Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Department of Family & Social Medicine

Team-Based Learning
Faculty
Facilitator Guide

Hypertension and Hyperlipidemia

Answer Key: ----

Contact: Dr. Zoon Naqvi at 718-430-2900

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GOALS AND OBJECTIVES

Educational Goal
Students will be able to demonstrate competencies of an effective clinician in evaluating and caring for patients with hypertension and hyperlipidemia in the Family Medicine ambulatory and community settings.

Medical Knowledge
The students will:

1. Apply the nationally accepted guidelines for preventing, screening, diagnosing, and managing hypertension and hyperlipidemia.
2. Define pre-hypertension, essential hypertension, and resistant hypertension.
3. Describe elements of lifestyle modification in both healthy, pre-hypertensive, and hypertensive patients.
4. Discuss the medications available to prevent and treat hypertension and hyperlipidemia.
5. Define special considerations in hypertensive management of women, minorities, and geriatric populations.
6. Review the clinical identification of metabolic syndrome.

Patient Care
The students will:

7. Explain critical elements of the patient history, physical examination, and laboratory testing that support the diagnosis of hypertension and hyperlipidemia.
8. Identify lifestyle, other risk factors, and concomitant disorders that affect prognosis and guide treatment.
9. Formulate appropriate medical and lifestyle management plans for the longitudinal care of patients with hypertension and hyperlipidemia.

Interpersonal and Communication Skills
The students will:

10. Describe relevant psychosocial and cultural issues that impact on care.
11. Appraise the importance of providing culturally sensitive and responsive education, counseling, and care to patients and their families.
12. Appreciate the importance of effective communication with patients and families and improved health outcomes.
13. Discuss empathic, respectful and non judgmental behaviors with patients.

Practice Based Learning and Improvement
The student will:

14. Participate in effective collaborative teaching and learning activities with peer medical students.

Professionalism
The student will:

15. Demonstrate professionalism by preparing for and participating in the hypertension-hyperlipidemia session.

LIST OF MATERIALS

- This faculty guide* for the session – one copy
- White paper copies of the associated 5 item Readiness Assurance Test (RAT)* – one for each student
- Scantrons – one for each student
- Scratch cards* for GRAT answers – one for each team (usually 3)
- Memory stick with power point presentation*
- The ACC / AHA 2013 algorithm – 1 for each student
- The JNC 8 2014 algorithm – 1 for each student
- Phase 3 TBL handout – one for each student – KEEP PARTS 1 & 2 SEPARATE
- Flashcards
- ETHNIC framework – one for each student
- Flip charts – one for each team
- Color markers for flip charts
- Pencils (for students who did not bring them) – Please collect afterwards

Never leave RATs / SCRATCH CARDS / faculty guides / slides with students.

*These should all be "Version ----" for this TBL.

All materials will be prepared by Adriana in advance and will be available in Mazer 430 by Friday afternoon prior to your session. The packet of materials will be in the bottom drawer of the filing cabinet on the right as you enter. Please return the materials to the same place following the session.

TBL SCORING

Some students may have questions about how the IRAT/GRAT scores will translate into clerkship points. Contrary to usual TBL principles, the IRAT/ GRAT scores are not included in the students' grades. However, relevant material is included on the final exam. If students have questions about the grading system, refer them to the Clerkship Directors.

TOPICS AND OBJECTIVES BY PHASE

Phase 1: Preparation

PCORE Web Modules: "Hypertension" and "Hyperlipidemia"

Phase 2: Readiness Assurance of Core Hypertension / Hyperlipidemia Concepts

Phase 3: Application of Concepts - Sociocultural Assessment & Plan in Patients with Hyperlipidemia

1. ETHNIC framework: explanatory models, sources of information, & treatment modalities
2. Patient-centered plan formulation

TIMING OF SESSION

First Session Only:
In most cases, the first session will be Prevention. During rotations where another TBL session is scheduled first, however, the facilitator MUST:

1. introduce the class to the concept of TBL including the purpose, process, and grading system prior to distributing the IRAT. This information is also posted on eMED.
2. during the IRAT, list the student names (by team) on the board. Team assignments are available in the schedules folder in eMED.
3. before the GRAT, explain how to properly use the scratch cards (stars may not be in the center; don't scratch too hard).

All Sessions:
The following process is standard for all sessions.

