Today's webinar on "How to Have Successful Patient Interactions" will begin shortly!

Interested in practicing skills you will learn today?

- **Patient–Pathologist Consultations: Face-to-Face Practice Sessions at CAP '11**
    - Sunday, September 11, 8:00 AM–5:00 PM
      Monday, September 12, 8:00 AM–4:00 PM
      Tuesday, September 13, 9:30 AM–5:00 PM

- Sessions are free and open to all CAP '11 attendees, but space is extremely limited—you must pre-register. To schedule your one-on-one learning opportunity, please go to CAP '11 website or email CAPF-PtSimulation@cap.org.

- To help pathologists meet a growing opportunity for direct patient contact, the CAP Foundation & CAP Transformation Program Office will host a unique skill-building exercise designed to simulate a pathologist/patient consultation. These private, one-on-one encounters with trained, standardized patients offer a risk-free environment to enhance patient communication skills and explore potential ways to incorporate patient consults into your practice.

- During a 30-minute session, you will talk with a specially trained, standardized "patient" to discuss the results of his/her breast, colon, lung, or coagulation pathology report. Immediately following the consult, the patient will provide specific feedback and suggestions you can use to improve patient consultations.

- **Sign-up early. Space is limited.**

Welcome to the PHC Webinar Series

This lecture on **"How to Have Successful Patient Interactions"** is given by
Mary Ann Abrams MD, MPH and
Barb Savage MT(ASCP)

Your host is Jill Kaufman, PhD.
For comments about this webinar or suggestions for upcoming webinars, please contact
Jill Kaufman at jkaufma@cap.org

THE WEBINAR WILL BEGIN MOMENTARILY. ENJOY!

How to Have Successful Patient Interactions: Health Literacy and Transforming Patient-Pathologist Communications

Mary Ann Abrams MD, MPH and Barbara Savage MT(ASCP)

This webinar presentation is funded by a grant from the CAP Foundation

August 17, 2011

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Mary Ann Abrams MD, MPH and Barb Savage MT(ASCP)

- Health Literacy Medical Advisor at Iowa Health System and Health Literacy Iowa
- Member of American College of Physicians Foundation Health Literacy Programs Committee and co-chaired the American Academy of Pediatrics Health Literacy Project Advisory Committee
- Co-authored publications on implementing health literacy-based interventions and collaboration

Mary Ann Abrams MD, MPH

Barb Savage MT(ASCP)

- Health Literacy Coordinator for Iowa Health System and Health Literacy Iowa
- Coordinates health literacy activities in the system and maintains liaisons with the health literacy teams in affiliate hospitals
- Presented educational sessions on health literacy through the AMA Alliance to state Medical Societies and their Alliances

Disclosure

- We have nothing to disclose

Data from Survey of CAP Members

- 30% of pathologists report they consult with patients directly on the implications of their test results
- 45% of pathologists report they would like more or much more direct consultation with patients
- 10% already consult directly with patients on implications of their genetic information
- 47% of PCPs, 39% of surgeons, and 34% of oncologists want pathologists to do more or much more consultation directly with patients
- Only 40% of pathologists make their direct contact information available to patients

A Personal Story…

"…One week ago my father was diagnosed with lung cancer. Today we met with the doctor to discuss the treatment plan. During our visit we were informed the cancer previously thought to be non-small cell was in fact small cell. The nurse said she would give us some information on this new diagnosis. She handed us a computer print-out titled "Pathobiology and staging of small cell carcinoma of the lung". It is 11 pages of single spaced text written at a level that even I, as a health professional, have NO IDEA how to interpret.

I was appalled at the fact that this was it – this was all the education he was going to receive – I spoke up. At the risk of sounding pretentious, I asked the nurse how she thought a patient would ever understand this information. How can a patient, specifically my 63-year old father who is an intelligent man, ascertain anything from this document?

The nurse simply responded that this was the "patient friendly" version they use all the time…"

M.G. 2007

Pathobiology and staging of small cell carcinoma of the lung

Anthony Elias, MD

UpToDate performs a continuous review of over 375 journals and other resources. Updates ai as important new information is published. The literature review for version 15.2 is current th April 2007; this topic was last changed on April 26, 2007. The next version of UpToDate (15.: released in October 2007.

INTRODUCTION — Small cell lung cancer (SCLC) is distinguished from non-small cell lung car (NSCLC) by its rapid doubling time, high growth fraction, and the early development of wides metastases. Although considered highly responsive to chemotherapy and radiotherapy, SCLC relapses and becomes refractory to treatment within one to two years.

The epidemiology, pathology, clinical presentation, staging, and prognostic factors of SCLC w reviewed here. The treatment of SCLC is discussed separately. (See "First-line chemotherapy for lung cancer" and see "Use of thoracic radiotherapy in the treatment of limited stage small cell lung can see "Prophylactic cranial irradiation for patients with small cell lung cancer").

EPIDEMIOLOGY — SCLC occurs almost exclusively in smokers and appears to be most comm heavy smokers [1].

The proportion of lung cancer in the United States that is classified as SCLC has steadily decr This was illustrated by an analysis of the Surveillance, Epidemiology and End Results (SEER) database, in which the proportion of SCLC declined from 17 percent in 1986 to 13 percent in This overall decrease in incidence was accompanied by an increase in the percentage of cases arising in women (28 percent in 1973 versus 50 percent in 2002).

These epidemiologic changes may be due to differences in smoking patterns (eg, decreased i [2]. In addition, changes in the pathologic criteria for SCLC may have led to a classification of cases as having large cell neuroendocrine carcinoma [1]. (See "Classification of SCLC" below).

