

# Implementing Effective Patient-Provider Communication for Diverse HIV-infected Patient Groups

## Introduction

Two studies from 2011 found communications differences along racial and substance-use lines between patients who are HIV-positive and their providers. Because African Americans and substance users are among the groups most affected by the HIV epidemic, these studies underline the importance of patient-provider communication in optimizing clinical encounters and patient outcomes.

Beach and colleagues reported that providers tended to be more verbally dominant with African American vs white patients—meaning that they expressed more complete thoughts than the patients and that African Americans vs whites provided less information to their providers during clinic visits.[Beach 2011] These researchers audio-recorded clinic visits involving 45 providers (physicians, nurse practitioners, and physician assistants) and 246 African American and 100 white patients and categorized the remarks made during the encounters as question-asking, counseling, or socio-emotional communication. Although the participating patients were generally satisfied with the care they received and the amount and quality of patient and provider socio-emotional communication was similar for African Americans and whites, African Americans spoke less during the visits. Therefore, the researchers recommend that providers make greater efforts to verbally engage their African American patients during clinical encounters.

Korthuis and colleagues analyzed the recordings from this same group of patients according to the patients' substance use habits and reported that providers spent less time talking with patients who reported either current or past unhealthy use of alcohol.[Korthuis 2011] They also found that providers used fewer patient-engagement and activating statements and fewer counseling statements regarding lifestyle or psychosocial behaviors with patients reporting current unhealthy drinking patterns and that these patients made fewer engaging, activating, and positive statements to their providers. Clinic visits for patients without a history of unhealthy drinking lasted an average of 4 minutes longer, and the patients received more patient-engagement and activating statements during the visits. Providers were also more likely to make negative statements and ask more questions during encounters with illicit drug users, and these patients made more negative statements. However, visits involving drug users vs alcohol users included the exchange of more counseling and lifestyle statements. The researchers observed that the communication patterns between providers and HIV-infected patients with unhealthy drinking habits suggest that there is a higher risk for poor HIV-related outcomes and suggested that more resources and time should be invested in the care of such patients.

## Health Literacy

In 2004, the US Institute of Medicine published a comprehensive, landmark report on issues of health literacy in the United States, *Health Literacy: A Prescription to End Confusion*. [Nielsen-Bohlman 2004] One chapter of that report discusses the definition of health literacy in detail, including the social and cultural backgrounds that shape a person's or group's ability to understand and navigate through the vast amount of health-related information that is available to the public. The core definition used in the

report is the one provided by the Healthy People 2010 report ([www.healthypeople.gov](http://www.healthypeople.gov)): Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” *Health Literacy* then explains that “capacity” refers to both an individual’s innate potential and his or her skills, as determined by education, culture, language, and the characteristics of health-related settings.

The tasks that appropriate health literacy enables a person to do include:[Nielsen-Bohlman 2004]

- Read and follow guidelines for physical activity
- Find health information on the internet or in periodicals and books
- Analyze risk factors in advertisements for prescription medicines
- Determine which health web sites contain accurate information and which do not
- Fill out health insurance enrollment or reimbursement care system forms
- Understand printed patient rights and responsibilities
- Find one’s way in a complicated environment such as a busy hospital or clinical center
- Ask for clarification
- Make appropriate decisions based on information received
- Comprehend required informed consent documents

## **Health Communication**

The Institute for International Medical Education offers this definition of communication: “The process by which information and feelings are shared by people through an exchange of verbal and non-verbal messages. In the context of medical education, its primary function is to establish understanding between patient and doctor” ([www.iime.org/glossary.htm#certification](http://www.iime.org/glossary.htm#certification)). Because any communication is a two-way process, patients’ health literacy represents a critical precondition both of effective patient-provider communication and of improved clinical outcomes. The US Department of Health and Human Services’ “Healthy People” program ([www.healthypeople.gov](http://www.healthypeople.gov)) points to these goals for effective health communication:

- Improve health care quality and safety
- Increase the efficiency of health care and public health service delivery
- Improve the public health information infrastructure
- Support care in the community and at home
- Facilitate clinical and consumer decision-making
- Build health skills and knowledge

The current curriculum, “Implementing Effective Patient-Provider Communication for Diverse HIV-infected Patient Groups,” will present a practical overview of the challenges of health literacy, the need for enhanced patient-provider communication, and strategies for improving communication in clinical encounters.

The 5 modules in this curriculum are:

1. State of Health Literacy in the United States
2. Barriers to Effective Patient-Provider Communication
3. Theoretical Frameworks for Effective Patient-Provider Communication
4. Practical Framework for Implementing Effective Patient-Provider Communication
5. Case Studies

## Learning Objectives of the Overall Curriculum

- Define health literacy and describe its importance to effective healthcare communication and patient outcomes
- Describe effective healthcare communication
- Identify 5 of the main barriers to effective patient-provider communication
- Discuss how healthcare providers' knowledge, attitudes, and beliefs regarding HIV-infected patients can affect patient-provider communication and clinical outcomes
- Define "interpersonal communication" (IPC) and "shared decision making" (SDM) and discuss their value in improving clinical outcomes
- Identify the potential frameworks for enhancing patient-provider communication
- Discuss specific approaches to improving patient-provider healthcare communication

## References

Beach MC, Saha S, Korthuis PT, et al. Patient-provider communication differs for black compared to white HIV-infected patients. *AIDS Behav.* 2011;15:805-811.

Korthuis PT, Saha S, Chander G, et al. Substance use and the quality of patient-provider communication in HIV clinics. *AIDS Behav.* 2011;15:832-841.

Nielsen-Bohlman L, Panzer AM, Kindig DA, eds. *Health Literacy: A Prescription to End Confusion.* Institute of Medicine of the National Academies; Washington, DC; 2004. Available at: [www.nap.edu/catalog/10883.html](http://www.nap.edu/catalog/10883.html).

## Module 1—State of Health Literacy in the United States

### Learning Objectives

- Define health literacy and describe its importance to effective healthcare communication and patient outcomes
- Describe the key elements of effective healthcare communication

### Pre-training Assessment

1. What proportion of Americans have some difficulty in reading and understanding written health information?

- A. Nearly one-quarter
- B. Nearly half
- C. Approximately one-third
- D. Approximately 1 out of 10

Answer: B. Nearly half

2. Which of the following populations is NOT more vulnerable to inadequate health literacy?

- A. Members of nonwhite racial and ethnic groups
- B. People with incomes at or below the poverty level
- C. Young adults
- D. Recent immigrants

Answer: C. Young adults

3. Which of the following is a short tool for assessing health literacy in adults?

- A. AHRQ
- B. Healthy People 2020
- C. Plain Writing Act

D. REALM

Answer: D. REALM

Not surprisingly, many of the most important and revealing studies of the state of Americans' health literacy have been conducted by national agencies whose missions include public health policies and programs. In 2004, the US Institute of Medicine (IOM), which is the health branch of the National Academy of Science, issued its comprehensive report, *Health Literacy: A Prescription to End Confusion*. A critical conclusion of the report was that nearly half of the adult population of the United States—some 90 million persons—encountered challenges in comprehending and making appropriate use of health information. To arrive at this conclusion, the authors of *Health Literacy* adopted this definition of 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.” [Ratzan 2000] The authors regard the current situation as so serious that they refer to an “epidemic of health illiteracy.” (The *Health Literacy* report is not a one-time event for the IOM, which has issued a range of roundtable discussions, reports, and other publications on the subject; these can be accessed by searching the institute's website, [www.iom.edu](http://www.iom.edu).)

The problem is not entirely limited to individuals with limited education or limited English-language proficiency. Complex written materials can be found in many different forms and contexts and their accessibility can depend on the types of information that a particular person is accustomed to encountering. Even people who have well-developed literacy abilities sometimes may have difficulty in obtaining, understanding, and using health information—e.g., a surgeon may have trouble helping a patient's family member fill out Medicare forms. This is because health literacy reaches beyond merely accessing information—on one hand, the expectations, preferences, and skills of persons who are seeking health information and services can differ from those of the persons who provide the needed information and services. Education, available health services, and a host of social and cultural factors come together to determine a person's health literacy.

## **Overall Literacy in the United States**

To put the issue of health literacy into context, the report cited the following general literacy findings from other studies:

- More than 47% of adults—approximately 90 million—have difficulty locating, matching, and integrating information in written texts accurately and consistently.
- Out of the 90 million adults with limited literacy skills, approximately 40 million can perform simple, routine tasks using uncomplicated written materials.
- An additional 50 million adults can locate information in moderately complicated texts, make inferences using print materials, and integrate easily identifiable pieces of information, but they have difficulty performing such tasks when they are complicated by distracting information and complex texts.

