Present Your Abstract at ACG 2022
The Deadline for Submission is Monday, June 20, 2022 at 11:59 pm ET

Abstract Categories:
- Biliary/Pancreas
- Colon
- Colorectal Cancer Prevention
- Endoscopy Video Forum
- Esophagus
- Functional Bowel Disease
- General Endoscopy
- GI Bleeding
- IBD
- Interventional Endoscopy
- Liver
- Obesity
- Pediatrics
- Practice Management
- Small Intestine
- Stomach
- Clinical Vignettes/Case Reports

Visit acgmeetings.gi.org to Submit!

Participating in the Webinar

All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.
How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR
ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2022 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2023 for this activity.

MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.
ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!

Week 17
Liver Biopsy Interpretation for Gastroenterologists
Paul Y. Kwo, MD, FACP
April 28, 2022 at Noon Eastern and 8pm Eastern!

Week 18
Empowering Patients Through the Transition of Care in IBD
Sneha Dave, Leah Clark, and Isabela Hernandez from the Crohn’s and Colitis Young Adults Network
May 5, 2022 at Noon Eastern and 8pm Eastern!

Visit gi.org/ACGVGR to Register

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Disclosures:

There are no relevant financial relationships with this activity.

Connie Arnold, PhD
Terry Davis, PhD
James D. Morris, MD, FACG
Practical Patient Education Tips and Strategies
(A Conversation and Discussion)

Terry Davis, PhD, Co-Chief, Healthcare Disparities
Connie Arnold, PhD, Co-Chief, Healthcare Disparities
James D. Morris, MD, FACP, Assistant Dean for GME and VA Affairs
LSU Health Shreveport, Department of Medicine

Objectives

• Recognize new challenges & common barriers to patient communication and education.

• Identify disparities that impact our patients’ health care, health behavior and outcomes.

• Improve written and verbal skills to aid patient health understanding, behavior and outcomes.

• Convey interest, empathy, and trust in patient encounters in the clinic, the bedside, telemed and through portals.
THE RIPPLE EFFECT OF LITERACY ON GI PROCEDURES

Low patient literacy often leads to
- Poor MD/patient communication
- Inadequate consent process
- Poor understanding & adherence to pre & post-op instructions

These may result in:
- avoidable surgery cancellations & postponements
- wasted OR time
- ↑ hospital expense
- ↓ patient outcomes
- ↓ patient satisfaction

Physician – Patient Communication
a Fundamental Pillar of Care

- Communication influences a patient’s satisfaction, quality of care, trust and outcomes – particularly in chronic disease.
- An essential goal is mutual understanding.
- Limited health literacy impedes ability of physicians and patients to have mutual understanding…of the problem, prognoses, tx plan.
- A new challenge is communicating effectively through patient portals, teledoc and dealing with misinformation patients see on social media.

Schillinger, Science 2022
Portal Communication with Patients

237,000 email exchanges, 4000 DM patients, 1100 PCPs

Method. Computer analysis of exchanges and H-CAHPS.

Results

• Physician use of overly complex language resulted in patient confusion, partial understanding and lack of trust.

• Patients with low health literacy spent a lot of time trying to comprehend meaning.

• Patients with low health literacy (HL) had increased understanding when physicians conveyed interest, tailored language to match complexity of patients' and made exchanges interactive.

Schillinger, Science 2022

Ochsner Patient Barriers to Digital Health
Preliminary Findings

40 PATIENTS mean age 51, 68% black; 73% F; 58% Medicaid; 24% Medicare

29 PCPs – zoom or in-person focus groups. mean age 39, 79% white, 48% F

• Patients used smart phones to access internet for health and other activities-pay bills, shop, google health Qs and telemed.

• Most used My Chart. Loved messaging PCPs, scheduling appointments, reviewing test results.

• Some used health apps often recommended by PCP.

• PCPs noted increase in in-basket workload, concerned about frequent messaging. Some felt overwhelmed with answering messages.
What about Telemed and Digital monitoring?

- Patients & PCPs felt telemed was appropriate for routine follow-up but preferred in-person visits.
- Patients noted convenience, not having to take sick day, drive in from small town, long wait in clinic.
- PCPs noted workflow disruptions when moving from in-person to video visits in same clinic session. Needed telemed scheduled a block.
- Few N. LA. pts enrolled but patients and PCPs said it could be valuable adjunct to chronic care

Health Communication and Care is influenced by Health Literacy (HL)

- **Health literacy** - ability to find, understand and use health information & services, to make appropriate health decisions (36% low HL skills).
- **Health numeracy** - ability to understand health information presented in drug labels, nutrition facts, lab values, tables, graphs, probability, and statistics (62% low health numeracy).
- HL is also affected by providers’ and health systems’ ability to provide understandable and useful information and services.
- We can not blame patients for not understanding information that we have not made clear to them.
- Everyone, no matter how educated, is at risk for misunderstanding health information if the issue is emotionally charged or complex.

http://www.nih.gov/clearcommunication/healthliteracy.htm
Communication Challenges with Patients who Speak a Language Other Than English

- 22% in US speak language other than English at home.
- 62 M Hispanics in US, more than 1/3 do not speak English well; health literacy low among this group with limited English (LEP).
- Want written materials in Spanish & provider who speaks Spanish.
- Want to include family in health decisions but not as translator.