PATHOLOGY

Classification of SCLC — The histologic classification of SCLC has evolved over several decade Initially, the World Health Organization (WHO) classified SCLC into the following three histolo subtypes [3],
oat cell, intermediate cell type, and a combined oat cell type (SCLC combined with squamous adenocarcinoma). However, the classic oat cell and intermediate subtypes did not appear to l different biologic or clinical behavior patterns. As a consequence, a later proposal by the Inte Association for the Study of Lung Cancer (IASLC), classified SCLC into pure SCLC, and two le: common variants, mixed small cell and large cell (accounting for 3 to 6 percent of cases), anc combined small cell type (1 to 3 percent) [3].

central nervous system metastases in small cell lung cancer: Potential benefit restricted to patients with complete response. Am J Med 1983; 74:615.
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GRAPHICS

Lung cancer staging system

AJCC TNM staging system for lung cancer

Primary tumor (T)
T1 - Tumor <3 cm diameter without invasion more proximal than lobar bronchus
T2 - Tumor >3 cm diameter **OR** Tumor of any size with any of the following:
Invades visceral pleura
Atelectasis of less than entire lung
Proximal extent at least 2 cm from carina
T3 - Tumor of any size with any of the following:
Invasion of chest wall

Insights

- How does this encounter demonstrate the relationship between health literacy, quality, and patient-centered care?
- What communication barriers were there?
- What could have been done differently?

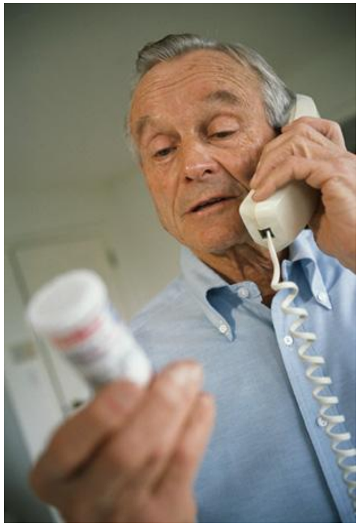
Objectives

- Define health literacy & explain its role in high quality, safe, patient-centered care, & the transforming health care system
- Recognize barriers that impede & opportunities to improve patient-pathologist communication
- Begin implementing health literacy-based strategies to improve communication with patients & families in your practice setting

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.