1. Sessions in the education center require you to bring your own laptop or tablet, and install software on your computer to wirelessly link to the video screen. Please arrive 10 minutes early to ensure time for set up. If the wireless system fails, there are cables hidden behind the video screen to plug into your device.

2. Start on time at 8am.

3. Students will record IRAT answers on a scantron. Give them the following instructions:
   a. Write your Banner ID on both the RAT and scantron.
   b. Use a #2 pencil.
   c. Fill in response bubbles completely. There is only ONE answer to each question.

4. Distribute the RAT and scantrons, notifying students that they have **10 minutes** to complete it. Write the end time (e.g., 8:15 AM) on the board.
5. During the IRAT, double check all AV equipment and open PowerPoint from jump drive (please do NOT move or copy the file from the jump drive to the computer).
6. Write the GRAT scoring system on the board.
    a. One scratch = 4 points
    b. Two scratches = 3 points
    c. Three scratches = 2 points
    d. Four scratches = 1 point
    e. Five scratches = 0 points

NOTE: Remind the students that both the IRAT and GRAT are closed book activities. No reference materials can be used.

7. Give students a verbal 5-minute warning.
8. When time is up, collect the scantrons ONLY. Allow students to retain their copy of the RAT through the GRAT process.
9. Ask students to break into groups (this is often done on their own in later sessions). Groups should be spread around the room as much as possible.
10. Distribute scratch cards. State the time for this portion of the session (**10 minutes**) and write the end time on the board. **If one team ends early, they should go over the rationale for why the incorrect answers are wrong – in preparation for their clerkship exam.** You can begin instructor feedback early if all groups finish before time is up.
11. **Walk around the room and listen to group dialogue**. The students will sometimes guess the right answer for the wrong reason. The only way to know this is to listen to their discussions. This will allow you to correct misunderstandings during the feedback section.
12. At the conclusion of the GRAT group time, have the students add up their GRAT scores and write the team scores on the board from this week to foster excitement about the competition.
13. Collect the scratch cards and begin faculty feedback (slides), which should run about **10-20 minutes**. Students keep the RAT questions during this discussion. In addition to the discussions you heard during the GRAT session, you can gauge which questions were more challenging by looking at the scratch cards.

*NOTE: New TBL faculty have a tendency to revert to lecture. Remember, if there are no questions or comments regarding an answer, move to the next item. If there is a critical **teaching point** (from the following pages) related to the item, state it and remind students to review the content on PCORE.*

If students have questions, you can refer the question back to other students, especially when you heard the correct information from a student during the GRAT process.

*NOTE: Timing in this section can be challenging. Be aware of the time needed for Phase 3 (they differ based on the session) to make decisions about the length of discussion. One option is to table a lengthy discussion on one question until you've reviewed all 5, returning to it at the end as time permits. **Leave at least 60 minutes for Phase 3.***

14. At the end of the faculty feedback (review of questions), ask students to put their names on the RAT and collect all copies. **Do not leave any copies behind.**

15. Distribute materials for Phase 3 and begin. Individual Phase 3 instructions are included in this Faculty Guide.

16. Count up RATs during beginning of Phase 3 to ensure you have collected all copies.

17. The students can keep the Phase 3 materials for their own use after the session.

*****VERY IMPORTANT FOR FACULTY FACILITATORS:*****
Reminder of CQI Assignment prior to the Diabetes TBL Session

Remind students of the upcoming diabetes assignment in PCORE. They will conduct chart audit of 4 patients (takes about 15 minutes). The Diabetes TBL session requires every student brings a copy of their CQI summary report to the session.

After the Session:
Please return all materials to the bottom drawer of the first filing cabinet on the right in Block 430 (Mazer was renamed Block in early 2013).

FACILITATION TIPS *(especially during instructor feedback portion of Phase 2)*

1. **Ask teams for the correct answer to each question -** If all teams reported the correct answer, you have several choices:
    a. Move on (especially important if time is running short)
    b. Ask one team to explain how they came up with the answer (they may not know why it is correct) "Tell me about your thinking?"
    c. Ask students to identify what they believe is the key teaching point of the question
    d. "What would make the incorrect answer – correct?"
    e. "Does anyone have a close second choice?"

2. **Try not to ask "do you have any questions about this?" -** In most cases, the students will say "no" (or just sit there in silence) and participation will wane. Rather ask questions such as 1b - e above.