Moreover, *Health Literacy* pointed to the following populations as being particularly vulnerable to the issues associated with inadequate health literacy:

- Adults older than 65 years of age
- Non-native English speakers
- People with incomes at or below the poverty level (income  $\leq$  \$23,550/year for a family of 4)
- People with less than a high school degree
- Recent refugees and immigrants
- Racial and ethnic groups other than white

The worrisome findings of IOM's *Health Literacy* report and the complex changes to the healthcare system that will be associated with the implementation of the 2010 Patient Protection and Affordable Care Act led the IOM to publish a follow-up report, *Health Literacy Implications for Health Care Reform*. [IOM 2011] The report intended to shed light on the significant challenges that persons with limited health literacy will confront in understanding the variety of choices that will be available and in completing the enrollment process for healthcare plans. Other recent important undertakings by federal agencies that aim to enhance Americans' health literacy include:

- National Plan to Improve Health Literacy [National Plan 2010]
- Plain Writing Act of 2010 [Plain Writing]
- Healthy People 2020 ([www.healthypeople.gov/2020/default.aspx](http://www.healthypeople.gov/2020/default.aspx))

### **Measuring the Impacts of Limited Health Literacy [Nielsen-Bohlman 2004]**

Measuring the impacts of limited health literacy with the currently available tools is not at all an exact science, but the information that is available is sobering:

- Several studies have reported that patients with chronic illness—which includes HIV disease—who also have limited health literacy have less knowledge of illness management vs those with greater health literacy.
- Other studies have found that patients with limited health literacy:
  - Are less able to share in decision making about prostate cancer treatment
  - Have lower adherence to anticoagulation therapy, higher likelihood of poor blood sugar control, and lower self-reported health status

The limited available data also point to an association between health literacy and health-care utilization and costs:

- One study found that public hospital patients with limited health literacy had higher rates of hospitalization vs those with adequate health literacy, possibly due to greater resource use. [Baker 2002]
- An analysis from the mid-1990s found an additional health expenditure of \$29 billion attributable to inadequate reading skills. [Friedland 1998]
- Analysis of a small sample of Arizona Medicaid patients reported patients with reading ability at or below third-grade level had mean Medicaid charges \$7,500 higher than those who could read above third-grade level. [Weiss 2004]

### **Tools for Assessing Health Literacy**

Researchers and health officials from a number of fields and organizations—many of them federal agencies—have developed instruments for assessing patients' health literacy. Some of these are more suitable for research purposes, but others can be useful in clinical settings. Following are brief descriptions of some of these health literacy assessment tools, along with links to associated websites or sources of further information (where available).

#### **REALM (Rapid Assessment of Adult Literacy in Medicine) 2009**

REALM is a screening tool designed to measure adults' ability to read common medical words or lay terms that correspond to parts of the anatomy or illnesses. Because REALM is a word recognition test, it does not assess comprehension, although it is highly correlated with other tests of comprehension. REALM takes approximately 3 minutes to administer and score. REALM-R (Rapid Assessment of Adult Literacy in Medicine-Revised) is a shortened version that is used to help identify literacy levels of adult patients. REALM-R consists of 8 items and is used to measure how well individuals can read words they may encounter in a medical setting. REALM was designed by the federal Agency for Healthcare Research and Quality (AHRQ) ([www.ahrq.gov/professionals/quality-patient-safety/quality-resources/health-literacy-measurement/index.html#](http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/health-literacy-measurement/index.html#)).

#### **SAHLSA (Short Assessment of Health Literacy for Spanish-speaking Adults) 2007**

The Short Assessment of Health Literacy for Spanish Adults (SAHLSA) consists of 50 items designed to assess a Spanish-speaking adult's ability to read and understand common medical terms. SAHLSA was based on REALM, the most easily administered tool for assessing health literacy in English. SAHLSA was also developed by the AHRQ ([www.ahrq.gov/professionals/quality-patient-safety/quality-resources/health-literacy-measurement/index.html#](http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/health-literacy-measurement/index.html#)).

#### **NVS (Newest Vital Sign) 2007**

The Newest Vital Sign (NVS) consists of a nutrition label with 6 accompanying questions to quickly identify patients at risk for low health literacy. NVS takes approximately 3 minutes to administer and is available in both English and Spanish versions. NVS was developed by Pfizer, Inc., with input from the University of Arizona and the University of North Carolina ([www.pfizerhealthliteracy.com/physicians-providers/newestvitalsign.aspx](http://www.pfizerhealthliteracy.com/physicians-providers/newestvitalsign.aspx)).

#### **NAAL (National Assessment of Adult Literacy) 2006**

National Assessment of Adult Literacy (NAAL) is a nationally representative assessment of English literacy among America adults  $\geq 16$  years of age. Sponsored by the National Center for Education Statistics (NCES), the NAAL is the most comprehensive measure of adult literacy in the United States (<http://nces.ed.gov/naal/health.asp>). The health literacy component of the NAAL introduced the first national assessment of adults' ability to use literacy skills with health-related materials and forms.

#### **TOFHLA (Test of Functional Health Literacy in Adults)**

The full Test of Functional Health Literacy in Adults (TOFHLA) consists of both a reading comprehension section (50 questions) and a numeracy section (17 questions). The entire test usually takes up to 22 minutes to administer. The reading passages and numeracy questions are taken from common medical scenarios. The s-TOFHLA is an abbreviated version that uses only questions from the reading comprehension portion of the full test, with 36 items that can be administered in 7 minutes. The scoring categorizes respondents into inadequate, marginal, or adequate levels of health literacy. TOFHLA was developed at Emory University.[Parker 1995]

### **Health Literacy Among Persons who are HIV-Positive**



The challenges of following instructions to maintain adherence to antiretroviral regimens and the reality that some 50,000 American still become HIV-infected each year—despite the wide availability of prevention messages—mean that issues of health literacy and communication continue to be serious impediments to effectively managing the HIV epidemic. And, of course, many of the groups identified in the IOM report as being at risk for inadequate health literacy are also the same groups who are already HIV-positive or at risk for acquiring HIV infection.

Unfortunately, the data concerning patients' health literacy regarding HIV treatment and prevention are quite limited, as studies of health literacy in this specific population of healthcare consumers have been very few in number. Ohl and colleagues performed one of those studies by comparing the accuracy of several different approaches to assessing the health literacy of HIV-infected patients at 2 HIV specialty clinics.[Ohl 2010] These researchers reported that healthcare providers overestimated the level of health literacy among HIV patients—they misidentified 53% of the study participants as having adequate health literacy when their literacy levels were in fact low.

From this finding, the researchers infer that, although providers and patients may routinely discuss other difficult HIV-related topics such as high-risk sex and substance use, discussions of patients' health literacy barriers are not common. Moreover, they mention that previous studies had shown that the health literacy of African American patients in particular may often be overestimated, potentially contributing to the well-established disparities in healthcare outcomes among African Americans.[Kelly 2007] Ohl and colleagues concluded that routine health literacy screening questions do not provide enough information to be useful in the setting of providing HIV care. They added that patients' self-reporting of their educational attainment level was overall a more accurate indicator of patients' health literacy levels, compared with either brief screening questions or providers' perceptions of a patient's health literacy level.

Given these observations, the researchers caution that providers should be aware that they may not accurately assess their patients who are HIV-positive health literacy. They go on to suggest that HIV clinicians and clinic directors should consider the use of interventions to improve health communication with all of the patients attending their clinics. These interventions can include simple measures such as printed materials at a reading level that is accessible to all patients (e.g., a fifth-grade level), routine use of visual aids, confirmation that patients have understood when discussions regarding care (“teach back”), and avoiding unnecessary medical jargon. Interventions such as these may benefit all patients, but they may be particularly helpful to patients with inadequate health literacy.

