

Section 3.8 Design

Approaches to Patient Communications

This tool identifies the types of communications a care coordinator (CC) and other health care staff and practitioners will have with patients in a community-based care coordination (CCC) program. It also provides links to scripts, brochures, documentation aids, and other tools that help in conducting and documenting patient communications.

Time required: 2 hours

Suggested other tools: CCC Program Workflow; Care Coordinator Sample Job Description; Establishing the Care Team: Roles and Communications

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How to Use

1. **Review** the Overview of Communications, Communication Channels, and Communication Strategies sections in this tool.
2. **Reflect** upon how each of the types of communications may take place, with whom, and when. Note those where additional research or understanding may be helpful.
3. **Identify** and address any gaps that may exist in the CCC program with respect to the following resources:
 - a. Sources of data to prepare for communication with patients
 - b. Support for documenting communications with patients

Overview of Communications

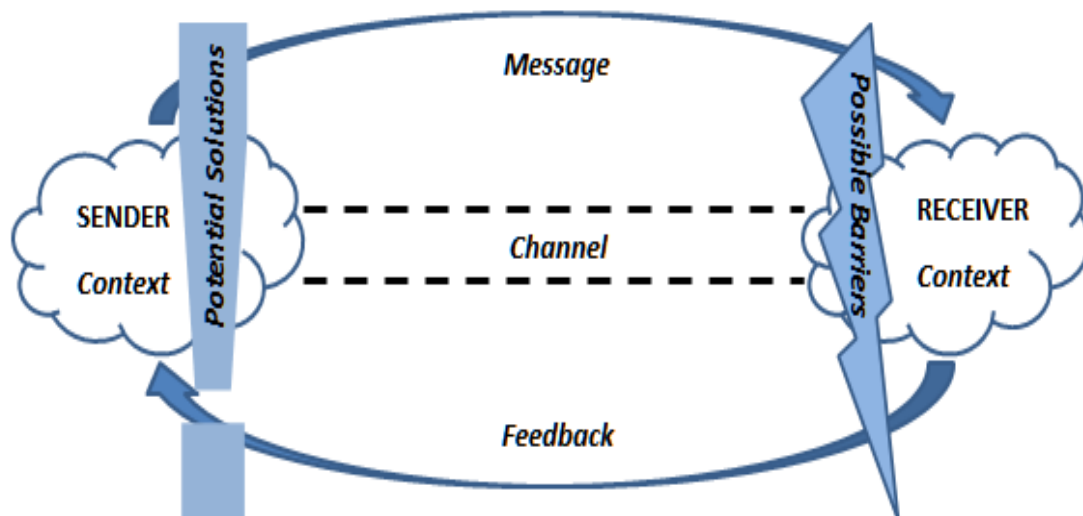
While communication is something we tend to take for granted, we also recognize that effective communications are not always easy to achieve. Sometimes it can be helpful to reflect upon barriers to effective communications and what strategies may mitigate some of these. This is especially true when coordinating care for patients who are generally older with multiple chronic diseases and potentially other lifestyle challenges.

Communication Model

The following communication model is derived from classic works of Berlo, Shannon and Weaver, widely recognized as pioneers in the study of communication.¹ Fundamental to every communication is the inclusion of at least two parties – a *sender* and a *receiver*; a *message* that the sender wants to have received by the receiver; and a *channel* through which the message is sent. The goal of communication is for the receiver to understand and generally act upon the contents of the message.

While there always is feedback available from the receiver to the sender (ranging from an obvious need for clarification or other immediate reaction to latent action or inaction), senders do not always have the opportunity to receive the feedback to determine what possible barriers are making the message less effective, and to quickly attempt to improve upon the communication.

In addition, *feedback* is also a form of message which the receiver may not effectively communicate to the sender, or the sender may have barriers blocking receipt. Possible barriers and potential solutions often reside within the context in which the sender and receiver exist. Once the structures associated with communications are dissected in this manner, it becomes obvious that effective communication is actually a highly complex process that is not always easy to improve upon.



Communication barriers may arise out of the choice of channel with which the communication is conducted and the context in which the message is delivered and received.