3. **Silence is OK** – Even when asking good questions, it usually takes 5 to 7 seconds for someone to respond. Then, the conversation will continue at a quicker pace.

4. **Respond to Questions by Asking Others** – One goal of TBL (and group learning) is to teach one another. They can learn from one another as much as (or more) that from a single speaker. Students expect you to be the "expert" and tell them the answer. It is appropriate in some cases, but to keep the team learning environment, see #5 below.

5. **Look up Answers** – If no one knows the answer, have the person who asked the question research the answer and report back to the group the next time you meet.

6. **Refer to Discussions During GRAT** – When discussing reasons for correct/incorrect answers, refer back to what was said in the group discussions. This demonstrates that their conversation is valuable and that you are paying attention.
7. **Connect to Clinical Experience** – Connecting the discussion with what students see in clinic will make it more real and applicable as a learning experience. Additionally, it is important to discuss how/why recommendations might differ from standard clinical practice.
8. **Keep Lights On –** They may want to see the PowerPoint better, but lights keep people awake.
9. **Encourage Debate –** Allow students to respond to one another as time permits. If debates (especially about specific RAT items) take more than a few minutes, table the discussion until the end of the session.
10. **Alternate Which Teams Respond –** During Phase 3, after the simultaneous report, vary which team discusses their responses first.
11. **Allow for Participation by All Team Members -** Do not assign a spokesperson for a team. It may allow for quicker reporting, but discourages team building (additionally, valuable input might be missed).
12. **Serve as a Role Model** – Show patience and consistency, and accept feedback without being defensive.

From Tulane School of Medicine: Effective Small Group Facilitators…

- **prepare** a plan for the small group session. Small group discussions can have different goals.
- **listen** well and are **patient**.
- are **supportive** of the group, individuals in the group, and the small group process itself.
- make learning a **shared responsibility**. The facilitator tries to involve all participants and monitors his own level of participation.
- are comfortable with **silence**. Learners think, and thought requires time.
- are prepared to **refocus** the discussion.
- take **risks** by expressing personal thoughts about a topic or patient. By being honest and authentic, the facilitator creates a setting where all members of the group are comfortable expressing themselves. The facilitator is not fearful of saying, "I don't know."
- **challenge** but do not threaten. Effective facilitators ask thoughtful questions and involve all participants but are careful not to belittle or judge individuals.
- are judicious with the use of **feedback**. A group discussion is principally about sharing information, ideas, and opinions, not making evaluative comments. However, at times feedback will promote continued positive group interaction.
- **summarize** progress or decisions when appropriate – during the session, end of the session.

PHASE 2: SUMMARY TEACHING POINTS

PHASE 2: IRAT/GRAT ANSWER KEY (---)

Team Based Learning: Hypertension - Hyperlipidemia
Individual & Group Readiness Assurance Test

PHASE 3: SUMMARY TEACHING POINTS

KEY TEACHING POINTS

Cultural competency relies on well-developed communication skills to serve a diverse population.

Better physician communication skills have been correlated with:
- increased patient satisfaction in many studies
- improved patient adherence in several studies
- improved blood pressure and glycosylated hemoglobin (A1c) in a few studies

2007 National Health Interview Survey showed that 38% of Americans use some form of complementary or alternative treatment.

ETHNIC
is a framework for providing culturally appropriate health care and can help to elicit most of the causes of non-adherence to recommended medications and treatment:

Explanation
Treatment
Healers
Negotiation
Intervention
Collaboration

Common barriers to adherence
• Socioeconomic stressors • Depression • Side effects and fears about potential side effects and consequences • Use of complementary/alternative therapies (including home remedies) • Different beliefs about the illness (explanatory models) • Low health literacy (including biomedical knowledge) • Financial barriers to obtaining medication • Mistrust of physicians and modern medicine • Previous health care experience • Polypharmacy

PATIENT-CENTERED PLAN:
Doctor/patient relationship
Patient preferences
Lifestyle intervention
Financial concerns
Familismo/ Importance of Family
Explanatory models
Follow-up/continuity

FINAL TEACHING POINTS:
- Exploring a patient's explanatory model through active listening results in higher adherence rates than educating the patient.
- Providers' personal attitudes/beliefs can impact how they respond and interact with patients.
- Continuity of care requires prioritizing interventions during each brief visit based on urgency and expected impact.