Besides this analysis by Ohl and colleagues, other studies have examined specific issues of health literacy among patients who are HIV-positive. Nachegea and colleagues evaluated the relationship among patients' health literacy, the quality of clinical communication, and adherence to HAART, emphasizing the critical need for improved patient-provider communication.[Nachegea 2012] An evaluation by Dickens and colleagues of the communication techniques used by HIV care providers urged that “educating HIV specialty providers about the prevalence of low health literacy increases their awareness about interacting with persons with low health literacy and that awareness can prompt change in the patient-provider clinical encounter.”[Dickens 2013]

## **Goals of Improved Health Literacy**

The IOM's *Health Literacy* report offers an overview of the kinds of services and social conditions that could develop if adequate levels of health literacy were designed and implemented throughout the US population: [Nielsen-Bohlman 2004]

- Everyone has the opportunity to improve their health literacy.
- Everyone has the opportunity to use reliable, understandable information that could make a difference in their overall well-being, including everyday behaviors such as how they eat, whether they exercise, and whether they get checkups.
- Health and science content would be basic parts of K-12 curricula.
- People are able to accurately assess the credibility of health information presented by health advocate, commercial, and new media sources.
- There is monitoring and accountability for health literacy policies and practices.
- Public health alerts, vital to the health of the nation, are presented in everyday terms so that people can take needed action.
- The cultural contexts of diverse peoples, including those from various cultural groups and non-English-speaking peoples, are integrated into all health information.
- Health practitioners communicate clearly during all interactions with their patients, using everyday vocabulary.
- There is ample time for discussions between patients and healthcare providers.
- Patients feel free and comfortable to ask questions as part of the healing relationship.
- Rights and responsibilities in relation to health and healthcare are presented or written in clear, everyday terms so that people can take needed action.
- Informed consent documents used in healthcare are developed so that all people can give or withhold consent based on information they need and understand.

Realizing these goals will present a host of formidable challenges as the country seeks to provide high-quality, affordable healthcare services for as many Americans as possible.

## Summary

In 2004, the US Institute of Medicine published its landmark report, *Health Literacy: A Prescription to End Confusion*, with the goal of painting a comprehensive picture of the issues involved in many Americans' inadequate skills in reading and comprehending health-related information. The report found that nearly half of US adults had some difficulty in reading and acting upon written medical information and that health illiteracy rates tended to be higher among marginalized populations—e.g., nonwhite ethnic groups, those with lower education levels, and those living below the poverty level. A variety of studies among different patient populations has found that inadequate health literacy has significant negative impacts on both clinical outcomes and the costs of healthcare services. Several well-documented tools have been developed to quickly assess an individual's health literacy level. Although data on the health literacy levels of HIV-infected patients are sparse, one important study found that, in the HIV care setting, routine screening questions are less useful than patients' own self-reported educational attainment level or a clinician's own assessment. That same study recommended that HIV clinics should enhance patient-provider communication for everyone, with a goal of improving support for those most in need of it.

## References

Ratzan SC, Parker RM. Introduction. In: National Library of Medicine Current Bibliographies in Medicine: Health Literacy. Selden CR, Zorn M, Ratzan SC, Parker RM, eds. Bethesda, Maryland; National Department of Health and Human Services; 2000.

Institute of Medicine. Health literacy implications for health care reform. National Academy of Sciences; Washington, DC; 2011. Available at: [www.iom.edu/Reports/2011/Health-Literacy-Implications-for-Health-Care-Reform.aspx](http://www.iom.edu/Reports/2011/Health-Literacy-Implications-for-Health-Care-Reform.aspx).

US Department of Health and Human Services. National Plan to Improve Health Literacy. Available at: [www.health.gov/communication/hlactionplan](http://www.health.gov/communication/hlactionplan).

Plain Writing Act of 2010. Available at: [www.plainlanguage.gov/plLaw/index.cfm](http://www.plainlanguage.gov/plLaw/index.cfm).

Nielsen-Bohlman L, Panzer AM, Kindig DA, eds. Health literacy: a prescription to end confusion. Institute of Medicine of the National Academies; Washington, DC; 2004. Available at: [www.nap.edu/catalog/10883.html](http://www.nap.edu/catalog/10883.html).

Baker DW, Gazmararian JA, Williams MV, et al. Functional health literacy and the risk of hospital admission among Medicare managed care enrollees. *Am J Public Health*. 2002;92:1278-1283.

Friedland R. 1998. New estimates of the high costs of inadequate health literacy. In: Proceedings of Pfizer Conference "Promoting Health Literacy: A Call to Action." October 7–8, 1998; Washington, DC; Pfizer, Inc.

Weiss BD, Palmer R. Relationship between health care costs and very low literacy skills in a medically needy and indigent Medicaid population. *J Am Board Fam Pract*. 2004;17: 44-47.

Parker RM, Baker DW, Williams MV, Nurss JR. The test of functional health literacy in adults: a new instrument for measuring patients' literacy skills. *J Gen Intern Med*. 1995;10:537-541.

Ohl M, Harris A, Nurudtinova D, Cai X, Drohobyczer D, Overton ET. Do brief screening questions or provider perception accurately identify persons with low health literacy in the HIV primary care setting? *AIDS Patient Care STDS*. 2010;24:623-629.

Kelly PA, Haidet P. Physician overestimation of patient literacy: a potential source of health care disparities. *Patient Educ Couns*. 2007;66:119-122.

Nachega JB, Morroni C, Zuniga JM, et al. HIV treatment adherence, patient health literacy, and health care provider-patient communication: results from the 2010 AIDS Treatment for Life International Survey. *J Int Assoc Physicians AIDS Care (Chic)*. 2012;11:128-133.

Dickens AT, Utley-Smith Q, Stott G, Relf MV. Evaluation of communication techniques used by HIV specialty providers caring for patients with low health literacy in an outpatient HIV clinical setting. *J Nurs Ed Pract*. 2013;3:114-119.

## Assessment Questions

1. What proportion of Americans have some difficulty in reading and understanding written health information?

A. Nearly one-quarter

**B. Nearly half**

C. Approximately one-third

D. Approximately 1 out of 10

2. Which of the following populations is NOT more vulnerable to inadequate health literacy?

A. Members of nonwhite racial and ethnic groups

B. People with incomes at or below the poverty level

**C. Young adults**

D. Recent immigrants

3. Which of the following is a short tool for assessing health literacy in adults?

A. AHRQ

B. Healthy People 2020

C. Plain Writing Act

**D. REALM**

## Module 2—Barriers to Effective Patient-Provider Communication

### Learning Objectives

- Identify 5 of the main barriers to effective patient-provider communication
- Discuss how healthcare providers' knowledge, attitudes, and beliefs regarding HIV can affect patient-provider communication and clinical outcomes

### Pre-training Assessment

1. Which of the following has NOT been identified as an issue associated with inadequate patient-provider communication?

- A. Poor patient adherence to treatment
- B. Over-representation of minority populations in clinical trials
- C. Under-diagnosis of certain illnesses
- D. All of the above
- E. B and C only

Answer: B. Over-representation of minority populations in clinical trials

2. Language differences can pose a communication barrier between patients and which of the following healthcare staff members?

- A. Physicians
- B. Receptionists
- C. Nurses
- D. Physician assistants
- E. A and C only
- F. All of the above

Answer: F. All of the above

3. Is the following statement True or False?

Researchers have developed assessment tools to evaluate healthcare providers' attitudes toward working with HIV-positive patients.

- A. True
- B. False

Answer: A. True

Although the various issues surrounding health literacy pose major barriers to patient-provider communication, they are by no means the only barriers to such communication. Communication barriers can arise from a wide range of cultural, economic, educational, language, personality, and other factors. A critical goal of improving patient-provider communication is to enhance patients' participation in their own healthcare and the decisions required to initiate, maintain, or modify treatments, as well as to understand and follow prevention messages.

### **Issues Associated with Inadequate Patient-Provider Communication**

Barriers to effective patient-provider communication such as those that will be reviewed in this module contribute to a range of serious problems in providing optimal healthcare services to patients at all socioeconomic, cultural, and language levels. Key problems associated with inadequate communication include:

- Misdiagnosis or under-diagnosis of certain illnesses—this can be especially true regarding certain mental disorders
- Inappropriate or ineffective treatment, even if an illness has been properly diagnosed
- Less than optimal clinical outcomes for patients—e.g., due to inability to understand treatment recommendations or to providers' lack of familiarity with particular cultural idioms or customs
- Decreased public health outcomes—e.g., because patients have not understood and acted on providers' instructions
- Less effective disease prevention efforts (e.g., HIV, hepatitis, heart disease, smoking cessation, substance abuse)
- Poor patient adherence to recommended treatment plans—a problem that has been a part of HIV care almost from the first days of the epidemic
- Under-representation by members of minority populations in clinical research trials
- Patient distrust of healthcare providers and systems
- Increased individual and societal healthcare expenditures

Evidence continues to accumulate confirming that effective communication and productive patient-provider relationships benefit both individual patients and the communities to which they belong.[Duffy 2004, Heisler 2002, Sullivan 2000, Zachariae 2003]

### **Spectrum of Potential Communication Barriers**

Barriers to effective patient-provider communication can arise from a wide range of circumstances and pose serious threats to optimal clinical outcomes. Some of the most important communication barriers include:

- Language differences, including not only those between patients and physicians but also between patients and any other staff members who have patient contact (e.g., receptionists, nurses, physician assistants, laboratory personnel, and others)
- Cultural differences between patients and any healthcare staff members who interact with them
  - Reluctance to establish or maintain eye contact
  - Deference to authority figures
  - Reliance on traditional healers, practices, and substances in some ethnic and immigrant communities

- Community reluctance to discuss such matters as sexual health or practices, drug use behaviors, or HIV risk factors
- Tendency to describe psychological distress in terms of physical manifestations
- Inadequate knowledge or skills regarding culturally competent care among healthcare practitioners
- Insufficient time available for clinical encounters—many healthcare providers work in settings where a limited amount of time is allotted for each patient visit
- Inadequate health literacy, primarily among patients (Please review the first module in this curriculum, “State of Health Literacy in the United States.”)
- Reluctance among some patients to participate in partnerships for decision making and treatment management
- Numerous socioeconomic factors
  - Need to secure childcare services
  - Inability to take enough time away from a job to attend clinic visits
  - Lack of health insurance coverage
- Provider beliefs and attitudes regarding patients who are HIV-positive

## Healthcare Provider Attitudes

Many of the above topics are discussed either in other modules in this curriculum or in other curricula in this set of curricula on providing culturally competent healthcare services for diverse patient populations. However, the topic of the last bullet in the list—the range of attitudes toward patients who are HIV-positive that providers may hold—deserves a brief discussion in order to demonstrate that difficulties in patient-provider communication are not entirely due to patient-related factors.

Like any other person, healthcare practitioners have personal attitudes and beliefs that may affect the amount and quality of care that they provide for the patients they serve. For example, some providers, particularly pharmacists, feel that their consciences will not allow them to prescribe and/or dispense Plan B emergency contraception.[Cantor 2004, Wernow 2008] However, providers’ attitudes and beliefs may go beyond what types of care or services to provide and involve concerns about whether practitioners are obligated to treat individuals whose lifestyles or behaviors conflict with the practitioners’ own values or beliefs—for example, sexual orientation or drug use behaviors. Understanding these attitudes can reveal whether providers at some level distinguish patients whom they regard as “innocent victims” or as persons who are themselves to blame for having acquired HIV infection.

Relatively early in the HIV epidemic, Shrum and colleagues developed an assessment tool—the AIDS attitude scale (AAS)—that may help shed light on practitioners’ beliefs and attitudes regarding patients who are HIV-positive.[Shrum 1989] Although the AAS was originally developed to assess college students’ attitudes, in the years since, it has been evaluated in other populations, particularly among nurses in various countries and cultures.[Froman 1997, Bruce 1998, Pickles 2012]

Providers who achieve high empathy and low avoidance scores on the AAS are more likely to engage in more effective communication with their patients and to provide higher-quality patient care. Fortunately, the history of assessing providers according to the AAS since its introduction has shown that providers’ attitudes toward HIV-infected patients have generally improved. This will likely be of

increasing importance as the numbers of diagnosed HIV patients increase during the coming years, due in part to the wider availability of care through the 2010 Affordable Care Act and in part due to the Centers for Disease Control and Prevention’s strategy of making HIV testing a routine part of clinical encounters. (Please see the curriculum, “Promoting HIV Testing in Diverse Populations.”)

**Q methodology**

Q methodology is a research method used in psychology and other social sciences to evaluate people’s “subjectivity.” Q methodology—developed in the 1950s by psychologist William Stephenson—has been used both in clinical settings for assessing patient attitudes and in research settings to examine how people think about a topic.[Stephenson 1953] Q methodology aims to identify individuals’ world views, opinions, interpretations, feelings, and so forth in terms of statistically independent patterns of response that are recognized by clustering together individuals who order items—generally attitude statements—on an assessment tool. Typically, the tool asks participants to sort items relative to one another along a dimension such as “agree”/“disagree,” with the responses then analyzed by Q-methodological statistics.

In 2001, Raghavendra S. Prasad, MD, adapted the Q sort methodology specifically to assess healthcare providers’ attitudes regarding HIV disease.[Prasad 2001] The aim of developing the Q-sort tool for HIV healthcare providers was to make available a tool to assess the effectiveness of HIV educational programs in modifying provider attitudes regarding HIV and HIV-positive patients, thereby improving patient care. Prasad selected 28 attitude descriptors that have high variability among individuals and used them to develop the HIV Q-sort assessment instrument. The instrument was completed by 191 physicians, 22 of whom then repeated the test to establish inter-test reliability. Prasad identified 3 factors that best accounted for participants’ varying responses to the 28 descriptors:

- Emotionality—a high score indicating that the provider feels accepting, caring, compassionate, and open-minded in managing patients who are HIV-positive
- Ability—the confidence that a healthcare provider has in her or his ability to manage patients who are HIV-positive (a higher score is preferable, indicating that the provider feels capable and comfortable in dealing with these patients)
- Reluctance—the degree of hesitation that a provider feels in working with individuals who are HIV-positive

Placing words like caring, open-minded, comfortable, or capable on a grid revealed positive attitudes toward treating patients who are HIV-positive, whereas placing words like anxious, sad, angry, or aversion revealed negative attitudes toward treating these individuals (Table). Prasad concluded that the Q-sort instrument could provide a reliable way to assess physician attitudes toward HIV patients and that it could be valuable in evaluating the effectiveness of educational programs that are intended to change providers’ attitudes.

**Table. Descriptors Used in the HIV/AIDS Q-Sort Tool**

Angry	Accepting
Unsympathetic	Capable
Compassionate	Helpless
Inadequate	Stimulated
Aversion	At risk
Anxious	Sad
Caring	Challenged
Empathetic	Comfortable
Dislike	Open-minded



Complicated	Pity
Uncomfortable	Cautious
Gratifying	Duty-bound
Disapproval	Rejection
Rewarding	Offended

Identifying healthcare provider attitudes that pose barriers to successful communication and developing interventions to reduce these barriers can contribute to improved patient-provider communication, in addition to reducing negative attitudes among both providers and patients.

## Overcoming Communication Barriers

Many of the barriers to sound patient-provider communication that have been discussed in this module may seem to pose formidable challenges to providing culturally competent care to patients who are HIV-positive of widely varying ethnic, cultural, and linguistic backgrounds. In recent years, however, there has been significant progress in developing both theoretical and practical frameworks not only for improving healthcare communication but also for applying those frameworks to enhance individual and public health outcomes.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care that have been developed by the US Office of Minority Health provide a critical foundation in the issues that healthcare providers and institutions need to be aware of and address to offer equitable healthcare services to all patients. The first curriculum in this series, “Understanding and Implementing the CLAS Standards,”[ offers an overview of the new enhanced CLAS Standards, as well as links to programs and activities that healthcare organizations can use to help their groups meet those standards. Other curricula in this series examine the culturally competence issues that are unique to a variety of the populations that make up the HIV community and offer resources to address their needs.

The theoretical frameworks that have been developed to help improve patient-provider communications include:

- McGuire’s communications framework
- The interpersonal communication (IPC) approach
- The shared decision making (SDC) approach

The next module in this curriculum will review the key features of these 3 approaches, and the fourth module will explore one framework for the practical application of improved communications techniques in the clinic.

## Summary

A range of difficulties—both individual and societal—can arise from inadequate patient-provider communication, including such critical ones as:

- Under-diagnosis of certain health conditions
- Recommendation of ineffective treatments
- Inadequate HIV prevention programs
- Poor patient adherence to recommended treatment plans

- Inappropriate use of limited healthcare funding

Communication barriers can occur on the part of both patients and healthcare care providers, and both can threaten optimal clinical outcomes. Barriers include:

- Language differences
- Failure to understand difference in cultural attitudes and expressions
- Poor health literacy
- Socioeconomic factors
- Beliefs and attitudes regarding HIV disease

Researchers have developed several approaches to improved communication that can enhance patient-provider relations, and these have been applied to practical frameworks for communicating across patient-provider barriers so that individuals from all ethnic and cultural backgrounds can receive appropriate healthcare services.

## References

Duffy FD, Gordon GH, Whelan G, et al. Assessing competence in communication and interpersonal skills: the Kalamazoo II report. *Acad Med.* 2004;79:495-507.

Heisler M, Bouknight RR, Hayward RA, Smith DM, Kerr EA. The relative importance of physician communication, participatory decision-making, and patient understanding in diabetes self-management. *J Gen Intern Med.* 2002;17:243-252.