  -Institute of Medicine, 2004



National Assessment of Adult Literacy, 2003

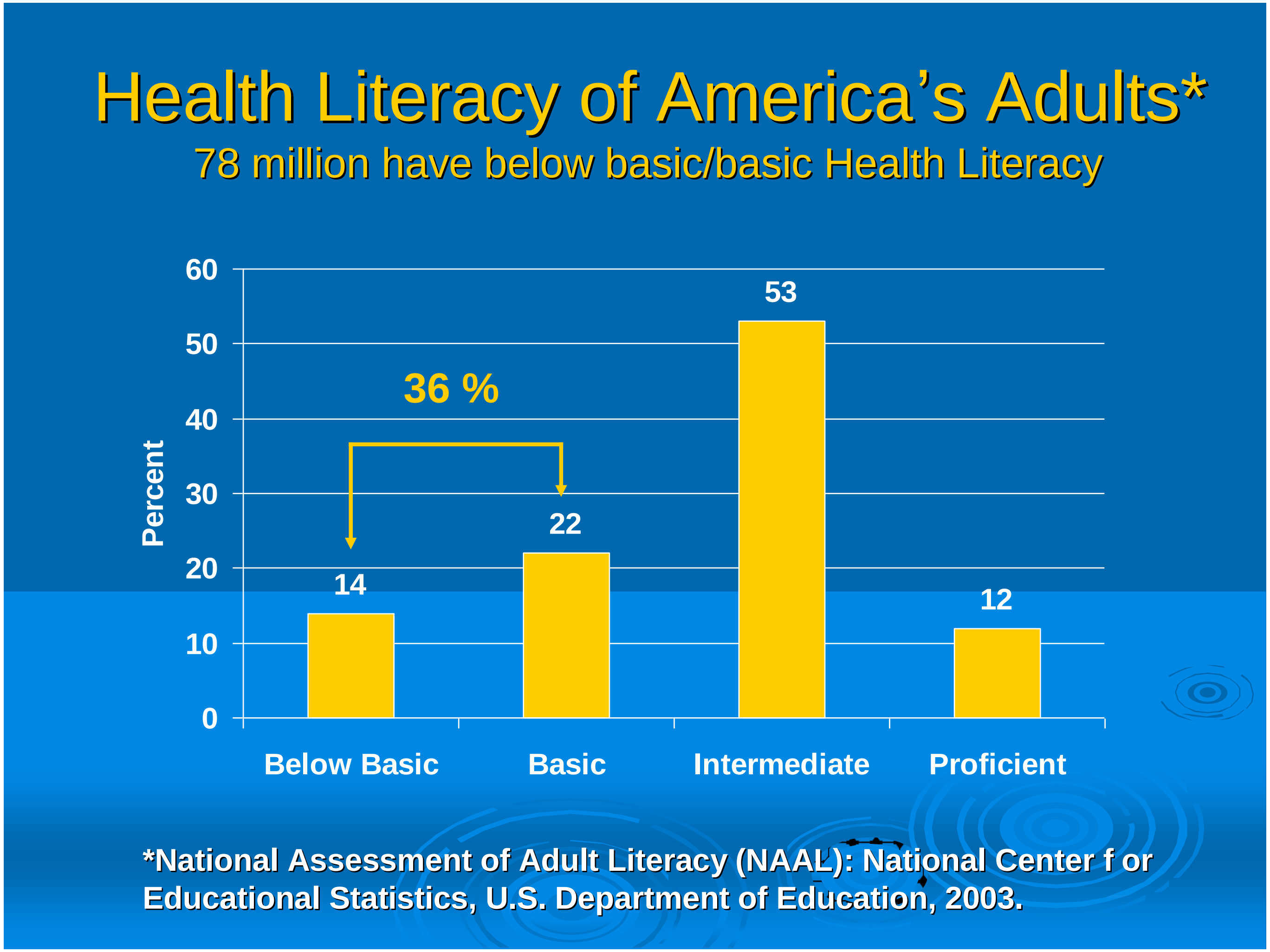


Figure 2-7. Percentage of adults in each health literacy level, by age: 2003

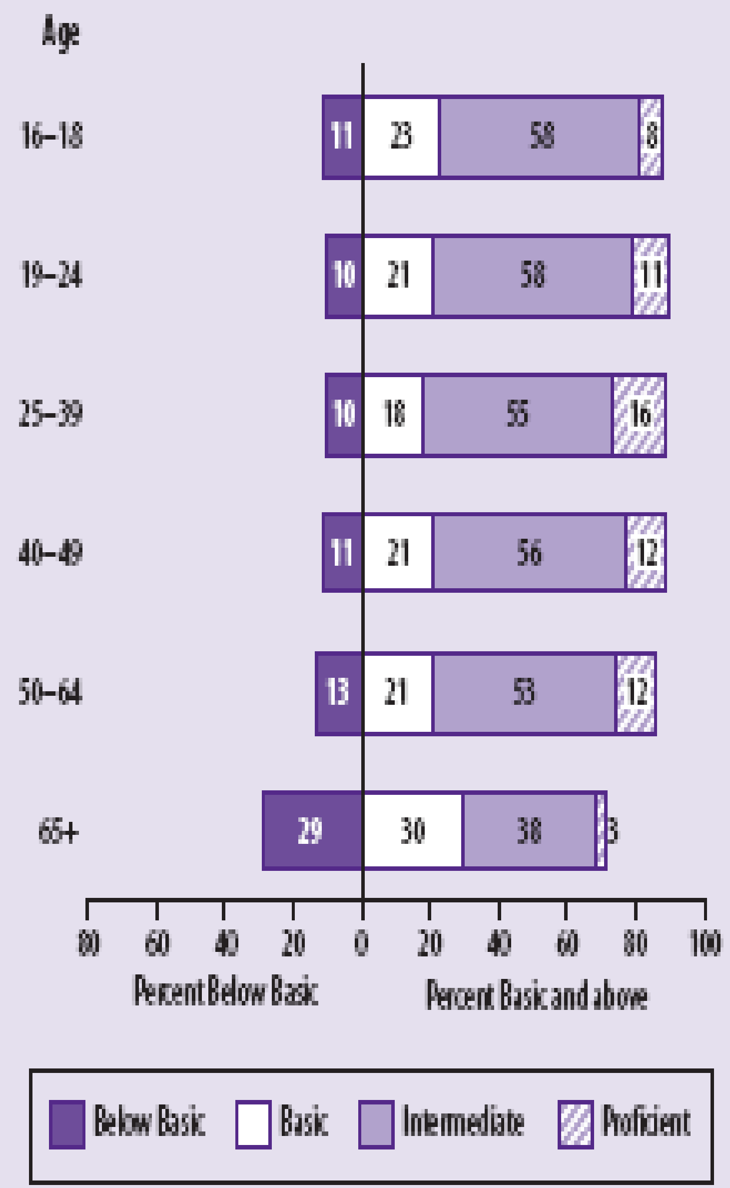
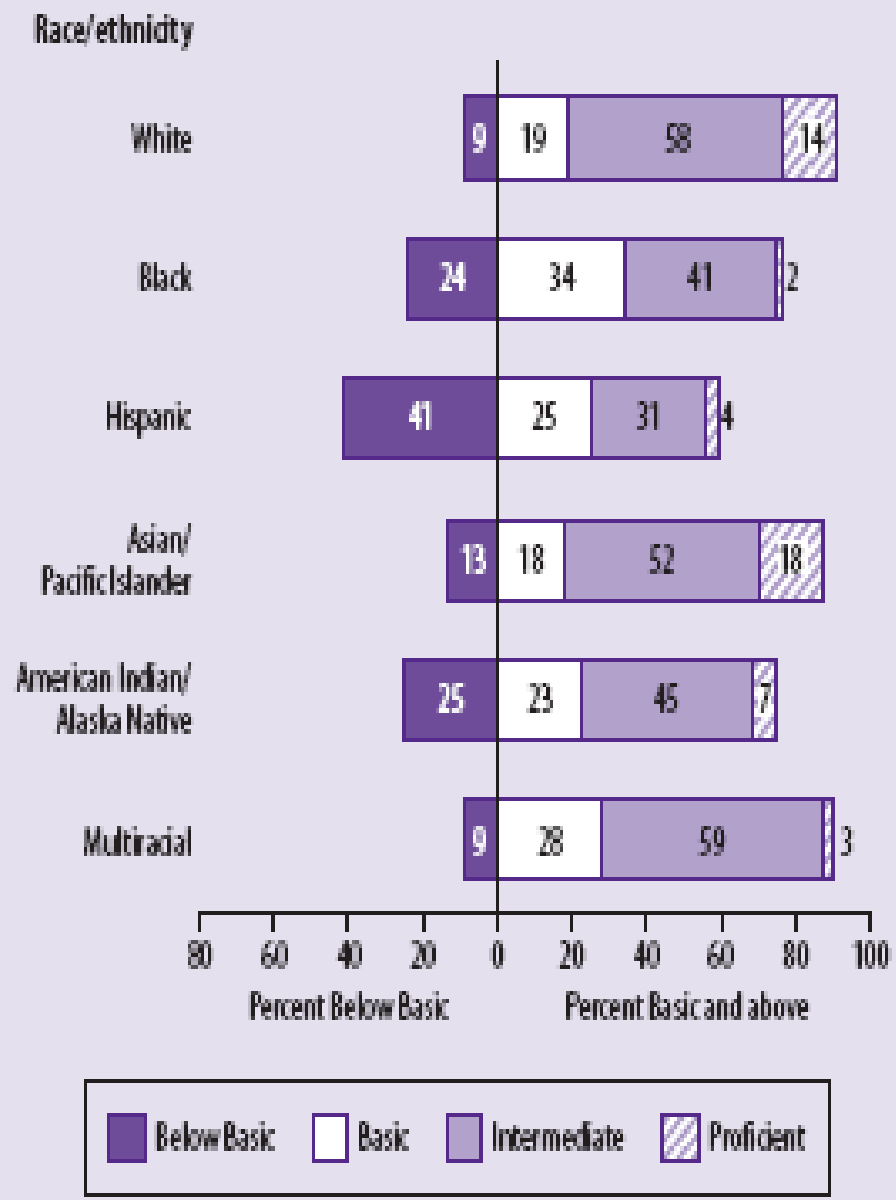


Figure 2-5. Percentage of adults in each health literacy level, by race/ethnicity: 2003



Prevalence of Low Literacy in Selected Cities NALS, 1993*

http://www.casas.org/lit/litcode/Search.cfm**

Boston	53%
Charlotte	45%
Chicago	63%
Dallas	55%
Honolulu	43%
Nashville	47%
New York	63%
Orlando	49%
Philadelphia	67%
Seattle	34%