PHASE 3: ANSWER KEY

Team Based Learning Workshops: Hypertension and Hyperlipidemia
Phase 3: Sociocultural Issues in Hypertension and Hyperlipidemia

Part 1 (20 minutes)

1) Take 10 minutes to individually review Part 1 of the case below, then discuss the case and associated question as a team.
2) Although there may be several possible answers, be prepared as a team to commit to a single answer and defend your choice. **Do not share your "team answer" with the entire class until instructed to do so.**
3) Using flashcards, **teams will reveal their "answer" simultaneously when prompted by the faculty member.** The faculty member will facilitate a discussion for 10 minutes on the responses of each team with the entire class.

Part 2 (25 minutes)

1) Take 10 minutes to review and discuss Part 2 of the case as a team.
2) Use the flipchart to record your team answers.
3) When instructed, each team will circle the room to review the responses of other teams (Gallery walk). Then return to your table and, as a team, choose the team with the best plan. Be prepared to discuss your decision. This should take about 5 minutes.
4) Using flashcards, **teams will reveal the "best plan" simultaneously when prompted by the faculty member.** The faculty member will facilitate a discussion for 10 minutes on the responses of each team and the entire class.

FACILITATOR INSTRUCTIONS

Distribute ONLY Part One of the case at the beginning of Phase 3. Take 5 minutes after teamwork on Part One of the case to review basic teaching points, including the ETHNIC framework (hand out a copy of the ETHNIC framework at this time). When you are done discussing ETHNIC, hand out a copy of Part Two of the case.

The overall timeline is as follows:

Time		Activity
10 min	Handout Part 1	Part 1: Individual Reading & Team Discussion
10 min		Part 1: Faculty Facilitation
5 min	Handout ETHNIC	Lecture: ETHNIC Framework
10 min	Handout Part 2	Part 2: Individual Reading & Team Discussion
5 min		Part 2: Gallery Walk
10 min		Part 2: Faculty Facilitation & Closing

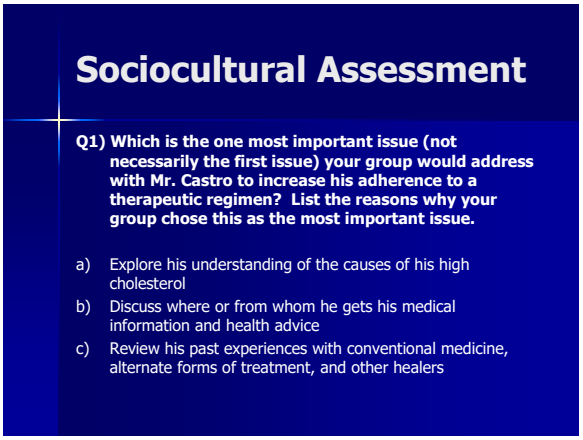
REMINDER: Students should complete the Diabetes assignment prior to the next TBL.

Part 1

Ramon Castro is a 39 year old Puerto Rican male who lives in the Fordham section of the Bronx where he also works in a car repair shop. He and his family have been your patients for 7 years. He lives with his wife, their 3 children (ages 10, 15 and 18) and his mother-in-law. The 18 year old just started her first year in college. His wife has a part-time job as a cashier in a supermarket. Mr. Castro has health insurance coverage for the whole family through his employer. Mr. Castro has been following up sporadically with you over the past few years.

His history includes hypertension and diabetes diagnosed 5 years ago, and a 20 pack year smoking history. Mr. Castro is currently smoking ½ pack per day (ppd) which is decreased from his previous 1 ppd. He is taking lisinopril for his hypertension and metformin and glargine insulin for his diabetes. There is a very strong family history of cardiovascular disease: his father died of a myocardial infarction at age 47, his 44 year old brother recently had bypass surgery and his 42 year old brother is scheduled for angioplasty next week. At the last visit, you discussed the results of his lipid panel (Total Cholesterol 240, LDL 168, HDL 35 and Triglycerides 190), started him on a statin, Lipitor, and gave him a follow-up appointment in a month.

He returns today 5 months after the last visit, and his BP is 130/80. He has gained 10 lbs. His weight is now 210 lbs with a BMI of 32. He states that he has been working on his diet and is surprised that he has gained weight. Mr. Castro never started the Lipitor which you prescribed for him.