Sullivan LM, Stein MD, Savetsky JB, Samet JH. The doctor-patient relationship and HIV-infected patients' satisfaction with primary care physicians. *J Gen Intern Med.* 2000;15:462-469.

Zachariae R, Pederson CG, Jensen AB, Ehrnrooth E, Rossen PB, von der Maase H. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. *Br J Cancer.* 2003;88:658-665.

Cantor J, Baum K. The limits of conscientious objection--may pharmacists refuse to fill prescriptions for emergency contraception? *N Engl J Med.* 2004;351:2008-2012.

Wernow JR, Grant DG. Dispensing with conscience: a legal and ethical assessment. *Ann Pharmacother.* 2008;42:1669-1678.

Shrum JC, Turner NH, Bruce KE. Development of an instrument to measure attitudes toward acquired immune deficiency syndrome. *AIDS Educ Prev.* 1989;1:222-230.

Froman RD, Owen SV. Further validation of the AIDS Attitude Scale. *Res Nurs Health.* 1997;20:161-167.

Bruce KE, Reid BC. Assessing the construct validity of the AIDS Attitude Scale. *AIDS Educ Prev.* 1998;10:75-89.

Pickles D, King L, Belan I. Undergraduate nursing student's attitudes towards caring for people with HIV/AIDS. *Nurse Educ Today*. 2012;32:15-20.

Stephenson, W. *The Study of Behavior. Q-Technique and Its Methodology*. Chicago, IL; University of Chicago Press; 1953.

Prasad RS. Development of the HIV/AIDS Q-sort instrument to measure physician attitudes. *Fam Med*. 2001;33:772-778.

## Assessment Questions

1. Which of the following has NOT been identified as an issue associated with inadequate patient-provider communication?

- A. Poor patient adherence to treatment
- B. Over-representation of minority populations in clinical trials
- C. Under-diagnosis of certain illnesses
- D. All of the above
- E. B and C only

Answer: B. Over-representation of minority populations in clinical trials

2. Language differences can pose a communication barrier between patients and which of the following healthcare staff members?

- A. Physicians
- B. Receptionists
- C. Nurses
- D. Physician assistants
- E. A and C only
- F. All of the above

Answer: F. All of the above

3. Is the following statement True or False?

Researchers have developed assessment tools to evaluate healthcare providers' attitudes toward working with HIV-positive patients.

- A. True
- B. False

Answer: A. True

## **Module 3—Theoretical Frameworks for Effective Patient-Provider Communication**

### **Learning Objectives**

- Identify the potential framework for enhancing patient-provider communication
- Define interpersonal communication (IPC) and discuss its value in improving clinical outcomes
- Define shared decision making and discuss its value in improving clinical outcomes

### **Pretraining Assessment**

1. Is the following statement True or False?

Interpersonal decision making refers to the discussions among healthcare providers in deciding what treatment to recommend for a patient.

- A. True
- B. False

Answer: B. False

2. Shared decision making in clinical settings does NOT include which of the following features?

- A. Developing a partnership with the patient
- B. Establishing the patient's preferences for receiving information
- C. Assigning the patient a role in decision-making
- D. Determining and responding to patients' ideas, concerns, and expectations

Answer: C. Assigning the patient a role in decision-making

Scholars and other researchers have studied the ways in which individuals communicate with each other to try to shed light on what are the core features that are involved in effective nonthreatening communication. This module will briefly review 3 theoretical frameworks that can help to support a practical approach to patient-provider communication.

## **McGuire's Communication Framework**

One approach to improved communication, McGuire's communication framework (proposed by social psychologist William J. McGuire), was developed more than 25 years ago as a way to understand the elements that are key to persuading an individual to understand and adopt a different behavior.[McGuire 1984] McGuire's framework comprises 5 factors, or input variables, that are part of a program or activity that is intended to facilitate communication and alter behavior. In the parentheses are the particular applications of each factor in patient-provider communication settings:

- Source (healthcare provider)
- Message (health information)
- Channel (spoken communication)
- Receiver (patient)
- Destination (patient's understanding of and acting on the health information)

With that background, any given HIV-related clinical encounter can be considered within McGuire's communication framework in this way:

- The healthcare provider is the source of a message.
- The message is the provider's recommendation regarding HIV treatment or prevention.
- The channel is the spoken and/or written information offered by the healthcare provider.
- The receiver of the message is the HIV-positive patient.
- The destination of the message is the extent to which the patient comprehends and follows the recommendations contained in the message—eg, adherence to an antiretroviral regimen or behavioral change to reduce the risk of becoming HIV-infected.

With the 5 communication factors in place, McGuire then described the steps through which an individual must be persuaded to pass to understand and then act on the intended behavior:[McGuire 1981]

- Exposure to the message
- Attention to the message
- Interest in the message
- Understanding of the message
- Personalizing the behavior to fit one's life
- Accepting the change called for in the message
- Remembering the message and continuing to agree with it
- Being able to recall the behavior
- Making decisions based on recalling the message
- Behaving as decided
- Receiving positive reinforcement for the intended behavior
- Incorporating the behavior into one's life

Healthcare providers and planners who keep these steps in mind can help to ensure that a communication effort or plan addresses all 5 factors so that patients receive and absorb the message, that the plan is adaptable to address patients' needs, which may vary over time, and that there is progress toward behavioral change.

Therefore, planning and carrying out efforts to enhance communication will involve selecting credible sources of information, choosing message strategies, and determining the most effective channels for imparting the message from provider to patient.

## **Interpersonal Communication Approach**

Whereas McGuire's framework establishes the core elements that characterize an effective act of communication, the interpersonal communication (IPC) approach moves that framework along the path toward enhanced clinical communication. For years, scholars have offered a wide range of definitions of interpersonal communication. For the purposes of defining IPC as it is relevant to patient-provider communication, the one developed by communications professors Trenholm and Jensen is particularly suitable: "Interpersonal communication [refers] to dyadic communication in which two individuals, sharing the roles of sender and receiver, become connected through the mutual activity of creating meaning." [Trenholm 2008]

*"Effective interpersonal communication (IPC) between health care provider and client is one of the most important elements for improving client satisfaction, compliance and health outcomes. 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."* [de Negri 2009]

The IPC approach offers a model for training healthcare providers and other patient-facing staff members in how to communicate effectively with patients. Five desired outcomes are associated with effective IPC:

- The patient reveals enough information about his or her health to allow the practitioner to make an accurate diagnosis.
- The provider, in consultation with the patient, recommends an appropriate treatment that is acceptable to the patient.
- The patient understands her or his condition and the recommended treatment regimen.
- The provider and the patient develop a positive rapport.
- Both provider and patient are committed to fulfilling their responsibilities during treatment and follow-up care.

The IPC model can provide a framework to give healthcare providers as many tools as possible to address patient-provider-communication issues. The time available for any given clinic visit means that training healthcare practitioners and other staff is critically important, both during medical school education and during routine clinic operations. For example, medical assistants who can recognize that a patient's words, slang, or other cues are being misunderstood or overlooked can help a healthcare provider to better appreciate a patient's situation and thus modify the current communications approach. [Todd 2006, de Negri 2009]

After following the IPC framework to diagnose and recommend a treatment regimen for a patient, the healthcare provider should suggest concrete behavioral changes that include specific steps that will support treatment adherence so as to result in optimal clinical outcomes.[de Negri 2009] In addition, the provider should try to motivate the patient to adhere to the treatment regimen and ensure that the patient understands how to take the medication, e.g., by asking the patient to describe the recommended treatment. The provider should also encourage the patient to ask questions for further clarification and to return to the clinic if any adverse effects or other difficulties with the treatment occur.

Diagnostic role play—a form of interpersonal communication—is one approach to bridging the gap in provider-patient communications.[Center for Global Communication 2002] Diagnostic role play can help practitioners and healthcare planners to identify prevailing attitudes toward healthcare within a particular community so that they can design effective strategies to encourage alternative behaviors that can support the patient’s health. During role play, community members can simulate typical attitudes regarding a specific situation, and this can aid practitioners and planners in understanding the community’s culture and belief systems. This knowledge can be used to develop practical approaches to changing attitudes and behaviors. For example, role play participants may be asked to enact conversations that could happen in their homes—e.g., discussions about HIV between parents and children—or to simulate discussion with a healthcare provider about the advantages and disadvantages of a recommended treatment.