Communication Channels

Communication channels typically used in care coordination include:

- **In-person discussions:**
 - In a meeting specifically arranged for care coordination (which may take place in a provider setting or patient's home)
 - During a patient encounter (in the clinic, hospital, nursing home, other provider setting, or patient's home)
- **Telephone calls:**
 - Initiated by the care coordinator
 - Initiated by the patient
- **Written communications via:**
 - Paper distributed in person
 - Paper sent through the mail
 - Downloadable material from a website
- **Electronic communications**
 - Secure electronic mail system
 - Electronic chat system (text or video)
 - Electronic monitoring systems
 - Social media

Feedback Challenges

The nature of the communication channel can present challenges in receiving feedback:

- In-person discussion is often considered the most effective for receiving immediate feedback, although it is also the most time-consuming and costly (for both the provider and patient). Not only can active acceptance or resistance be identified, but body language can be read and further probing can be performed through additional questioning, teach back strategies, and other techniques.
- Telephone encounter is generally the next best option. The sender must concentrate on cues for feedback, such as pauses, changes in speech patterns and pitch, change in breathing patterns, or strategies deployed by the receiver to cut the conversation short.
- Written communications are very effective follow up communication channels, but should not be relied upon as the sole means of communication for important messages.
- Electronic communications are increasingly being used, even by the elderly or their family/ caregivers.² These should not be discounted as an effective means to both convey and obtain feedback or to help a person find a support group (via social media). Research suggests that electronic communications about sensitive matters, such as reporting on alcohol or substance use, depression, suicidal thoughts and others, are more effective than in-person or telephone communications.³ Alternatively, too much computer use can lead to depression, so encouraging the right balance is important.⁴

The most important lesson is to recognize that each type of communication channel has important uses, with both pros and cons. It is the care coordinator's challenge to find the most effective mix of channels with which to communicate with each patient – and one size does not fit all!

Communication Context

Context of the communication includes both the physical environment of the sender and receiver, and personal characteristics of the sender and receiver.

- **Physical environment** factors include who is present during the communication and physical distractions.
 - *Who is party* to the communications may be limited to only the sender and receiver, or may include multiple parties. For example, the care coordinator may have another member of the health care team present during a communication. The patient may wish to have one or more family members and/or a caregiver present. Either party may introduce a language interpreter. Some activities may be conducted in a group setting where there may be multiple senders (e.g., care coordinator, provider, community resource representative, therapist, others) and receivers (other patients with common interests, such as those receiving education on diabetic diets or tobacco cessation).
 - *Physical distractions* can include any number of things, such as construction noise outside of the examining room in the clinic where the communication is taking place, a television program of interest to the patient that is drawing attention away from a conversation, poor telephone reception, or noisy grandchildren in the same room. Minimizing physical distractions is the task of the care coordinator. For example, it may be necessary to move to another room (in the clinic or in the patient's home), turn off the television, or schedule an in-person visit if there is no alternative telephone capability.
- **Personal characteristics** of both the sender and receiver are important context factors to recognize and find ways to accommodate.
 - Care coordinator:
 - The care coordinator's voice may not be loud enough or with too high a pitch for someone with hearing loss to hear well. It may be necessary to sit closer, increase volume on a telephone, or ask the patient what other assistance can be provided.
 - Language, dialect, and choice of words may be inconsistent with the patient's education level, or what a patient is accustomed to. Some of these can be altered by the care coordinator, such as using lay terms that are more familiar to the patient.
 - Information processing issues may present in several different forms:
 - *Information overload* is one of the most common – in which the care coordinator may believe it necessary to repeat important information and results in providing too much information or the information becomes confusing. Gauging the patient's level of understanding through observation, teach back, and other strategies helps overcome overload. Many patients complain they get conflicting information from different providers or at different times. Providing patients with written material also can help. This can include handwritten notes or checklists that are easily accessible to the care coordinator and patient.