* Estimates of adult literacy proficiency: Percent marginal or limited literacy (1993 NALS, 1990 US census)

** Reder S. Adult literacy estimates. Portland, Ore: Portland State University; 1996.

Low Health Literacy & Health Outcomes

- Poorer health status
- Lack of health knowledge
- Reduced use of preventive care
- Decreased adherence
- Increased medication error
- Excess hospitalization
- Adverse health outcomes
- Increased mortality
- Mediator of racial disparities
- Lack of <u>informed</u> consent

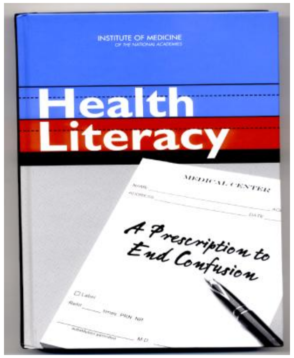
Cost of Low Health Literacy

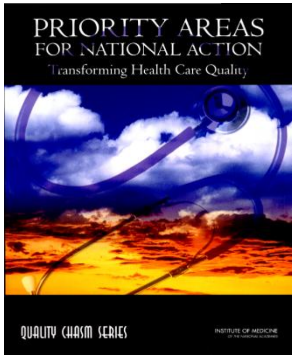
- US Health System*
  - $106 billion - $238 billion
- Attributed to:
  - Premature mortality
  - Avoidable morbidity
  - Racial, ethnic, & socioeconomic disparities in health & health care
  - Avoidable costs

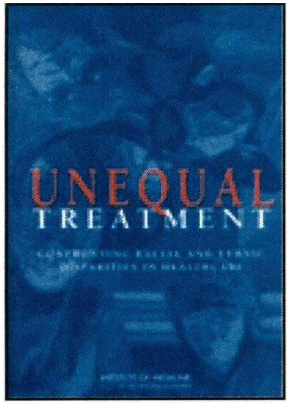
* Low Health Literacy: Implications for National Health Policy. Vernon JA, Trujillo A, Rosenbaum S, DeBuono B. 2007

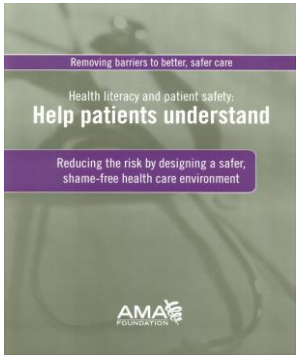
Health Literacy - Foundation

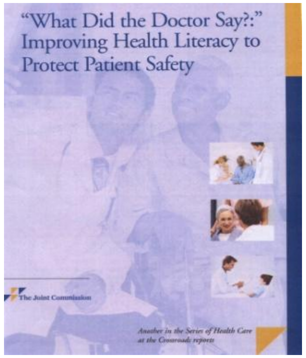
- "Health literacy is fundamental to safe, high-quality, patient-centered, equitable care" (IOM, 2004)











The Transforming Health Care System

- Affordable Care Act
- Value-based purchasing
  - Clinical quality measures
  - Satisfaction measures
- Quality Initiatives
  - Reducing Readmissions
  - Hospital-acquired conditions
- Accountable Care Organizations
- Medical Home
- Patient portals

The Challenge

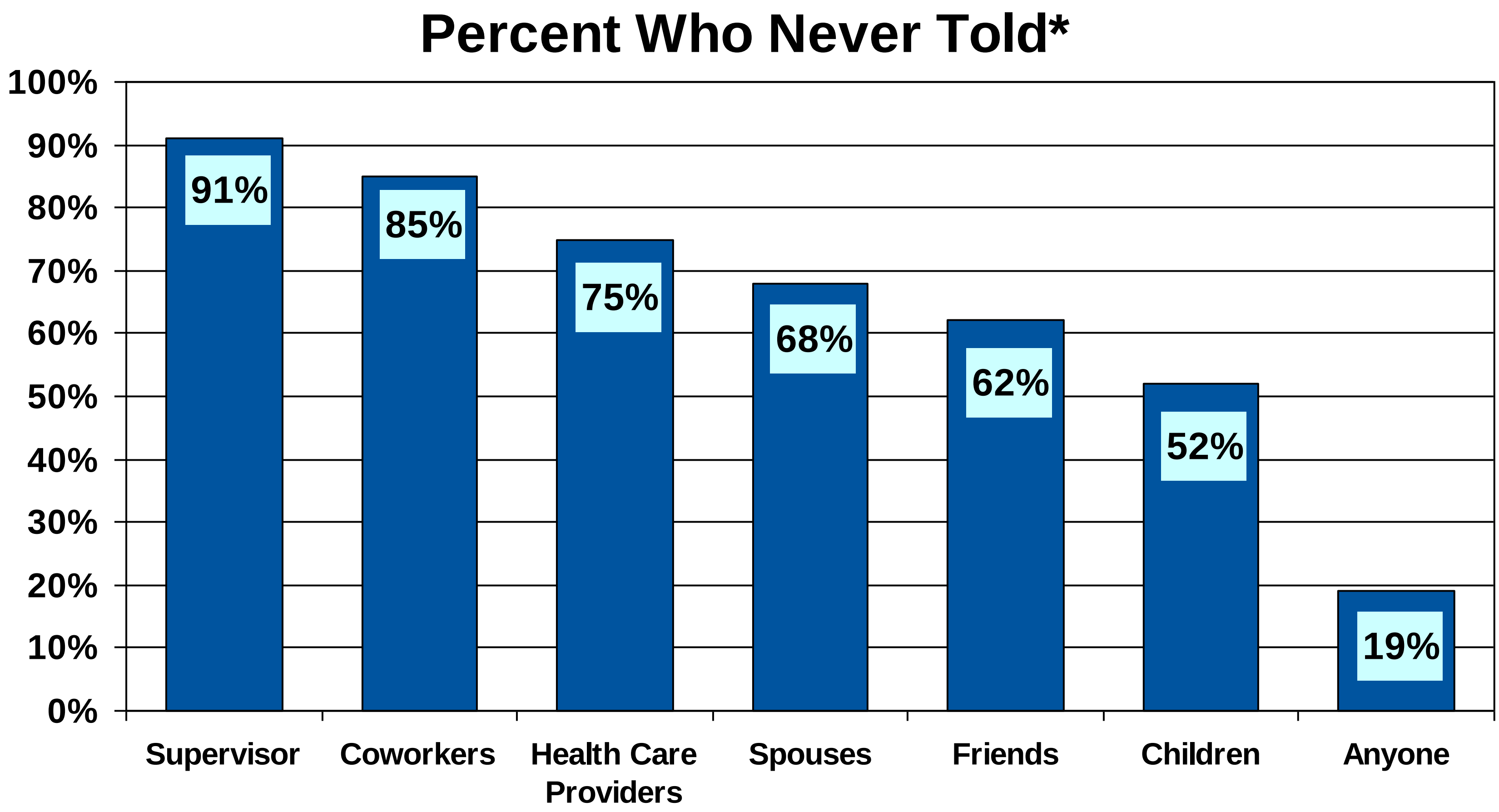
- Research shows patients remember and understand less than half of what clinicians explain to them.