Q1) Which is the one most important issue (not necessarily the *first* issue) your group would address with Mr. Castro to increase his adherence to a therapeutic regimen? List the reasons why your group chose this as the most important issue.

a) Explore his understanding of the causes of his high cholesterol
b) Discuss where or from whom he gets his medical information and health advice
c) Review his past experiences with conventional medicine, alternate forms of treatment, and other healers

FACILITATOR INSTRUCTIONS

- Instruct teams to simultaneously report their answers using the flashcards.
- Usually, groups will choose different issues to address, in which case you can focus the discussion between groups on why they chose different issues.
- Occasionally, 2 or more groups will choose the same issue, in which case you may want to probe why they did not choose the other issues.

a) Explanatory Models for Health and Illness:
"Explore his understanding of the causes of his medical conditions, including his high cholesterol"

KEY TEACHING POINTS

Exploring a patient's explanatory model through active listening results in higher adherence rates than educating the patient.

Patients may pursue two seemingly contradictory treatment strategies simultaneously.

Physician empathy is correlated with better patient control of chronic illness.

The first step in practicing culturally competent clinical care is to explore the patient's understanding of his/her illness and explanatory health beliefs. Although patient education is important, studies have shown that exploring a patient's explanatory model through active listening resulted in higher adherence rates than educating the patient (Lang et al, 2000).

Patients and physicians may have different understanding about the nature of an illness, whether culturally based or otherwise. Patients with an explanatory model that diverges from standard medical models may be less likely to believe that standard medical therapy will work. Mr. Castro may not understand his illness in quite the same way as his physician. However, there is no particular belief or explanatory model about the illness itself that prevents him from believing in medical treatment. Many people (Mele, 1997), including physicians (Chimonas et al, 2007), simultaneously hold contradictory beliefs, and some beliefs win out over others in particular situations.

Empathy will enhance trust between the patient and physician. There is recent evidence that patients of more empathic physicians achieve better control of their chronic illness (Hojat et al, 2011). By showing an understanding of the patient's concerns, the physician can gain the patient's trust and allow for a more open discussion.

(Sources: Lang F, Floyd MR, Beine KL. Clues to Patients' Explanations and Concerns About Their Illnesses. Arch Fam Med. 2000;9:222-227. Mele AR. Real self-deception. Behavioral and Brain Sciences. 1997;20(1):91-102. Chimonas S, Brennan TA, Rothman DJ. Physicians and

drug representatives: exploring the dynamics of the relationship. Journal of general internal medicine. 2007;22(2):184-190.)

b) <u>Sources of Information</u>:
"Discuss where or from whom he gets his medical information and health advice"

KEY TEACHING POINTS

Patients seek information from different sources and process it depending on a range of factors, including:
- individual characteristics
- subjectives norms
- hazard characteristics
- affective response
- nformation sufficiency
- information gathering capacity
- channel beliefs

Doctors are still the most trusted source of information, but not all patients trust doctors.

Trust in sources of health information, particularly found online varies by age, education level, income, health information orientation, and strength of health beliefs of the consumer.

Patients would prefer to obtain information first from doctors, but in actual practice more often seek information online first.

Patients seek information from different sources and process it depending on a range of factors (Griffin et al, 1999), including: (1) individual characteristics (demographics, politics, hazard experience); (2) subjectives norms about seeking and processing information; (3) perceived hazard characteristics; (4) affective (emotional) response; (5) personal sense of having sufficient information; (6) perceived information gathering (learning) capacity; and (7) relevant beliefs about usefulness of information from different channels (channel is a communications term for source of information).

Doctors are the most trusted source of information for patients, but not all patients trust doctors. Individuals trusting the local doctor tend to be younger, and hold stronger health beliefs; individuals trusting the local hospital tend to be less educated, low health information oriented, and hold weaker health beliefs. People with greater trust in health insurance companies as online health information sources tend to be less educated and less health information oriented. Trust in medical universities is positively associated with education, income, and health information orientation. Similarly, individuals with greater trust in federal sources tend to be more educated and health information oriented (Dutta-Bergman, 2003).

While about half of patients would prefer to seek information from their doctor first, about half of patients go online first (as of 2005, probably more now), with only one in ten asking their doctors first (Hesse et al, 2005).