Developing skills in face-to-face interaction is key to enabling healthcare providers to establish positive rapport with patients. During an interpersonal communication session, a provider should:

- Strive to build a positive relationship with the patient throughout the session
- Communicate carefully with the patient to make an accurate diagnosis and recommend appropriate treatment
- Counsel the patient to ensure that he or she understands both the diagnosis and the recommended treatment

## **Shared Decision Making**

When patients feel they have not been adequately informed about a diagnosis or recommended treatment approaches, they are less likely to participate in the decision-making process. Because shared decision making first requires a set of communication competencies on the parts of both the patient and the practitioner before it can be effectively implemented, the IPC approach discussed above can lay the groundwork for an improved communication environment. On that basis, the shared decision making approach can then support equal participation in healthcare planning and management by patients. Shared decision making (SDM) is an approach that equally values the contributions of both the patient and the healthcare provider regarding healthcare decision making, including:

- Developing a partnership with the patient
- Establishing or reviewing the patient’s preferences for receiving information—ie, the amount of detail and the format (spoken, written, preferred language, and so forth)
- Establishing or reviewing the patient’s preferred role in decision-making
- Determining and responding to patients’ ideas, concerns, and expectations



Shared decision making takes into account the best available scientific evidence, along with the individual patient's values and preferences. This approach thus incorporates the practitioner's expert knowledge and the patient's right to be fully informed about all treatment options and the potential benefits and risks involved with each. This process provides patients with the support they need to make the healthcare decisions that are best suited to their own needs and attitudes while also allowing providers to feel confident about the care that they recommend.[2013 IMDF]

By participating in shared decision making, practitioners and patients collaborate in selecting tests, treatment regimens, and health management plans that are based on reliable clinical evidence and patients' preferences. Shared decision making can be thought of as occupying the middle ground between an older, more traditional physician-centered practice, in which patients depend on their healthcare providers to make healthcare decisions and a consumerist approach, in which patients are given information and then are free to make their own decisions.[2013 Health Foundation]

Moreover, a recent op-ed article in the *New England Journal of Medicine* not only offers a reminder that shared decision making is one of the provisions of the 2010 Affordable Care Act but also argues that shared decision making can help reduce costs throughout the US healthcare system as a whole.[Oshima Lee 2013]

## Summary

Researchers have followed many lines of investigation to identify the key components of effective communication. However, in recent years, 3 theoretical frameworks have emerged as having particular relevance to enhancing communication between patients and healthcare providers:

- McGuire's framework set forth 5 key factors—source, message, channel, receiver, and destination—that need to be present for a communication act or program to achieve its goals.
- The interpersonal communication framework stresses the importance of exchanging information between the patient and the healthcare provider in a mutually respectful, productive manner.
- The shared decision making framework provides a context in which the patient's preferences and the provider's expertise are equally considered in making healthcare decisions.

## References

McGuire WJ. Public communication as a strategy for inducing health-promoting behavioral change. *Prev Med.* 1984;13:299-319.

Trenholm S, Jensen A. *Interpersonal Communication* (6th ed). New York; Oxford University Press; 2008.

de Negri B, DiPrete Brown L, Hernández O, Rosenbaum J, Roter D. Improving interpersonal communication between health care providers and clients. USAID, Quality Assurance Project; Bethesda, MD; 2009. Available at:

[http://www.globalhealthcommunication.org/tool\\_docs/47/qap\\_improving\\_interpersonal\\_communications\\_part\\_1.pdf](http://www.globalhealthcommunication.org/tool_docs/47/qap_improving_interpersonal_communications_part_1.pdf).

Todd J, Baldwin CM. Palliative care and culture an optimistic view. *J Multicultural Nurs Health*. 2006;12:28-32.

Unite for Sight. Health communication online course; module 3. Available at:  
<http://www.uniteforsight.org/health-communication-course/module3>.

Burleson BR. The nature of interpersonal communication: a message-centered approach. In: *The Handbook of Communication Science*; Berger CR, Roloff ME, Roskos-Ewoldsen DR, eds. Sage Publications; Thousand Oaks, Calif.; 2009.

Center for Global Health Communication and Marketing. Guide to diagnostic role play. 2002. Available at:  
[http://www.globalhealthcommunication.org/tool\\_docs/45/guide\\_to\\_diagnostic\\_role\\_play\\_%28full\\_document%29.pdf](http://www.globalhealthcommunication.org/tool_docs/45/guide_to_diagnostic_role_play_%28full_document%29.pdf).

Informed Medical Decisions Foundation (IMDF). What is shared decision making? Available at:  
<http://informedmedicaldecisions.org/what-is-shared-decision-making/>.

The Health Foundation. What is shared decision making? Available at:  
<http://shareddecisionmaking.health.org.uk/basics-of-shared-decision-making/>.

Oshima Lee E, Emanuel EJ. Shared decision making to improve care and reduce costs. *N Engl J Med*. 2013;368:6-8.

## Assessment Questions

1. Is the following statement True or False?

Interpersonal decision making refers to the discussions among healthcare providers in deciding what treatment to recommend for a patient.

- A. True
- B. False

Answer: B. False

2. Shared decision making in clinical settings does NOT include which of the following features?

- A. Developing a partnership with the patient
- B. Establishing the patient's preferences for receiving information
- C. Assigning the patient a role in decision-making
- D. Determining and responding to patients' ideas, concerns, and expectations

Answer: C. Assigning the patient a role in decision-making

## Module 4—Practical Framework for Effective HIV-Related Patient-Provider Communication

### Learning Objectives

- Identify the theoretical frameworks for enhancing patient-provider communication
- Discuss specific approaches to improving patient-provider communication in the setting of HIV care

### Pretraining Assessment

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

- A. Discussing what HIV means to the patient
- B. Asking the patient about his or her preferences regarding healthcare
- C. Inquiring about sources of stress in the patient's life
- D. All of the above
- E. A and B only

Answer: D. All of the above

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

- A. Active substance use
- B. Depression
- C. Race or ethnicity
- D. All of the above
- E. A and B only

Answer: E. A and B only

3. Which of the following statements is True?

A. White and minority patients who are HIV-positive experience similar average delays between HIV diagnosis and starting HAART.

B. Minority patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs white patients.

C. White patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs minority patients.

D. None of the above

Answer: B. Minority patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs white patients.

Going from an understanding of the theoretical frameworks provided by McGuire’s framework, interpersonal communication, and shared decision making (see Module 3 in this curriculum) to the practical concerns of patient-providers communication in the HIV care setting will involve a review of some basic elements of a cultural competence framework that is appropriate for patients who are HIV-positive.

## **Elements of a Cultural Competence Framework**

Many HIC healthcare providers manage patients from diverse racial/ethnic and cultural backgrounds, and being able to provide care that is appropriate for each patient’s particular needs is a critical skill. One HIV clinician has advocated the use of “a cultural competence framework.” [Stone 2004, Carrillo 1999] This framework, reviewed below, offers the advantage of not requiring the clinician to be familiar with the specific beliefs and practices that are characteristic of each different group. Rather, it utilizes a structured provider-patient dialogue that allows the patient to introduce key issues that are important to her or him, whether involving culture, lifestyle, religion, sexual behaviors, healthcare attitudes, or other factors. Most importantly, this framework offers a practical application of issues discussed in the preceding modules in this curriculum.

The steps to employ this cultural competence framework are:

- Identify the patient’s core cultural issues—by asking about values and preferences related to healthcare, while being alert for any spoken or nonverbal hints about these preferences.
- Explore what HIV means to the patient by asking what he or she believes might have led to becoming HIV-positive and how HIV affects his or her life. This can induce patients to offer information about how they regard their own culture’s values.
- Ask about the patient’s social situation:
  - To what extent does the patient feel in control of life—e.g., are there financial or other material difficulties?
  - Has the patient experienced any change in environment, such as immigration?
  - What is the patient’s preferred language and what is her or his literacy level, especially health literacy?
  - What kind of support systems does the patient have, including factors such as sources of stress, living situation, religious affiliation, family and friends?
- Negotiate with the patient to develop a treatment plan that is agreeable to both patient and practitioner—ie, apply the key lessons of shared decision making.

This framework allows a patient to communicate to a practitioner the key issues that are important to the patient—e.g., the extent to which he adheres to the traditional values of his culture or is more assimilated to mainstream US society—and to incorporate them into a treatment plan. In addition, however, practitioners who manage diverse groups of patients need to take further measures to optimize clinical outcomes, as discussed in the following sections.