Ley, Communicating with patients: improving communication satisfaction, and compliance 1988
Rost, Predictors of recall of medication regimens and recommendations for lifestyle change in elderly patients 1987

How Patients Feel

- Patients may have negative feelings and emotions related to their limited reading ability or limited understanding.
  (Institute of Medicine, 2004)
- The health care environment can make it hard for patients to tell us they don't read well or do not understand.
- They hide this with a variety of coping techniques.
  (Parikh, Pt Educ and Counseling 1996)

People may hide their limited reading ability



*Parikh, Pt Educ and Counseling 1996

Universal Communication Principles

- **Everyone** benefits from clear information.
- Use same clear communication tools for everyone, since you can't tell by looking if someone doesn't understand.
- Adequate general literacy does not ensure patient understanding in the clinical setting.

Reducing the Risk by Designing a Safer, Shame-Free Health Care Environment. AMA, 2007

Universal Communication Principles

- Conversations and interactions structured as though every patient may have limited health literacy.
- Clear communication practices and removal of health literacy barriers can improve care for all patients.

Health Literacy Universal Precautions Toolkit. AHRQ Publication No. 10-0046-EF, April 2010.

3 Strategies to enhance health literacy…

- Create a shame-free care environment that fosters communication and encourages questions.
- Improve interpersonal communication with patients and families, especially through teach-back.
- Use reader-friendly written materials.

Creating a shame-free, patient-centered environment…

- Attitude of helpfulness, caring, & respect
- Easy-to-follow instructions for appointments and follow-up
- Simple telephone processes
- Confidential assistance
- All staff recognize low literacy “red flags”
    - Skipped tests & referrals
    - Non-adherence
    - Difficulty explaining medical concerns
    - No questions

The Biopsy

- 90 yo man at follow-up derm appointment s/p biopsy
- New nurse in exam room: "You have cancer. We're going to remove the lesion."
- Physician:
  - It's cancer; I'm going to remove it.
  - Examined lesion; decides to refer for removal
  - Gives patient copy of pathology report
- Pt sends copy of report to relative, a pathologist who:
  - Explains report
  - Responds to patient's question about whether lesion should be removed affirmatively
- Pt waits 5 weeks for removal appointment
  - Continuous anxiety
  - Vacillates about whether to have lesion removed
  - Ongoing "consults" with pathologist relative

PATHOLOGY REPORT

DIAGNOSIS:

- Skin (right ear): Consistent with squamous cell carcinoma in situ arising in actinic keratosis (please see note)

- Note: The lesion extends to all margins of the specimen. The sections may not be representative of the entire lesion.

Insights

- What could have been done differently in this encounter to provide a patient-centered care environment that encouraged questions and fostered discussion?

Talking with Patients & Families

Always:

- Use Plain Language.
  - Slow down.
  - Use short statements.
- Focus on the 2 or 3 most important concepts—the "Need-to-Know"
- Check for understanding using **teach-back**.

Plain Language

- is clear
- uses only as many words as needed
- is not baby talk
- lets people focus on the message instead of the complex words

Adapted from: Eagleson, Australia
http://www.plainlanguage.gov/whatisPL/definitions/eagleson.cfm

Examples: Plain Language Alternatives

- Biopsy - Taking a small piece of tissue to examine to find out what is wrong
- Benign - Not cancer; new growth that doesn't go into the area around it or spread to other parts of the body
- Malignant - New growth that goes into the area right around it & spreads to other parts of the body
- Neoplasm - A new growth; can be benign or malignant
- Lesion - An abnormal growth on the body

Plain Language Alternatives

• Cells	- Tiniest parts that make up the body, only seen with a microscope; there are different kinds of cells for different parts of the body
• Metastasis	- Spread of a malignant growth to a place in the body beyond where it started
• Path Report	- Results of examining a biopsy to find out what's wrong
• Margins	- Edges of abnormal growth

Plain Language Alternatives

- Control
- Dysplasia
- Hyperplasia
- Hypertrophy
- Metaplasia
- Mucosa
- Necrosis
- Polyp
- Tumor

Example: Surgical Pathology Report

ORIGINAL - TECHNICAL:

A. GE JUNCTION, 35 CM, BIOPSY:
CHRONIC ACTIVE GASTRITIS WITH REACTIVE ATYPIA.

B. ESOPHAGUS, 33 CM, BIOPSY:
BARRETT'S ESOPHAGUS WITH LOW GRADE DYSPLASIA.

C. ESOPHAGUS, 30 CM, BIOPSY:
BARRETT'S ESOPHAGUS WITH CHRONIC ACTIVE INFLAMMATION, INDEFINITE FOR DYSPLASIA.

D. ESOPHAGUS, 32-34 CM, LESION, BIOPSY:
FRAGMENTS OF TUBULOVILLOUS ADENOCARCINOMA WITH HIGH GRADE
DYSPLASIA AND CHRONIC ACTIVE INFLAMMATION.

The Surgical Pathology Report

NEW – PATIENT-FOCUSED:

Your throat, esophagus, stomach, and intestines each have a lining. The linings are all different, and look different when we use a microscope.

A. This sample from near your stomach shows signs of irritation. It does not show cancer.

B. This sample from your esophagus (the tube that food goes down to your stomach) shows some mild changes that have a very low chance of turning into cancer.