Health Literacy Tips
- Consider language before patient is sitting in front of you. Is the interpreter prepared with clear information?
- Focus on patient - not the interpreter or family member.
- Think “what does this patient need to understand and what do they need to take away from this encounter.”

HL and Social Determinants of Health (SDOH) Impact Health Disparities

Cardiovascular disease
- 50-75% higher among adults with low education and income.
- 28% higher for Blacks vs Whites

Diabetes
- 2X higher among Blacks vs Whites

Female Obesity
- 56% Blacks, 47% Latino vs 48% W

Cancer Mortality
- 15% higher for Blacks vs Whites
- Higher in rural areas (180/100,000) vs urban (158/100,000)
Disparities Impact Health and Health Behavior

- 13.5% in U.S. live in Poverty
- 19.5% Blacks, 17% Hispanics
- 8.2% whites, 8.2% Asians

Poverty line
$12,000/year 1 person
$26,500 family of 4

25% neighborhoods have no internet

Health Behavior
- Obesity  42% (Blacks 50%, BF 57%, Hispanics 45%)
- Inactivity 28% (Blacks 30%, BF 45%, Hispanics 32%)
- Smoking 12.5% (B14%,W13%)
- (32% GED, 3% graduate degree)

Statista.com; CDC 2022, Trust for Americans health

SDOH Critical Aspect of Health

- 40% Social economic
- 30% Health Behavior
- 20% Clinical Care
- 10% Physical Environment

Low-Income Patients Experience Disproportionately Worse Outcomes

Patients with low HL
- have significantly shorter pre op visit - half time as pts w adequate HL (UAB)
- more likely to have post op complications for major procedures - even w no pre-op complications (UAB),
- 59X greater odds of being readmitted compared to those w adequate HL (Vanderbilt)
- Blacks compared to whites
- more likely to be given inconsistent information — rely on family for information
- more likely to have 1 day longer stay after surgery. (VA)
- 1.6 X more likely to be re admitted after discharge.
- have 8-57% higher mortality across numerous surgeries

Disparities arise from patient factors and unequal treatment

Surgeons are important barriers and facilitators to adequate patient understanding.
LITERACY REQUIREMENTS EXPAND WITH INCREASING DEMANDS OF SOCIETY

"...at a level needed to function on the job and in society."

National Literacy Act, 1991; S. White, Project Director  NAALS 2016

LOW LITERACY IS A NATIONAL PROBLEM
(NATIONAL ADULT LITERACY SURVEY)

- 21% U.S. Adults are Level 1
- 48% level 1 and 2 – “lack sufficient literacy skills to function in society”
- Hispanic – 79%; African-American – 75%

National Institute for Literacy 1998
Hidden Problem: Health Numeracy

You drink this whole bottle of soda. How many grams of total carbohydrate does it contain?

- 67.5 grams
- 32% answered correctly
- 200 primary care patients
  - 73% private insurance
  - 67% at least some college
  - 78% read ≥ 9th grade
  - 37% math > 9th grade


Percentages & Probability are Challenging

Approximately half of U.S. adults unable to calculate tip.

1 in 5 college-educated adults don’t know:
- what is a higher risk – 1%, 5%, or 10%
- or understood .01 is the same as 1 in 100.

We Need to do a Better Job of Patient Communication and Support

- 1 in 5 patients recall what physicians tell them.
- Patients commonly say they understand yet be poorly informed about their diagnoses, prognosis & care plan.
- 20% - 30% do not fill initial prescriptions.
- 50% do not take meds as prescribed. 50% with chronic diseases stop taking meds in the 1st year.
- Clinic visit times and hospitalizations are shorter.
- Patients may need ongoing support to take meds.