(Sources: Griffin RJ, Dunwoody S, Neuwirth K. Proposed Model of the Relationship of Risk Information Seeking and Processing to the Development of Preventive Behaviors. Environmental Research 1999;80:S230-S245.Dutta-Bergman M. Trusted online sources of health information: differences in demographics, health beliefs, and health-information orientation. Journal of Medical Internet Research. 2003. 5(3).Hesse BW, Nelson DE, Kreps GL, Croyle, RT, Arora NK, Rimer BK, Viswanath K. Trust and Sources of Health Information. Arch Intern Med. 2005;165:2618-2624.)

c) <u>Treatment Modalities</u>:
"Review his past experiences with conventional medicine, alternate forms of treatment, and other healers"

KEY TEACHING POINTS

Learning about the patient's past experience with different treatments guides the conversation.

The patient's experience with illness may be focused on short-term remedies rather than chronic disease management.

Doctors in training learn about how conventional medical treatments affect a particular organ or affect a group of patients in a study. A patient often has primarily their personal experience (in relation to family, community, culture, and the media) to guide what they consider to be effective treatments. Learning what the patient has tried in the past for treatments, whether conventional, complementary, or otherwise, and how effective the patient found these treatments, will help to guide the conversation.

The patient's experience with illness may be focused on short-term remedies rather than chronic disease management (Ortendahl and Fries, 2002), especially if chronic disease management was not available in the patient's home country. He may have lacked access to health care and medications while growing up, which could have led to more self-reliant behavior (home remedies) and fear of the unfamiliar.

Long-term decisions are very sensitive to perception of changes in gains or losses over time (discount rates). Patients are more driven by losing something good than worried about preventing something bad ("discount rates are greater for gains than for losses"). Perceptions of gains or losses over time vary "by domain, by outcome, by individuals,…and by level of certainty." "Individual preferences may reverse themselves over time."

(Source: Ortendahl M, Fries JF. Time-related issues with application to health gains and losses. Journal of clinical epidemiology. 2002;55(9):843-848.)

FACILITATOR INSTRUCTIONS

Take 5 minutes after Part One of the case to review basic teaching points, including the ETHNIC framework (hand out a copy of the ETHNIC framework at this time). When you are done discussing ETHNIC, hand out a copy of Part Two of the case.

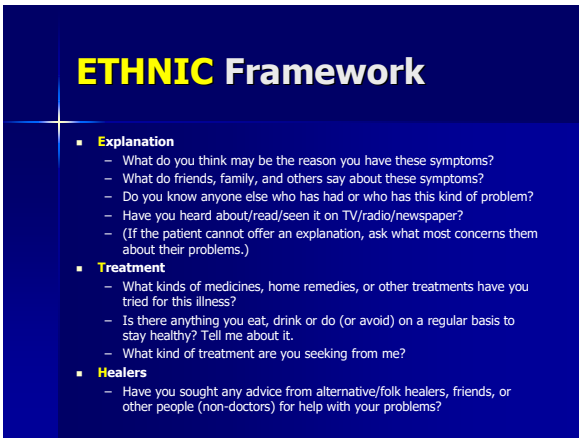
KEY TEACHING POINTS

Cultural competency relies on well-developed communication skills to serve a diverse population.

Better physician communication skills have been correlated with:
- increased patient satisfaction in many studies
- improved patient adherence in several studies
- improved blood pressure and glycosylated hemoglobin (A1c) in a few studies

2007 National Health Interview Survey showed that 38% of Americans use some form of complementary or alternative treatment.

ETHNIC is a framework for providing culturally appropriate health care.



E: Explanation
What do you think may be the reason you have these symptoms?
What do friends, family, and others say about these symptoms?
Do you know anyone else who has had or who has this kind of problem?
Have you heard about/read/seen it on TV/radio/newspaper?
(If the patient cannot offer an explanation, ask what most concerns them about their problems.)

T: Treatment

What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?

H: Healers

Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems?

N: Negotiate
Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate, your patient's beliefs.

I: Intervention Agreement
Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (eg, food eaten or avoided in general and when sick).

C: Collaboration
Collaborate with the patient, family members, other health care team members, healers, and community resources.

(SOURCE:Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics. Patient Care. 2000; 34:188-9.)