C. This sample from your esophagus shows irritation and other changes that might get worse.

D. This sample from your esophagus shows irritation and other changes, but also cancer.

Insights

- What Plain Language principles do you see in the patient version of the surgical pathology report, compared to the technical version?
- What are the implications of giving a patient a copy of their pathology report without additional explanation, supporting information, or assessing understanding?

Need-to-Know vs. Nice-to-Know

- What matters to the patient
- Key information or actions

- More likely to remember
- Easier to come back to most important content later
- Complex biology/pathophysiology last, or not at all

Key Messages—the 2 or 3 most important points: The Colonoscopy

- 52 yr old woman with initial screening colonoscopy
  - Ascending colon, polypectomy: TUBULAR ADENOMA WITH HIGH GRADE MUCOSAL DYSPLASIA.
  - Transverse colon, polypectomy: TUBULAR ADENOMA.
  - Rectum, polyectomy: HYPERPLASTIC POLYP.
- These types of polyps are abnormal growths from the inside lining of the colon. Generally a polyp projects into the interior of the colon. Sometimes they can be flat. The cells which make up the polyp appear abnormal, and the type of abnormalities mean different things for the patient.

The Colonoscopy - 2

- Although some polyps are flat, many resemble a tadpole, with a head and a tail of varying length connecting the head to the colon's wall. A flat polyp is more likely to contain a malignant cell population.
- Some types of polyps represent the first step in developing malignant colon carcinomas. Not all polyps present a risk.

The Colonoscopy - 3

- The name of the polyp is determined by the types of cell changes seen on the slides. Cells have nuclei, where the cell's genetic material is located, and cytoplasm, the outer portion of the cell which contains other structures important in the cell's function. Nuclei are generally round to oval, with smooth outlines and a structure with evenly distributed clumps. Abnormal nuclei vary in size and shape, are generally larger, and have uneven sharp points inside. These changes are termed dysplasia. The distribution of the nuclei can vary, and sometimes nuclei are not located at the bottom of the cell but are found in several layers. Size of the polyp is also important in determining how much of a risk the polyp poses to a patient.

The Colonoscopy - 4

- Tubular adenoma polyps have abnormal nuclei and a structure where the cells form tubules. Some polyps have long finger-like projections, which are termed villi. Neither polyp A or B has villi, but polyps which do have them are more likely to have areas of malignant cells. Polyp B has dysplasia, but nuclear changes are less marked, more closely resembling normal nuclei. Polyps of this type are associated with development of colon cancer later. Tubular adenomas indicate that the colonoscopy should be repeated in five years, where hyperplastic polyps do not indicate any need for another colonoscopy.

The Colonoscopy - 5

- The polyp from the rectum, C, has normal nuclei, but the gland or tubule is abnormal, filled with mucus. These glands have a saw tooth appearance. These polyps are called "hyperplastic." They do not create any risk for colon cancer.

- The nuclei in polyp A are more abnormal. They are enlarged and appear to form layers, piled on one another. Nuclei of this kind can be seen in cancers. This is called "high grade dysplasia." This polyp is small, 1 cm, and the portion of the polyp with these abnormal nuclei is small and located well away from the point where the polyp was cut or burned free from the colon wall. Most doctors would repeat the colonoscopy within 3 years with a polyp with these changes. Some would stick with a repeat in 5 years, given the minimal amount of high grade dysplasia seen on the slides.

The Colonoscopy - 6

- In summary, you have a set of polyps with different implications for future development of colon cancer. None of them is malignant now or shows changes indicating that any further treatment is needed now. Repeat colonoscopy is needed in either three or five years to detect if any other polyps have developed, or sooner if any symptoms such as blood in the stool appear. If the colonoscopy is repeated depending on these findings, the risk of later developing colon cancer is reduced 90% at three years, 84% at six years, and 76% at seven years.

The Colonoscopy: 3 Key Messages

- You have 3 kinds of polyps. 2 of them mean you have a higher chance of getting colon cancer in the next 3 to 5 years.

- You need to talk with your doctor about what to do, and plan to have another colonoscopy in 3 to 5 years to check for more polyps or early cancer. Your doctor will also have you check for blood in your stool.

- By doing this, you lower your chances of getting colon cancer. Or, if you do get colon cancer, you have a good chance of catching it early when it can be cured.

Insights

- What differences related to Plain Language do you see between the original and revised discussion points?
- What are some strategies to help frame key messages and make sure patients understand?

What Is *Ask Me 3*?

- Promotes three simple, but essential, questions and answers for every healthcare interaction:

  What Is My Main Problem?

  What Do I Need To Do?

  Why Is It Important For Me To Do This?

- Promotes clear communication between patients and providers to improve health outcomes
- Providers' goal should be for patients/parents to know the answers before leaving

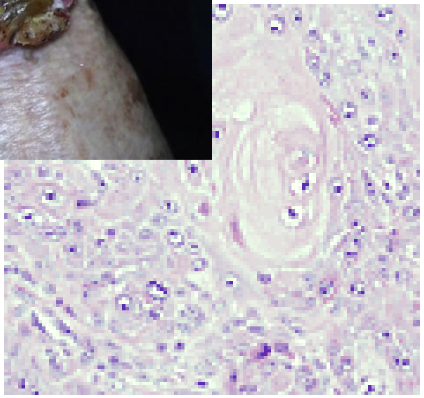
www.npsf.org/askme3/

Example: "You have cancer…"

Path report given to patient:

"Consistent with squamous cell carcinoma in situ arising in actinic keratosis"

- What is squamous cell carcinoma?
- What is actinic keratosis?
- What do I need to do?
- What does this mean for me?



Teach-back

- Asking people to explain **in their own words** what they need to know or do, in a friendly way
- **NOT** a test of people, but of how well ***you*** explained a concept.
- A way to check for understanding and, if needed, re-explain the information, then check again.

Teach-back

Evidence:

- "Asking that patients recall and restate what they have been told" is one of 11 top patient safety practices based on strength of scientific evidence.

  (AHRQ, 2001 Report, Making Health Care Safer)

- Physicians' application of interactive communication to assess recall or comprehension was associated with better glycemic control for diabetic patients.

