As of this writing, the continuing education forums remain well received by the community and, largely by request, the Houston Center for Quality of Care and Utilization Studies continues to conduct 8-10 forums per year at the local level. Based on recent inquiries, strategies for expansion of current dissemination activities at the national level are in the process of being evaluated. In addition, the feasibility of 3- to 6-month follow-up strategies is also being considered for inclusion in the program.

REFERENCES

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2. Tran AN, Haidet P, Street R, O'Malley KJ, Martin F, Ashton C. Empowering communication: A community-based intervention for patients. *Patient Education and Counseling* 2002. In Press.
3. The Patient Confidence in Communication Scale (PCCS) is a communications measure created by researchers from the Houston Center for Quality of Care and Utilization Studies, Houston, Texas. The PCCS is a 7-item Likert-type scale with 6 response categories ranging from "strongly disagree" to "strongly agree." The PCCS was developed to assess participants' confidence in their ability to list goals, barriers, and necessary skills to effectively communicate with their doctor. Scores on the PCCS are computed by summing responses to the 7 items and rescaling total scores to

range from 0 to 100. Higher scores indicate higher patient communication confidence.

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