## **Improving Communication in Clinical Practice**

Studies have identified inadequate or ineffective communication as a key driver of minority patients’ dissatisfaction with the healthcare care services that they receive. The amount of time spent with a

healthcare provider can help predict patient satisfaction,[Warde 2001],and many minority patients may require more time to learn enough about the available HIV treatment options and to make appropriate decisions regarding them. As the first module in this curriculum discussed, health literacy rate among Americans often are not sufficient to make well-informed healthcare decisions. Within practical limits of clinical practice, clinicians should try to spend more time with patients whose health literacy level is low, with a particular focus on listening to the patient. Clinicians can enhance patients’ comprehension by assessing their understanding in a sensitive, non-condescending manner—e.g., by asking, “Does that make sense to you?” or asking the patient to reiterate the treatment plan that has been agreed upon. Providing written materials in the patient’s preferred language and at an appropriate health literacy level can further improve comprehension. In addition, other clinical staff—such as nurses, physician assistants, case managers, or peer counselors—can be responsible for spending more time with the patient and answering additional questions. For some minority patients, this may mean becoming familiar with some commonly used culture-specific terms, particularly regarding sexual practices, recreational drugs, and so forth.

### **Importance of Staff Diversity**

According to an analysis from the HIV Cost and Services Utilization Study, racial concordance between HIV-positive patients and their healthcare providers is one of the keys to eliminating the disparities in time to starting HAART for minority patients.[Stone 2004] Findings like this underscore the important potential benefit of diversifying the clinical staff who are involved in providing care for patients who are HIV-positive. However, too few physicians who manage HIV patients are members of racial/ethnic minorities. Although recruiting HIV-specializing physicians can present major challenges, adding other patient-facing staff who belong to the same racial or cultural groups that a healthcare facility serves can substantially increase patients’ comfort level. Such staff may include front-desk personnel, medical assistants, and others. Furthermore, both current and new staff members at all levels should receive regular cultural competence training. (Please review the curriculum “Understanding and Implementing the new enhanced CLAS Standards” [for a more thorough discussion of the types of trainings that are available and who should participate in them.]

### **Optimizing HIV Care and HAART**

Almost since the beginning of the HIV epidemic, disparities in care, including being prescribed antiretroviral therapy, have been reported among patients belonging to racial/ethnic, cultural, and linguistic minorities. For example, nonwhite patients often experience a longer average delay between being diagnosed with HIV infection and accessing HIV care, and, once linked to care, they are less likely to receive HAART than white patients.[Stone 2004, Cunningham 2006, Dennis 2011]

Practitioners who manage diverse groups of HIV patients should be familiar with this pattern of disparities and should develop strategies to optimize the probability that HAART will be recommended to these patients and that they will in fact take their medications. Such strategies include working to build trust in the patient-provider relationship, ensuring that the patient participates in decisions about his or her own care, and providing enough time and information—from other clinical staff members if there is not adequate time for a physician to do so—for the patient to make an informed decision and understand the importance of taking the medications as directed.[Stone Perspectives 2004] Moreover, practitioners should develop approaches to manage comorbidities (such as hepatitis C infection, sexually

transmitted diseases, or substance use disorders) and patients' concerns about antiretroviral adverse effects or other treatment-related toxicities. This can help to minimize the risks of non-adherence and to optimize the likelihood of attaining full virologic suppression.

## **Enhancing Adherence to HAART**

Researchers and clinicians have long known that patient adherence is critical to achieving full virologic suppression and good immune reconstitution in patients receiving HAART, leading to an interest in whether certain factors could be associated with predicting adherence and, therefore, whether certain patients might be at greater risk for non-adherence and treatment failure. As far back as 2001, investigators showed that a patient's demographic characteristics generally are not predictive of adherence to HAART—when other key predictors of non-adherence are taken into account.[Stone 2001, Battaglioli-DeNero 2007] Studies of HAART adherence have demonstrated that only a limited number of patient factors and behaviors can reliably be associated with inadequate adherence:[Malcolm 2003, Alfonso 2006, Cohn 2011]

- Depression
- Active alcohol abuse
- Active injection drug use
- Low health literacy

Discussing such potentially highly sensitive issues will require healthcare providers to be thoroughly familiar with all of the available techniques for improving healthcare communication that discussed earlier in this curriculum.

**Health literacy.** Clinicians should endeavor to assess patients' health literacy levels and to correct any misconceptions.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Zekeri 2009, Sebbing 2004] Although a patient's racial/ethnic background has generally not been found to be predictive of adherence, some highly charged emotional factors may disproportionately affect minority patients' willingness and ability to adhere to HAART. These include distrust of traditional healthcare practices and concerns about potential harm associated with medications that some may regard as toxic, experimental, or ineffective.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Stone 2004, Cunningham 2000] Support groups, peer educators, and treatment buddies are among the strategies that clinical staff can use to help patients develop more positive attitudes and beliefs about HAART.

**Depression, substance use.** Depression is common in HIV-positive persons, as is alcohol and substance abuse; some experience both types of concerns.[Angelino 2001, Angelino 2008, Tegger 2008, Starace 2002] Furthermore, in minority patients, depression may be more difficult to diagnose. For these reasons, practitioners who manage HIV-infected patients should perform routine screening for depression in all patients before initiating HAART. Likewise, all patients—not just those who likely became HIV-positive via injection drug use—should be screened for potential substance abuse issues. (For more detailed discussion of this subject, please review the curriculum, "Culturally Competent Care for Substance Users Diagnoses with HIV Disease.") [ Before prescribing HAART for patients in whom depression, substance or alcohol use issues, or some combination of these is identified, clinicians should have a management plan in place. The risk of poor adherence is greater if these issues remain unaddressed. HIV practitioners should make an effort to collaborate with patients' mental health or



drug treatment providers to optimize both HIV treatment and mental health and substance use outcomes.[Stone 2004]

Cultivating a trusting clinician-patient relationship before beginning HAART can enhance adherence. Several important studies of adherence have shown that the quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly for nonwhite patients.[Stone 2004, Simoni 2008, Malcolm 2003] Logistical supports—such as directly observed therapy—can significantly enhance patients’ adherence to HAART if a practitioner observes indications that a patient may be at risk for poor adherence.[Moitra 2011, Mitty 2002, Goggin 2007]

Within a cultural competence framework for managing patients who are HIV-positive like the one reviewed in the earlier sections of this module, there are several broad approaches that are key to achieving an overall enhanced level of appropriate care for HIV-positive minority individuals.

**Importance of trust.** Cultivating a trusting clinician-patient relationship before beginning HAART can enhance adherence. Several important adherence studies have shown that the quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly for minority patients.[Stone 2004, Simoni 2008] Communication can be critically important to cultivate trust among some minority patients—due not only to potential language issues but also to a host of other culture-specific issues. This may require practitioners to take special care that patients both understand and agree with recommended treatments. Logistical supports—such as directly observed therapy—can significantly enhance patients’ adherence to HAART if a practitioner observes indications that a patient may be at risk for poor adherence.[Moitra 2011, Mitty 2002, Goggin 2007]

## Improving Rates of HIV Testing and Access to Care

Increasing the numbers of individuals from diverse ethnic, cultural, and linguistic populations who are aware of their HIV status represents a critical first step. Studies have shown that individuals who know that they are HIV-positive typically reduce risky sexual behaviors, thereby helping to reduce ongoing HIV transmission and community viral load.[Colfax 2002] In addition, HIV-positive persons who are not aware of their status are the primary cause of new HIV infections.[Marks 2006] Efforts to expand the number of individuals who know that they are HIV-positive will require that both those who are at risk for HIV infection and healthcare providers become knowledgeable about the Centers for Disease Control and Prevention’s current guidelines for HIV testing.[Branson 2006] (For more information, please review the curriculum, “Promoting HIV Testing in Diverse Populations.” [

## Summary

A sound understanding of the central issues involved in improving patient-provider communication is necessary to the implementation of effective communication in clinical practice. These issues include:

- Health literacy in the United States today
- Tools for assessing patients’ health literacy
- Effects of improved health literacy
- Barriers to effective patient-provider communication
- Theoretical frameworks for understanding effective communication

With that background, practitioners should be better equipped to cultivate more effective communication with their patients during clinical encounters. Healthcare providers can then explore minority populations' beliefs, attitudes, and behaviors through a "cultural competence framework" that allows them to learn the issues that are important to their patients and to incorporate that knowledge into treatment plans. Effective communication is key to patient satisfaction with healthcare encounters. Using the techniques provided by the interpersonal communication and shared decision making approaches, practitioners should take appropriate measures to ensure that patients understand and participate in decisions regarding recommended treatment plans. A host of print and online resources regarding clinical communication is available to assist practitioners in understanding HIV-related behaviors, risks, and clinical management among HIV-positive patients who belong to a diversity of ethnic, cultural, and linguistic backgrounds.