  (Schillinger, Arch Intern Med, 2003, "Closing the Loop")

Asking for a Teach-back - Examples

- “I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?”
- “It’s important that you understand what your choices are for following up on these results. I want to be sure I explained them well. Could you please list them back for me, in your own words, so I can be sure I was clear?”

Asking for a Teach-back - Examples

- “What will you tell your husband about the results of your biopsy?”
- “You’ve had a big shock today, and your family will have a lot of questions. I want to be sure I was clear when I explained your results, so you feel comfortable talking with them. To make sure, can you please go over what we discussed, using your own words?”

Teach-back – Using it Well

- Caring voice & attitude
- Plain Language
- Assume responsibility
- Ask people to explain using their own words, not yes/no questions like:
    - "Do you understand?"
    - "Do you have any questions?"
- Explain again and re-check, as needed
- 1 topic at a time

The INR…

- 64 yo man on warfarin
- INRs stable (2.3-2.4) for several months
- This month's result 4.5
- Patient doubts result, complains to receptionist, & pathologist talks with him

"I'm always in the expected range. I already take aspirin. Why did it change so much? Why do I need 2 medicines?"

- Warfarin is different from aspirin.
- Warfarin prevents clots in slow-moving blood.
- Aspirin prevents clots in vessels with faster-moving blood.
- Warfarin helps keep you from having a clot that could go through your bloodstream to your brain, and cause a stroke.
- That's why you need both.

Why is my INR so different all of a sudden?

- Warfarin works by interfering with Vitamin K.
- Your body uses Vitamin K to help your blood clot.
- The amount of Vitamin K is different in different kinds of food.
- Lots of drugs affect how much warfarin you have in your blood, even if you take it regularly.

Resolution

- Patient remembered he had started taking herbal medicine with Ginkgo Biloba
  - This can make warfarin blood levels go higher.
- Stopped herbal medicine
- INR back to previous level in 2 weeks

Teach-back

- I want to be sure I answered your questions clearly. What will you tell your wife about why your INR was high this time?

- Let's make sure you know what to watch for so this doesn't happen again. Please go over 3 things you plan to look out for so your INR stays in the right range.

Insights

- What health literacy-related techniques did the pathologist use when talking with this patient?
- How does teach-back "close the loop" in health communication?
- What can happen if we don't assess for and ensure understanding?

Written Materials for Patients & Families: Barriers to Effectiveness

- Lack of familiarity → misunderstand health terms
- Mismatch between reading ability & reading level of material
- Too much information
- Text density
- Distractions/Impairment: worry, busy, sleep-deprivation, illness, pain, altered mental status
- Sometimes not used at all

Reader-Friendly Print Materials: Principles

- Content
  - Need-to-know
  - Key points
  - Minimize anatomy & physiology
- Layout & Design
  - Font & readability
  - Spacing & alignment
  - Organization
  - Visuals

Application: A Health Literacy-Based Consent

Consent for Surgery or Procedure

- Please **read** the form.
- **Ask** about any part you do not understand.
- **Be sure** you have your questions answered **before** you sign this form.
- When you **sign** it, you are giving us permission to do this surgery or procedure.

I, ____________________(patient's name) agree for Dr. ________________along with any assistants the doctor may choose, to do this surgery or procedure on me at__________(facility):

____

____

____

Name of surgery or name of procedure in medical words – including left, right or level
(Doctor or health care worker fills this out)

____

Name of surgery or name of procedure in my own words
(What the patient or family says back to the doctor or health care worker – quote patient or family)

1. I understand that my doctor may find other medical conditions he/she did not expect during my surgery or procedure. I agree that my doctor may do any extra treatments or procedures he/she thinks are needed for medical reasons during my surgery or procedure.
2. I understand I may be given medicine to put me to sleep, make parts of my body numb, or help control pain. People with special training will give this medicine. These people may be an anesthesiologist, a nurse anesthetist (CRNA), a nurse, or the doctor doing my surgery or procedure.
3. I understand the doctor may remove tissue or body parts during this surgery or procedure. If it is not used for lab studies or teaching, it will be disposed of, as the law requires.

Turn Page Over

4. I understand pictures or video of my surgery or procedure may be taken, if my doctor thinks it is needed for medical reasons.
5. I understand someone may watch or help with my surgery or procedure for medical teaching. These people are usually medical or nursing students. A technical advisor may watch if my doctor thinks one is needed.
6. I understand that **<u>if my doctor thinks I need blood</u>** for medical reasons, **<u>it will be given.</u>**

I understand and my doctor has told me:

- What I am having done and why I need it.
- The possible risks to me of having this done.
- What might happen to me if I don't have it done.
- What other choices I can make instead of having this done.
- What can happen to me if I choose to do something else.
- What can happen to me if I choose no treatment.
- That there is no guarantee of the results.

Be sure you have your questions answered **before** you sign this form

I give my permission for this surgery or procedure.