- *Information filtering* is also common in health care: invalid assumptions can be drawn from information received. For instance, a care coordinator may ask the patient why a special diet is difficult for the patient. If cost of food is the first thing the patient states, that may suggest to the care coordinator the need to provide a list of low cost ingredients. While in reality, the cost burden is due to restaurant meals! Being mindful of “jumping to conclusions” too early and probing for additional information can help overcome the tendency to filter information.
 - *Too little information* may result from too little time, not wanting to scare the patient, or the care coordinator not knowing what to suggest in a given situation. Taking the time to get to know the patient and “reading” the patient’s reactions will help determine if more is needed. If additional information cannot be provided when necessary, arrange for another opportunity to discuss further. Make sure that the patient understands how the information presented relates to previous information given.
- Patients exist within an environment that can be highly complex. Such contextual issues may be due to various causes, and manifest in various ways.
 - **Causes of barriers** may include:
 - Age, gender, race/ethnicity, language, cultural background, and education are all *contextual factors* that can be barriers to effective communications. Care coordinators may want to take a diversity training program that provides a comprehensive set of potential solutions for these contextual issues.⁵ As a first step, simply being mindful of the potential for such barriers is a critical step toward mitigation.
 - *Health beliefs, health values, and perceptions* vary among individuals, and may or may not be related to the above contextual factors. For example, some people have a higher tolerance for pain than others. There may be underlying causes for why some patients are willing to do certain things about their health condition while others are not. Some of these may be simple to solve and others may have to be accepted by the care coordinator as a variance, and recognized in subsequent care planning.
 - **Manifestation of barriers** may occur as:
 - *Passiveness*, which is often a difficult manifestation to recognize as a barrier. The patient may be silent, say little, or even appear to be accepting of a communication but will not take desired action. Frequent communications with emphasis on obtaining feedback – in many forms – is necessary. Earning the patient’s trust is essential.
 - *Defensiveness*, which is an obvious manifestation, sometimes making it easier to address. Care coordinators should be aware that patients can be defensive and still will take the desired action because the initial defensiveness is simply a part of the change process for them. Showing respect and empathy for the patient while soliciting feedback and negotiating how the action can be taken is important.

- *Acceptance-modification*, which is a strategy that some persons use to manipulate another, especially if there is the perception of untoward consequences that may result from being negative toward a message. For example, the patient may agree to walk for 20 minutes and then document on their exercise diary that they walked 20 minutes because that is the amount of time they estimated they walked around the house throughout the entire course of the day. Sometimes a care coordinator can spot this strategy when a person who has not been compliant with other treatment regimens agrees too quickly to doing something, or is vague about how they will do it. Explicit instructions and gaining written agreement on the patient's action plan can help, but constant follow up, monitoring, and feedback are necessary – all performed in a helpful and caring and not accusing manner.

Communication Strategies

Several examples of potential solutions to overcoming barriers have been offered in the discussion above. The following summarizes these and provides additional resources.

- **Tone** – From the first words spoken, a respectful, warm, and empathetic tone go a long way to overcoming perceptual barriers and even differences in values. Letting frustration or anger show during tense communications is feedback from the sender to the receiver that is a powerful negative and difficult to overcome. The following links offer a variety of insights, each in their own way helpful.
 - *Communicating with Dignity* from the Royal College of Nursing is an interactive tool to visualize the impact of verbal and non-verbal communications. Available at: http://www.rcn.org.uk/development/practice/cpd_online_learning/dignity_in_health_care/communicating_with_dignity
 - *The Expression of Emotion through Nonverbal Behavior and Medical Visits* is a scholarly work focused on physician communication, but compelling for all health care workers. Read it and pass it along to providers! Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484830/pdf/jgi_306.pdf
 - *Is Your Tone of Voice Professional?* This is a lighter take on modulating your tone of voice with posts of interesting comments. Available at: <http://www.communicationdiva.com/is-your-tone-of-voice-professional/>
- **Truth** – Closely related to information filtering, ensuring communications are truthful is an important way to overcome communication barriers. The title of an article published in *Palliative Medicine* may say it best: “*Truth may hurt but deceit hurts more: communication in palliative care.*” Free abstract is available at <http://pmj.sagepub.com/content/16/4/297.abstract>. There are many scenarios, however, in which how much of the truth should be told, when, and to whom may be debated. The following references offer some interesting insights and case studies:
 - *Telling the Truth to Patients and Relatives* offers insights and suggestions, especially from the perspective of psychiatry. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738366/>

- A companion to the above article, *The Doctor's Dilemma: Truth Telling*, offers views on the truth telling dilemma in health care. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738333/?report=printable>
- *Truth-telling and Withholding Information* from Ethics in Medicine, University of Washington School of Medicine, provides practical tips to common dilemmas, along with two case studies. Available at: <http://depts.washington.edu/bioethx/topics/truth.html>
- **Trust** – Trust goes hand-in-hand with truth. There is a growing body of research and resulting evidence that trust relations in health care are changing and have a direct correlation with patients' willingness to seek health care. The following two articles make the case for building a trusting relationship with your patients:
 - *Trust Relations in Health Care – The New Agenda* makes the case for trust and how to nurture trust. Available at: <http://eurpub.oxfordjournals.org/content/16/1/4.full.pdf>
 - *Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults* offers insights not only into trust issues but with racial/ethnic sensitivity. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696665/>

But getting patients to trust you enough to reveal their inner-most thoughts and fears is more than just telling the truth. It is a matter of becoming trustworthy. One way to learn how to become more trustworthy in the eyes of your patients is to study those whom you trust and do not trust. Observe what the people you trust do differently than the people you don't trust. The following are two short articles from those who are building or helping others build trust.

