Translating Patient-Centered Strategies into Clinical Practice to Overcome Healthcare Disparities

Lisa A. Cooper, MD, MPH
Professor of Medicine, Epidemiology, and Health Policy & Management
Johns Hopkins University School of Medicine
Johns Hopkins Bloomberg School of Public Health

Disclosures

Accelerating the Dissemination and Translation of Clinical Research into Practice

The Following Faculty have No Relevant Financial Relationships with Commercial Interests

Dr. Lisa Cooper

Panel Discussion II: Integrating Dissemination into Existing Practice: Models used for Successful Translation

Patient-centered care*

- One of the six domains of quality of care
- Customizes treatment recommendations and decision making in response to patients' preferences and beliefs
- Informed by an understanding of patients' needs and environment, which includes home life, job, family relationships, cultural background, and other factors
- Characterized by informed, shared decision-making, and development of patient knowledge and skills needed for prevention and self-management behaviors
- Improves patient satisfaction and health outcomes

*Institute of Medicine, "Crossing the Quality Chasm, 2001

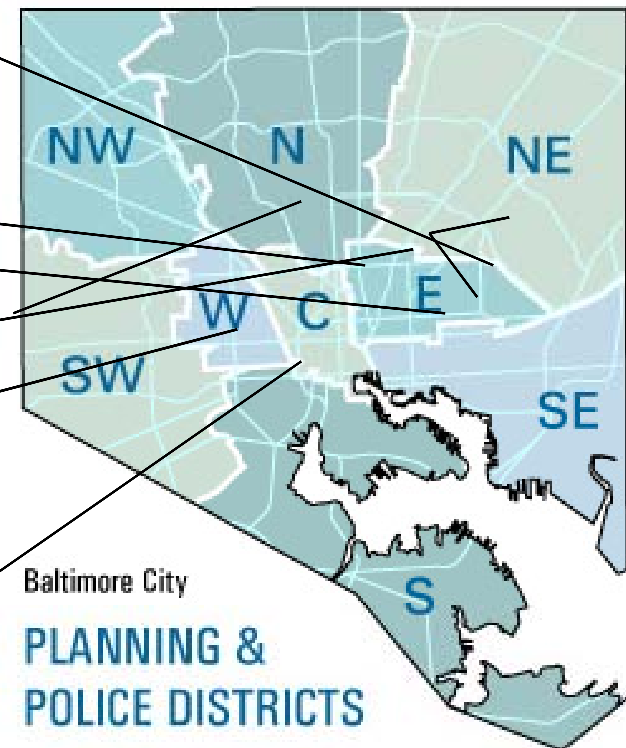
Patient-Physician Partnership to Improve HBP Adherence

- Design: Randomized controlled trial, factorial design
- Population: 42 primary care MDs and 279 ethnic minorities and poor persons with high blood pressure (HBP)
- Setting: 15 urban, community-based clinics in East and West Baltimore
- Interventions: Communication skills training on interactive CD-ROM for MDs; Patient coaching and activation by community health worker
- Main Outcomes: patient-physician communication, patient adherence, and BP control at 3 & 12 mo follow-up

Supported by the National Heart, Lung, and Blood Institute
R01HL69403, 09/01/01-08/31/07

PPP Clinical Sites & Partners

- Baltimore Medical System (BMSI)
- Jai Medical Center
- Johns Hopkins Outpatient Center
- Johns Hopkins Community Physicians (JHCP)
- Total Health Care
- University of Maryland Medical Center
- Owings Mills Crossroads (Baltimore County)

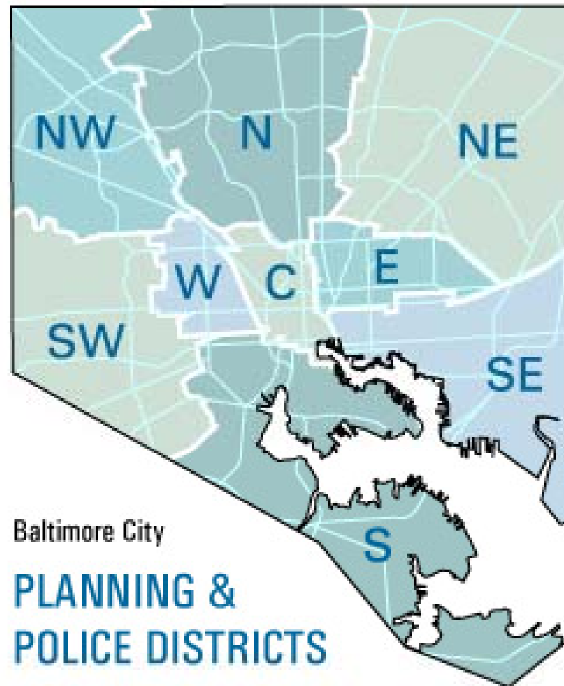


Blacks Receiving Interventions for Depression and Gaining Empowerment

- **Design:** Randomized controlled trial
- **Population:** 27 primary care providers and 132 African American patients with depression
- **Setting:** 10 urban, community-based clinics in Baltimore, MD and Wilmington, DE
- **Interventions:**
  - Standard quality improvement program
  - Patient-centered, culturally tailored program
- **Outcomes:** depression resolution, guideline-concordant care, and patient ratings of care at 6 & 12 mo follow up

Supported by AHRQ R01HS013645, 9/30/03-8/31/08

Bridge Clinical Sites & Partners



- Johns Hopkins Community Physicians
- Sinai Hospital
- Baltimore Medical System (BMSI)
- Baltimore Medical Surgical Associates
- Henrietta Johnson Medical Center, DE Associates
- Westside Healthcare, DE

Recruitment

Clinicians

- Via letter from medical director and PI
- CME credit and individualized feedback on communication style
- Organizations given incentive for MD/NP/PA participation in research (~$200/clinician)

Patients

- Via claims data and invitation letter or onsite by RA
- Consent obtained in person
- Intervention assignment done onsite for one study and one the phone for the other
- Monetary compensation ($75) and educational materials given to all participants

Challenges

- Community-based participatory approach requires time from investigators and practice leaders
- Staff training and supervision needs are intensive
- Enrollment of diverse clinicians and patients is difficult in a non-integrated and fragmented healthcare system
- Patients and clinicians do not always understand or trust research methods and results
- Urban, community-based practices are reluctant to change current care models in an environment that demands high productivity with limited resources (e.g., no electronic medical records, lack of specialized staff)

What works?

- Meeting with medical directors and practice leaders ahead of time to align priorities and get leadership commitment
- Ongoing communication with medical office staff to specify roles of interventionists vs. clinicians and staff
- Adapting delivery methods to meet needs of practices
- Offering incentives and benefits to practices and patients
- Culturally and linguistically appropriate messages and materials that are simple and concise
- Interventionists that are culturally sensitive and have experience in community
- Intensive training and oversight of interventionists

Conclusions: Translation Strategies

- Implement quality improvement strategies across different sites
  - Develop toolkits (e.g., training manuals, outcomes measurement tools) for dissemination
  - Customize/adapt interventions for special populations & settings with input from community members, clinicians, and healthcare delivery systems
  - Engage in ongoing dialogue to improve upon existing strategies
- Evaluate implementation effort
  - Ensure adequate resources & technical assistance
- Create partnerships between funding agencies, researchers, policy-makers, and communities
  - Simplify messages and make them consistent