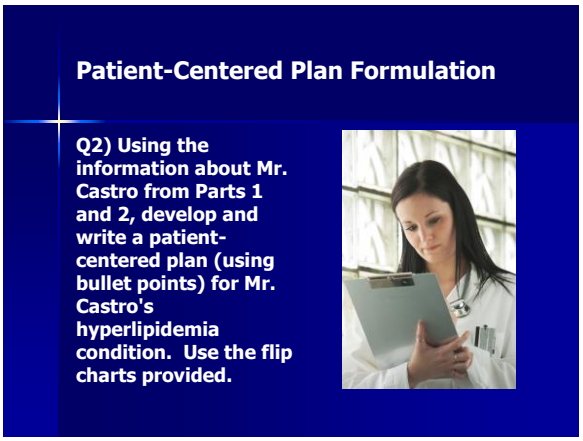
Part 2

Mr. Castro states that he cannot afford to take time off from work for medical appointments. He is the main source of income for his family, and has been working overtime for his daughter's college tuition. He says that he cannot afford a gym membership or expensive "health" foods. Instead, he has been buying Chinese diet pills.

On further discussion, Mr. Castro tells you that he brought the Lipitor prescription to his pharmacist. It was not on his health plan's formulary and he could not afford the $50 co-pay after paying the regular co-pays for his metformin, lisinopril, glargine, lancets, glucose strips and insulin syringes. He buys the alcohol pads, gauze and aspirin out of pocket.

In addition, he explained his wife had heard on the radio that statins can damage your muscles and liver and told him not to take it. He informs you that he would prefer to take garlic pills and herbs from the neighborhood "botanica." His younger sister, Sonia, also has hypertension and high cholesterol but her blood pressure and cholesterol are much better since she started the garlic and herbs.

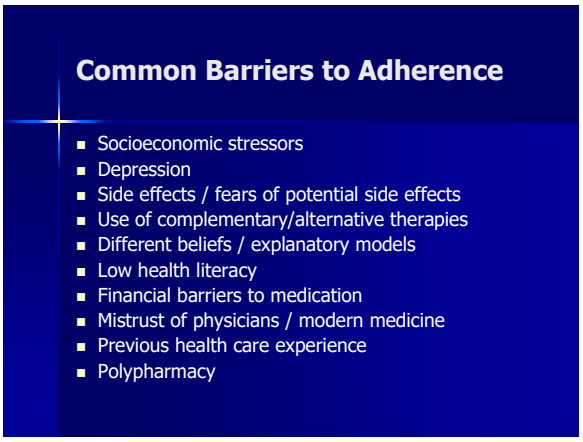
He also feels that it is only a matter of time before he will have surgery like his brothers or die from a heart attack like his father. Mr. Castro tells you that he may not be able to return for regular care and requests 5 refills on his prescriptions.



Q2) Using the information about Mr. Castro from Parts 1 and 2, develop and write a patient-centered plan (using bullet points) for Mr. Castro's hyperlipidemia condition. Use the flip charts provided.

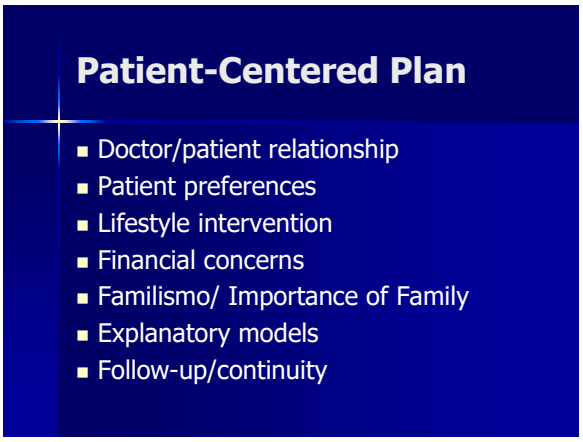
FACILITATOR INSTRUCTIONS

- Ask students to stand up and circle the room to review each team's management plan, then return to their tables and decide as a team which management plan was the "best" or the most "patient-centered." This process should only take 5-6 minutes.
- Instruct teams to simultaneously report their answers using the flashcards.
- Engage students in discussion about key teaching points to follow. Ask a different team to share their explanation first.



Common barriers to adherence

- Socioeconomic stressors
- Depression
- Side effects and fears about potential side effects and consequences
- Use of complementary/alternative therapies (including home remedies)
- Different beliefs about the illness (explanatory models)
- Low health literacy (including biomedical knowledge)
- Financial barriers to obtaining medication
- Mistrust of physicians and modern medicine
- Previous health care experience
- Polypharmacy



KEY TEACHING POINTS

Summary of important issues to address or emphasize with patient:
Doctor/patient relationship
Patient preferences
Lifestyle intervention
Financial concerns
Familismo/ Importance of Family
Explanatory models
Follow-up/continuity

The following suggestions for generation of a patient-centered plan came from generating a consensus among faculty within our department.