- *How to Make Someone Like and Trust You in 60 Seconds or Less*, from an ophthalmologist. Available at: <http://carolynandersonmd.com/blog/how-to-make-someone-like-and-trust-you-in-60-seconds-or-less>
- *Building Trust: 5 Tips to Enhance Your Patient Relationships* from a patient advocate training professional. Available at: <http://www.patientadvocatetraining.com/news/63380/Building-Trust-5-Tips-to-Enhance-Your-Patient-Relationships.htm>
- **“Trust but verify”** – These well-known words are vitally important in health care. In fact, it is as important for a patient to trust the health care professional as it is for the health care professional to trust the patient. So, taking the temperature of what your patients are telling you – in a way that does not reduce their trust in you – is a skill well learned. The following references offer some thoughts:
 - *Is There a Moral Duty for Doctors to Trust Patients?* from the Journal of Medical Ethics is readable discussion of the importance of trust, barriers, and how to build mutual trust. Available at: <http://jme.bmj.com/content/28/2/77.full.pdf+html>

- *Physician-Patient Relationship* is another article with practical advice and case studies from Ethics in Medicine, University of Washington School of Medicine. Available at:
<http://depts.washington.edu/bioethx/topics/physpt.html>
- **Token** – In keeping with this list of “T” strategies to overcome communication barriers, token may be a good way to express an indication, proof, or reminder of a small success. It cannot be expected that chronically-ill patients will completely recover from all of their illnesses. But it can be expected that the quality of their lives can improve (as the quality and cost of care improve). It is important to acknowledge small successes and motivate patients to keep making forward progress.

“Motivational interviewing” is a counseling approach made popular by clinical psychologists William R. Miller, PhD and Stephen Rollnick, PhD. The technique is non-judgmental, non-confrontational, and non-adversarial, and is designed to guide a person’s awareness of potential problems caused by their behavior and to elicit and strengthen motivation for change. While initially used with problem drinkers, the technique has been found to improve the likelihood of making many different kinds of lifestyle changes. Additional information and scripts that can be used to conduct motivational interviewing may be found in the following Web sites and documents:
 - [Motivationalinterview.org](http://www.motivationalinterview.org) is a website dedicated to using motivational interviewing techniques, primarily for substance abuse patients:
<http://www.motivationalinterview.org/>
 - *Using Motivational Interviewing Techniques in SMART Recovery* (Jim Braastad) is a distance training program for those with any form of addiction. The tips and scripts included, however, can be helpful for motivating any form of lifestyle change. Available at:
<http://www.smartrecovery.org/resources/UsingMIinSR.pdf>
 - *Motivational Interviewing Strategies and Techniques: Rationales and Examples* (Sobell and Sobell, 2008) provides additional examples of scripts to motivate change. Available at:
http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf
- **Teach-back** – Teach-back is a technique to confirm that you have explained to the patient what they need know in a manner the patient understands. Instead of asking, “Do you understand the instructions I’ve just given you?” the teach-back approach suggests you ask patient to explain or demonstrate how they will undertake a recommended treatment or intervention. If the patient does not explain correctly, re-teaching the information using alternative approaches is performed until the patient is able to explain the process or show you how he or she would perform the task. Teach-back has been found to be highly effective in reducing avoidable readmissions:
 - *The Implementation Guide to Reduce Avoidable Readmissions from the Health Research & Education Trust (HRET)* describes the teach-back