Medication Error - Most Common Medical Mistake

1.5 M Adverse Events (Patient Error >700,000)

- >20,000 Rx drugs approved by FDA
- 2 out of 3 patients leave MD visit with Rx
- More Rx drugs moving to OTC
- 20 c every 1$ consumers spend is on FDA regulated product
- Elderly take >5 Rx, see 8 physicians
- 1 in 6 pediatric Rx not dosed correctly
- >300,000 OTC meds (>600 contain acetaminophen)

- Most labels and inserts are in English only

U.S. Census Bureau; 2009; PDR for Non-Prescription Drugs, Dietary Supplements and Herbs (2007); IMS Health 2005; IOM 2006;
Kaiser Family Foundation. Yns. | Peds 2016
“How Would You Take This Medicine?”

395 medicine clinic patients in 3 states
48% <9th grade reading, averaged 1.4 meds

• 46% did not understand instructions ≥ 1 labels
• 38% with adequate literacy missed at least 1 label
• <10% attended to warning labels


“Show Me How Many Pills You Would Take in 1 Day”

Rates of Correct Understanding vs. Demonstration
“Take Two Tablets by Mouth Twice Daily”

Correct (%)

<table>
<thead>
<tr>
<th>Patient Literacy Level</th>
<th>Understanding</th>
<th>Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>71</td>
<td>35</td>
</tr>
<tr>
<td>Marginal</td>
<td>84</td>
<td>63</td>
</tr>
<tr>
<td>Adequate</td>
<td>89</td>
<td>80</td>
</tr>
</tbody>
</table>

John Smith        Dr. Red
Take two tablets by mouth twice daily.
Humidib LA 600MG
1 refill

American College of Gastroenterology
PATIENT CENTERED LABEL MADE DIFFERENCE

- Prioritized information
- Larger font size
- Increased white space
- Made instructions explicit, using the Uniform Medication Schedule

- Improved adherence among patients with
  - Limited literacy
  - Medications to be taken ≥2 times a day

**Rx Labels that are More User-Friendly**

**CVS Label**

- **Bigger Bottle**
- **Larger Print**
- **Patient name**
  - in bold to prevent mix-ups
- **Dosage**
  - indicated by rising sun, red sun, setting sun, and moon

**Examples for the Gastroenterologist**

- H. Pylori treatment (Quadruple Therapy)
- Mesalamine for Ulcerative Colitis
- Vancomycin for C. difficile

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**Helping Patients Manage Their Health:**

*Houston, do we have a problem?*

- Much self-management information we give patients has little thought into what’s being asked.

- We must figure out what’s unrealistic for particular patients & partner with them to make an acceptable and achievable plan.
Key Ways to Improve Patient Education

• Slow down – focus on patient’s “need to know and DO”
• Use plain language – Avoid jargon,
• Use pictures, pamphlets, brown bag meds
• Limit advice (1-3 concepts)
  • Write brief take-home information
  • Repeat and summarize info
• ‘Teach back’ / ‘show back’ to confirm understanding
• Check on progress - ‘touch points’ are good.

SOLUTION : “STRIP IT DOWN, BRING IT HOME, MIX IT UP”
EASY WAYS TO REDUCE ‘LITERACY BURDEN’ IN ‘FACE-TO-FACE’ COMMUNICATION

Strip it down.
Limit unnecessary use of jargon and complex language.
Goal - engage patient in conversation that facilitates understanding, establishes rapport and diminishes social distance.

Bring it home.
Make health information personally relevant. Make it concrete by grounding it in the patient’s life. Begin by asking patients what they know.

Mix it up
Cut the ‘mini lectures’/monologues. Increase “the back and forth”.
Talk less - listen more. Check for understanding, buy in, or questions.

Have normal conversation.
Roter, D. 2011 Nursing Outlook
G.I. Patient Communication Tips

- Sit down, speak slowly, use simple words.
- Make sure your patient understands terminology you are using - don’t just go rote through your spiel.
- Use analogies
- Use drawings - pts may not know where colon is or what it does
- Ideal to have family members in the room when explaining things - Pts usually have a hard time remembering.
- Use sandwich approach to reinforce information. Physician visits are very brief make sure your nurses, team have same plan, info so message is.
- Use “teach back” / “show back” to confirm understanding.

TRANSLATE TO PLAIN LANGUAGE

- Polyp
- Polypectomy
- Resection
- Colonoscopy
- Endoscopic
- Esophagogastroduodenoscopy
- Gastritis
- CT vs MRI

*http://firstclinical.com/glossary/
TRANSLATE TO PLAIN LANGUAGE

• Clear liquids
• Intern
• Resident
• Power of attorney

• Hepatology
• In and out
• Deep breath

Pictures can be Good Teaching Tools

Patients may not understand or use measurements.

Fruits and Veggies
Proteins
Healthy Carbs
User-friendly does not mean “Dumbed-down”

Adults with high education still prefer simpler material.