Examples of issues which might be addressed in the plan:

Doctor/patient relationship

Develop a partnership/work with patient as a team
Set agenda (2-3 things) based on your concerns and patient preferences, cannot do everything
Reward things done right (decreased smoking, good BP control)
Express your concerns (e.g., "I am concerned about stroke / heart attack if you do not start a statin.")
Explore why not adherent – e.g., cost, side effects, wife's influence
Discuss likelihood of possible risks/benefits (of disease and medications)

Motivational interviewing - patients are more likely to pursue behavior change when they devise their own solutions

Patient preferences

Put issues in context and combine with patient concerns
- Highlight data – e.g., try patient's way for three months - show him result when he does it his way
- Explain risk and surveillance

Do not need to follow algorithms of care strictly – need to individualize

Alternative medicine including treatments and healers
- Assess safety of diet pills and herbs

Lifestyle intervention

Stop smoking

Increase exercise – access to free, safe areas for physical activity may be limited, need to find low cost community resources

Go over healthier diet options/portion control - healthier food is often more expensive and harder to find in poor neighborhoods (Green Carts/Farmers Market)

Financial concerns

Find less expensive options **–**
- find statin covered by patient's formulary (generics may be cheaper through special programs at CVS, Target, Pathmark, etc., than the co-pay**)**
- Healthy Foods - Green Carts, Farmer's Market
- Exercise **-** Walking, NYC is My Gym campaign
- See below for concern with appointments

Ledger of weekly expenses (food, cigarettes, medications, botanica) for comparison and analysis

Familismo/ Importance of Family

Family support

Connect taking care of "you" as taking care of "your family" (discuss long term plans, seeing youngest graduate, etc.)

Acknowledge support from the family - the influence of his family on solving problems including medical decisions

Collaborate with family – lifestyle intervention (who does shopping, cooking; who else smokes)

Enlist helpful family supports and opinions - encourage to bring wife

Explanatory models

Explore fatalismo – perhaps God doesn't want you to die yet – you need to be there to take care of your family

Self-efficacy / control over heart disease

What does patient know about high cholesterol – what does he think it is caused by

Explanatory model of wife and sister – what else are they doing or saying - there may be other positive behaviors

Follow-up/continuity

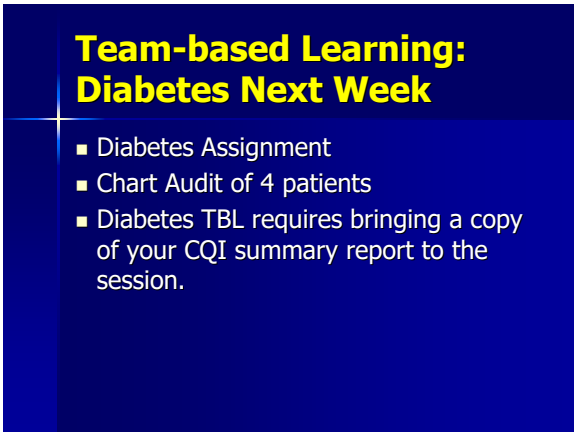
Why can't patient return for care? Is it because of financial barrier or lack of time?
Phone conversations/e-mails instead of actual visits
Be flexible about schedules – evening hours, weekends, co-manage with colleagues
Don't have to take care of everything on this visit – can follow-up

FINAL TEACHING POINTS:

- Exploring a patient's explanatory model through active listening results in higher adherence rates than educating the patient.
- Providers' personal attitudes/beliefs can impact how they respond and interact with patients.
- Continuity of care requires prioritizing interventions during each brief visit based on urgency and expected impact.

SOURCES:

J. Emilio Carrillo, MD, MPH; Alexander R. Green, MD; and Joseph R. Betancourt, MD, MPH, "Cross Cultural Primary Care: A Patient-Based Approach." Ann Intern Med. 1999; 103:829-834



*****VERY IMPORTANT FOR FACULTY FACILITATORS:*****
Reminder of CQI Assignment prior to the Diabetes TBL Session

- **Remind students of the upcoming diabetes assignment in PCORE**
- **They will conduct chart audit of 4 patients (takes about 15 minutes)**
- **The Diabetes TBL session requires every student brings a copy of their CQI summary report to the session.**