Sign Here → ______________________
Patient's Signature

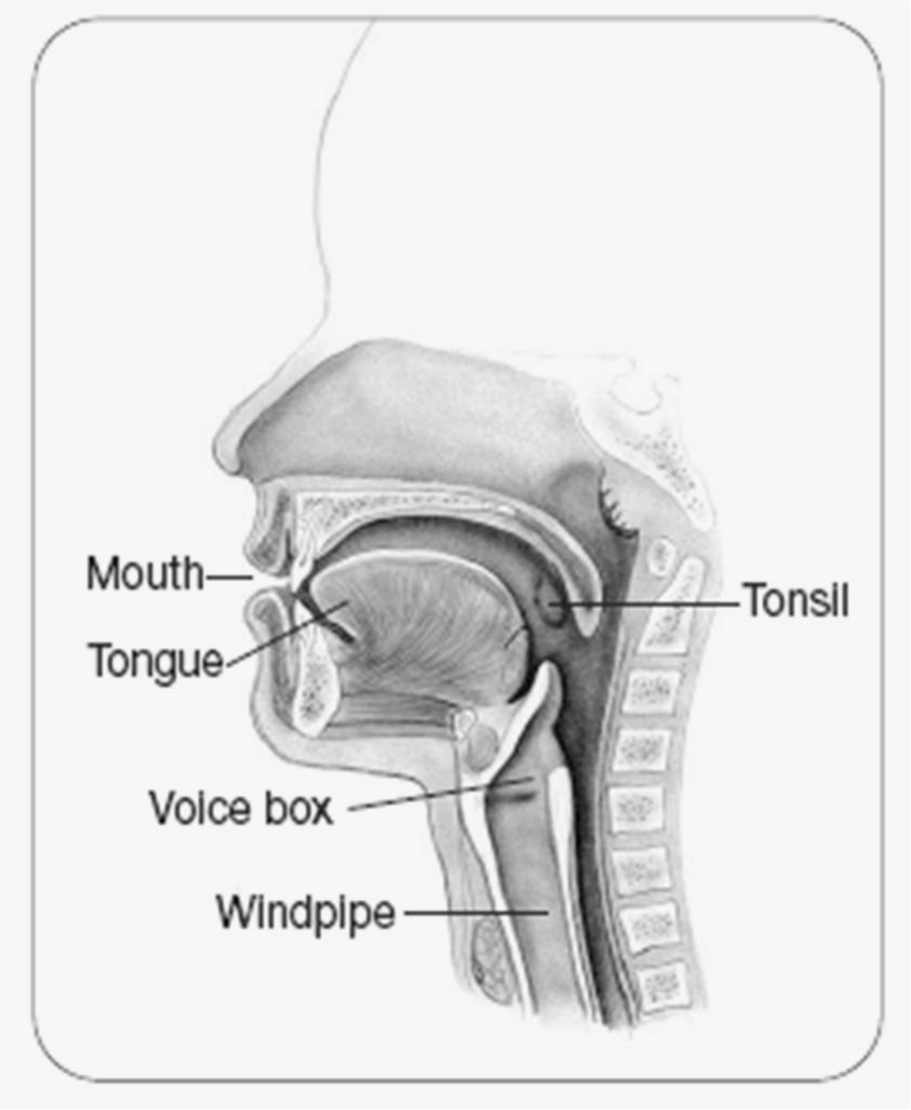
__________ Date/Time
______________________ Witness to Signature

Section for a Patient who is a minor, or is not legally able to sign. Signature is from a person who has legal rights to consent for the Patient.

______________________ Signature of Person

______________________ Legal Consent Relationship

__________ Date/Time
______________________ Witness to Signature



American Academy of Pediatrics. *Plain Language Pediatrics*, 2009

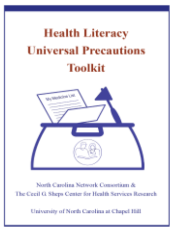
Objectives

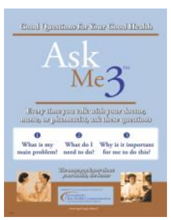
- Define health literacy & explain its role in high quality, safe, patient-centered care, & the transforming health care system
- Recognize barriers that impede & opportunities to improve patient-pathologist communication
- Begin implementing health literacy-based strategies to improve communication with patients & families in your practice setting

Get Started…

- Watch for communication mismatches
- Focus on patient & family perspective
- Talking Tips:
  - ~3 need-to-know messages
  - Plain language
  - Teach-back
  - Reader-friendly print materials
- What can you do by Tuesday?

To Learn More





MyBiopsy

- AMA Health Literacy Toolkit
  - http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health.page?
- AHRQ Health Literacy Universal Precautions Toolkit
  - http://www.ahrq.gov/qual/literacy/
- Ask Me 3
  - www.npsf.org/askme3/
- Information Rx
  - http://www.informationrx.org/
- MyBiopsy
  - www.mybiopsy.org

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- **New Readers of Iowa**

Next in the Series of Free PHC Webinars

- **The Why, What and How of Identifying Patients at Risk**, **Thursday, September 8th, 10:00-11:00 am CT**
  - Alexis Carter MD, FCAP
- Go to www.cap.org/institute For All Upcoming Webinars!
- Past Webinars Available Now Online at www.cap.org/institute
  - Next-Generation Sequencing for the Clinical Laboratory
  - Accountable Care Organizations
  - Whole Genome Analysis as a Universal Diagnostic
  - How to Build and Fund a Financially Viable Molecular Lab
  - Cancer: The Critical Role of Pathology
  - Molecular Markers in Breast Cancer
  - Bethesda System: Integrating Cytology and HPV Molecular Testing

CAP Events of Interest

- Don't Forget to Register for CAP'11 – THE Pathologists' Meeting – September 11 – 14, 2011 held at the Gaylord Texan in Grapevine, Texas!

  – Go to www.cap.org/CAP11 or call 1-800-967-4548. International attendees please call 1-847-996-5891.

For more information go to www.cap.org/CAP11

Tuesday, Sept 13th:

TP120 Breakfast Workshop – Hot Topics in Pathology: What Every Community Pathologist Should Know About Clinical Requests for Molecular Tests (6:30-7:45 am)
Faculty--Samuel K. Caughron, MD, FCAP
Frederick L. Kiechle, MD, PhD, FCAP
Michael S. Brown, MD, FCAP

ST109 Companion Diagnostics for Targeted Therapy in Cancer (2:00-5:30 pm)
Faculty--Sanja Dacic, MD, PhD, FCAP
David Hicks, MD, FCAP
Jeffrey Kant, MD, PhD, FCAP

Wednesday, Sept 14th:

ST110 Direct-to-Consumer Genetic Testing: Staying Ahead of Patients in This Current Trend (8:00-9:00 am)
Faculty--Nazneen Aziz, PhD
Elizabeth A. Mansfield, PhD

ST111 What's in It for Me? Using Technology to Become a Diagnostic Hero (8:00-11:30 am)
Faculty--Kenneth J. Bloom, MD, FCAP
John W. Turner, MD, FCAP

For more information go to www.cap.org/CAP11

Tuesday, Sept 13th:

FP100 The Best of Futurescape (9:00-11:30 am)
Faculty—Wayne W. Grody, MD, PhD, FCAP
Michael Laposata, MD, PhD, FCAP
Cindy L. Vnencak-Jones, PhD

Wednesday, Sept 14th:

ST112 CAP Foundation Keitges Program on Medical Ethics: Genetic Testing in Late Onset Autosomal Dominant Disorders (1:00-3:00 pm)
Faculty—Kimberly A. Quaid, PhD
Gail H. Vance, MD, FCAP