### **Selected Resources**

- Nacheга JB, Morroni C, Zuniga JM, et al. HIV Treatment Adherence, Patient Health Literacy, and Health Care Provider-Patient Communication: Results from the 2010 AIDS Treatment for Life International Survey. *J Int Assoc Physicians AIDS Care (Chic)*. 2012;11:128-133.
- Kreuter MW, McClure SM. The role of culture in health communication. *Annu Rev Public Health*. 2004;25:439-455.
- Ohl M, Harris A, Nurudtinova D, Cai X, Drohobyczer D, Overton ET. Do brief screening questions or provider perception accurately identify persons with low health literacy in the HIV primary care setting? *AIDS Patient Care STDS*. 2010;24:623-629.
- Lee RT, Lovell BL, Brotheridge CM. Relating physician emotional expression to shared understanding and shared decision-making with patients. *International Journal of Work Organisation and Emotion*. 2010;3:336-350.
- Lovell BL, Lee RT, Brotheridge CM. Interpersonal factors affecting communication in clinical consultations: Canadian physicians' perspectives. *International Journal of Health Care Quality Assurance*. 2012;25(6):467-482.
- McGuire, W. J. (1984). Public communication as a strategy for inducing health-promoting behavioral change. *Preventive Medicine*, 13(3), 299–313.
- Auerbach SM. Do Patients Want Control over their Own Health Care? A Review of Measures, Findings, and Research Issues. *J Health Psychol*. 2001;6:191-203.
- Burleson BR. The nature of interpersonal communication: a message-centered approach. In: *The Handbook of Communication Science*; Berger CR, Roloff ME, Roskos-Ewoldsen DR, eds. Sage Publications; Thousand Oaks, Calif.; 2009.
- Shared Decision Making National Resource Center, Mayo Clinic. <http://shareddecisions.mayoclinic.org/>.

- Informed Medical Decisions Foundation. <http://informedmedicaldecisions.org/shared-decision-making-in-practice/decision-aids/>.
- International Patient Decision Aid Standards (IPDAS) Collaboration. <http://ipdas.ohri.ca/>.
- Shared Decision Making Resource Centre. <http://shareddecisionmaking.health.org.uk/>.
- Dartmouth-Hitchcock Center for Shared Decision Making. [http://patients.dartmouth-hitchcock.org/shared\\_decision\\_making.html](http://patients.dartmouth-hitchcock.org/shared_decision_making.html).
- RAND Corporation. Shared decision making between patients and doctors has promise, but obstacles Remain. Available at: [http://www.rand.org/health/feature/shared\\_decision\\_making.html](http://www.rand.org/health/feature/shared_decision_making.html).

## References

Stone V. Optimizing the care of minority patients with HIV/AIDS. *Clin Infect Dis*. 2004;38:400-404.

Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med*. 1999;130:829-834.

Warde C. Time is of the essence. *J Gen Intern Med*. 2001;16:712-713.

Cunningham WE, Sohler NL, Tobias C, et al. Health services utilization for people with HIV infection: comparison of a population targeted for outreach with the U.S. population in care. *Med Care*. 2006;44:1038-1047.

Dennis AM, Napravnik S, Seña AC, Eron JJ. Late entry to HIV care among Latinos compared with non-Latinos in a southeastern US cohort. *Clin Infect Dis*. 2011;53:480-587.

Stone VE, Jordan J, Tolson J, Miller R, Pilon T. Perspectives on adherence and simplicity for HIV-infected patients on antiretroviral therapy: self-report of the relative importance of multiple attributes of highly active antiretroviral therapy (HAART) regimens in predicting adherence. *J Acquir Immune Defic Syndr*. 2004;36:808-816.

Stone VE. Strategies for optimizing adherence to highly active antiretroviral therapy: lessons from research and clinical practice. *Clin Infect Dis*. 2001;33:865-872.

Battaglioli-DeNero AM. Strategies for improving patient adherence to therapy and long-term patient outcomes. *J Assoc Nurses AIDS Care*. 2007;18:S17-S22.

Malcolm SE, Ng JJ, Rosen RK, Stone VE. An examination of patients with excellent adherence to HAART. *AIDS Care*. 2003;15:251-261.

Alfonso V, Geller J, Bermbach N, Drummond A, Montaner JS. Becoming a “treatment success”: what helps and what hinders patients from achieving and sustaining undetectable viral loads. *AIDS Patient Care STDs*. 2006;20:326-334.

Cohn SE, Jiang H, McCutchan JA, et al. Association of ongoing drug and alcohol use with non-adherence to antiretroviral therapy and higher risk of AIDS and death: results from ACTG 362. *AIDS Care*. 2011;23:775-785.

Corbie-Smith G, Thomas SB, St. George DMM. Distrust, race, and research. *Arch Intern Med*. 2002;162:2458-2463.

Kumar D, Schlundt DG, Wallston KA. Patient-physician race concordance and its relationship to perceived health outcomes. *Ethn Dis*. 2009;19:345-351.

Armstrong K, Ravenell KL, McMurphy S, Putt M. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health*. 2007;97:1283-1289.

Zekeri AA, Habtemariam T, Tameru B, Ngawa D, Robnett V. Conspiracy beliefs about HIV/AIDS among HIV-positive African-American patients in rural Alabama. *Psychol Rep*. 2009;104:388-394.

Cunningham WE, Sohler NL, Tobias C, et al. Health services utilization for people with HIV infection: comparison of a population targeted for outreach with the U.S. population in care. *Med Care*. 2006;44:1038-1047.

Angelino AF, Treisman GJ. Management of psychiatric disorders in patients infected with human immunodeficiency virus. *Clin Infect Dis*. 2001;33:847-856.

Angelino AF, Treisman GJ. Issues in co-morbid severe mental illnesses in HIV infected individuals. *Int Rev Psychiatry*. 2008;20:95-101.

Tegger MK, Crane HM, Tapia KA, Uldall KK, Holte SE, Kitahata MM. The effect of mental illness, substance use, and treatment for depression on the initiation of highly active antiretroviral therapy among HIV-infected individuals. *AIDS Patient Care STDs*. 2008;22:233-243.

Starace F, Ammassari A, Trotta MP, et al. Depression is a risk factor for suboptimal adherence to highly active antiretroviral therapy. *J Acquir Immune Defic Syndr*. 2002;31:S136-S139.

Simoni JM, Amico KR, Pearson CR, Malow R. Strategies for promoting adherence to antiretroviral therapy: a review of the literature. *Curr Infect Dis Rep*. 2008;10:515-521.

Moitra E, Herbert JD, Forman EM. Acceptance-based behavior therapy to promote HIV medication adherence. *AIDS Care*. 2011;23:1660-1667.

Mitty JA, Stone VE, Sands M, Macalino G, Flanigan T. Directly observed therapy for the treatment of people with human immunodeficiency virus infection: a work in progress. *Clin Infect Dis*. 2002;34:984-990.

Goggin K, Liston RJ, Mitty JA. Modified directly observed therapy for antiretroviral therapy: a primer from the field. *Public Health Rep.* 2007;122:472-481.

Colfax GN, Buchbinder SP, Cornelisse PG, Vittinghoff E, Mayer K, Celum C. Sexual risk behaviors and implications for secondary HIV transmission during and after HIV seroconversion. *AIDS.* 2002;16:1529-1535.

Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS.* 2006;20:1447-1450.

Branson BM, Handsfield HH, Lampe MA, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recomm Rep.* 2006;55:1-17.

## Assessment Questions

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

- A. Discussing what HIV means to the patient
- B. Asking the patient about his or her preferences regarding healthcare
- C. Inquiring about sources of stress in the patient's life
- D. All of the above
- E. A and B only

Answer: D. All of the above

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

- A. Active substance use
- B. Depression
- C. Race or ethnicity
- D. All of the above
- E. A and B only

Answer: E. A and B only

3. Which of the following statements is True?

- A. White and minority patients who are HIV-positive experience similar average delays between HIV diagnosis and starting HAART.
- B. Minority patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs white patients.
- C. White patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs minority patients.

D. None of the above

Answer: B. Minority patients who are HIV-positive experience longer average delays between HIV diagnosis and starting HAART vs white patients.

AIDS Education and Training Center – National Multicultural Center (AETC-NMC)  
1840 7<sup>th</sup> Street NW, 2<sup>nd</sup> Floor  
Washington, DC 20001  
202-865-8146 (Office)  
202-667-1382 (Fax)  
*Goulda Downer, Ph.D., RD, LN, CNS*  
*Principal Investigator/Project Director (AETC-NMC)*  
**[www.aetcnmc.org](http://www.aetcnmc.org)**  
**HRSA Grant Number: U2THA19645**