UNC Heart Failure study
• Specific and to the point
• Pictures and colors convey message
• Action oriented

How Bad Is Your Congestive Heart Failure?
You can tell how well your heart is doing by how you feel and what you can do.

SWELLING
OK – Swelling is going down
Bad – Swelling is going up

WALKING
OK – Walking is easier than yesterday
Bad – Walking is harder than yesterday

SLEEPING
OK – Sleeping well
Bad – Restless

Current materials available at: http://www.nchealthliteracy.org/hfselfmanage.html

Beware of Faulty Assumptions about Patient’s Need to Improve Health Behavior

• The patient ought to change, wants to change, knows how to change
• If patient does not change – visit has failed
• Patients are either motivated to change or not
• Now is the right time to change
• I’m the expert – patient must follow my advice

Behavior change is most effective if patient – not provider – chooses area to work on. Then they are more likely to own it.

Rational arguments and mini lectures are not effective in resolving resistance.
Bunny or Duck?

1. **ASK:** *Is there anything you're willing to do this week to improve your health? Then wait, don't jump in.*

2. **BRIEFLY** review education material if appropriate

3. **COACH** patients to set goals and create action plan to change behavior. “Baby steps”

4. **ASSESS** confidence (7 on 10-point scale).

5. **TEACH BACK** to confirm understanding.

*Provider serves as partner, not expert, in helping patient change behavior.*

Guides focused on:

- Patient not disease
- ‘Need to know and do’

Help patients change health behavior:

- Increase knowledge and confidence managing disease
- Solve self-care problems

Over 5 million distributed nationally
www.acponline.org/patient_tools
Customer Service -800-338-2746 ext 2600

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Health Behavior Change Tips

1. Think about what you are asking patients to do - be concrete, specific, give benefits.
2. Consider “harm reduction” rather than “all or nothing” change.
3. Make it interactive. Ask patients what they are willing to do this week—“how likely are you to do this?”
4. Patient “buy-in” is essential – their improved health behavior must fit in the context of their lives, family, and culture.
5. Check on progress – ‘touch points’ are good.
Inpatient Communication
Patients & Caregivers Perception

**Supportive**
- Transparent
- Actionable
- Empathic
- Respectful
- Timely
- Collaborative
- Purposeful

**Frustrating**
- Unpredictable
- Conflicting
- Condescending
- Unilateral
- Hurried

40 focus groups Medicare pts d/c in last 2 months

Mitchell, SE, Ann Fam Med. 2018

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In Patient Communication: What Matters?

Providing emotional support and empathy fosters trust in the health care team and care they provide.
- Providers who do not appear rushed/distracted
- Connect with patients on a personal level.
- Calling patients by name makes them feel “known”.

**Collaborative**
- Sense of being involved in medical decision making
- Encouraged to talk and feel comfortable asking questions including questions about appropriateness of care, tests, drugs.

**Anticipation of needs at home**
- Transportation, meds, equipment, follow-up appointments and tests, awareness of patient/caregiver skills and confidence providing post d/c care.
- **Who do I call if I have a problem or question?**

Li Med care, 2021
### National Patient Survey Findings

**Bottom Line: Trust Matters**

- 7939 surveys mailed to patients 51 days after d/c (phone interview if needed)
- Mean age 72, 53% F, 59% > HS education, 75% White, 10% Black, 15% Hispanic

**Patients** who reported:
- Providers conveyed trust, used plain language
- Tailored care planning (med reconciliation)
- Provided easy to use care transition summary, post d/c outreach.

**Results**
- Patients reported better mental health (p<.001) and greater participation in daily activities (p=.004), less pain (p<.01)
- Lower likelihood of 7-day ED visit (p=.01), less 30-day readmission (p=.01)

### Surgeon Communication:

**Med Student Study at UAB**

- Audio taped surgeon /patient encounters (5 faculty surgeons) 52pts
  - 44% male, 23%, black, 4% Asian. 70% had adequate literacy

**Rate of speech**
- Surgeons 192-216 words per minute
- Normal conversation 120-150 wpm (auctioneers 250 wpm)

**Visit length**
- Pts with adequate literacy 11.8 min
- Pts with limited literacy 5.5 min

**Percent time patients spoke**
- Patients 12-30%

- **Bottom line physicians need to slow down – use more understandable words and allow more time for patients to speak**
Communication Takeaways

- Slow down, be emotionally present.
- Sit down, focus on your patient, call them by name.
- Listen to their concerns, acknowledge them.
- Use plain language that is easy to understand.
- Make it interactive - take turns.
- Include family when appropriate.
- Patients more likely to remember if you limit information.
- Use “teach back” to confirm understanding.

What’s our Bridge to Action?

What practices could we implement to make our communication more user friendly?
Questions?

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