- process, and provides information on identifying high risk patients, developing self-management skills in patients, and strategies for coordination of information across the health care continuum. Available at: http://www.dcha.org/wp-content/uploads/readmission_changepackage_508.pdf
- *Teach-back* is effective not only in reducing readmissions but improving outcomes, such as for diabetics, asthmatics, and other patients who must perform a significant amount of self-management. The North Carolina Health Literacy program offers a tip sheet for quickly learning the teach-back technique. Available at: <http://www.nchealthliteracy.org/toolkit/tool5.pdf>
- Teach-back is part of the Agency for Health care Research and Quality (AHRQ) *Health Literacy Universal Precautions Toolkit*. Available at: <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>
- The University of Arkansas for Medical Sciences has produced videos on *health literacy* administered by the University's Center for Rural Health. They are viewable at: <http://ruralhealth.uams.edu/health-literacy/videos>
- **Tell vs. Engage** – Patient engagement, self-management, and shared decision making are strategies to engage the patient in conversation, management, and decision making about their health and health care. There is strong evidence that these strategies improve the quality, cost, and patient experience of care (the Triple Aim⁶ of health care):
 - Patient engagement is defined in *A New Definition of Patient Engagement: What is Engagement and Why is it Important?* from the Center for Advancing Health, 2010, as “Actions individuals must take to obtain the greatest benefit from the health care services available to them.” Available at: http://www.cfah.org/file/CFAH_Engagement_Behavior_Framework_current.pdf
 - *Patient Engagement*, Health Affairs, February 2013, describes the evidence that demonstrates patients who are more actively involved in their health care experience have better health outcomes and incur lower costs. Available at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86
 - *National eHealth Collaborative Patient Engagement Framework* outlines specific strategies to engagement patients. Available at: http://himss.files.cms-plus.com/HIMSSorg/NEHCLibrary/HIMSS_Foundation_Patient_Engagement_Framework.pdf
 - *Patient Engagement Toolkit*, KHA REACH, provides a variety of tools for providers and patients. Available at: <http://www.khareach.org/patient-engagement-portal>

- Patient self-management is defined as “the decisions and behaviors that patients with chronic illness engage in that affect their health” in *Patient Self-Management Support Programs: An Evaluation from the Agency for Health care Research and Quality*, November 2007. This resource also describes four models of self-management support and provides case studies and effectiveness measurement methods. Available at: <http://www.ahrq.gov/research/findings/final-reports/ptmgmt/ptmgmt.pdf>
- Shared decision making (SDM) is considered a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available and the patient’s values and preferences. It honors the provider’s expert knowledge and the patient’s right to be fully informed of all care options and potential harms and benefits.
 - Mayo Clinic Shared Decision Making National Resource Center provides decision aids, publications, videos, and other resources on SDM. Available at: <http://shareddecisions.mayoclinic.org/>
 - Minnesota Shared Decision Making Collaborative (<http://msdmc.org/>) also provides a variety of resources, including PowerPoint presentations for providers and patients and a Shared Decision-Making Implementation Roadmap. Available at: <http://msdmc.org/pdf/MSDMCRoadmap.pdf>

Source of Data and Documentation

In order to prepare for any communication with the patient, the care coordinator should review applicable information about the patient from a variety of primary sources, including the patient’s clinical summary (ideally in electronic form, but if not available, as may be provided via clinic notes, referral report, and discharge summary), the EHR (with various health risk assessment templates, or paper-based health records and forms as applicable), diagnostic study reports, patient health diaries, home monitoring devices, patient’s personal health record (PHR) and other information. Although an intake form may be used during the initial encounter, it is advisable to use these primary resources.

The primary means of documentation of all communications should be the EHR (or paper-based health record as applicable). Appointments should be documented on the care coordinator’s schedule, and ideally posted through registry functionality of the EHR or a free-standing registry. Secondary documentation may need to be made in other databases, such as those for the provider and community resource directories. It may be appropriate for the care coordinator to review the technology currently available in order to plan use of specific sources of data and documentation types. (See *Technology Tools and Optimization for CCC*.)

References

¹ For an excellent outline of basic concepts related to the communication model, see <http://www.comprofessor.com/2009/10/i.html>

² See a list of reports chronicling the growing online health care revolution at: <http://www.chcf.org/publications/2013/01/pew-survey-online-health>

³ See as an example: Lawrence, S.T. et al. *Routine, Self-Administered, Touch-Screen, Computer-based Suicidal Ideation Assessment Linked to Automated Response Team Notification in an HIV Primary Care Setting*, *Clinical Infectious Diseases*, 2010; 50:1165-1173. Available at: <http://cid.oxfordjournals.org/content/50/8/1165.full>

⁴ See as an example: Stone, J. *Mental Health Negatively Affected by Excessive Cellphone and Computer Use: Study*, *International Business Times*, July 22, 012. Available at: <http://www.ibtimes.com/mental-health-negatively-affected-excessive-cellphone-and-computer-use-study-730100>

⁵ For a good overview, see: *Cultural Diversity and Competency Considerations for Health Care*, VHA Office of Rural Health. Available at: www.diversity.va.gov/training/files/cultural-competency.ppt

⁶ The Triple Aim is a framework developed by the Institute for Health care Improvement (IHI) that describes an approach to optimizing health system performance. It has been adopted by the Centers for Medicare and Medicaid Services (CMS) in its Innovation Center. Available at: <http://www.ihl.org/topics/tripleaim/pages/default.aspx>

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For support using the toolkit

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