Effective Communication Strategies for Strengthening Patient-Clinician Relationships in Safety Net Settings

August 29, 2017
Webinar Reminders

1. Everyone is muted.  
   • Press *7 to **unmute** and *6 to **mute** yourself.

2. Remember to chat in questions!

3. Webinar is being recorded and will be posted and sent out via email
## Today’s Focus

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<th>Time</th>
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<tr>
<td>11:00 – 11:05 AM</td>
<td>Introduction to Webinar and Faculty</td>
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| 11:05 – 11:35 AM | • Overview of Webinar Objectives & FAQs  
|               | • Eliciting Patient Narratives, Vulnerabilities & Resilience          |
| 11:35 – 11:45 AM | • Overview of Health Communication Literature  
|               | • Skills Covered in Sept. 7 Workshop                                   |
| 11:45 – 11:55 AM | FAQ Session                                                             |
| 11:55-12:00 PM | Closing                                                                 |
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Today’s Presenters

Dean Schillinger, MD
UCSF Professor of Medicine in Residence
Chief, Division of General Internal Medicine
Director, Health Communications Research Program
UCSF Center for Vulnerable Populations @ SF General Hospital

Richard M. Frankel, PhD
Professor of Medicine and Geriatrics
Indiana University School of Medicine
Indianapolis, Indiana USA
Professional Staff
Education Institute
Cleveland Clinic
Webinar Objectives

1. Recognize the importance of eliciting the patient’s narrative, assessing for vulnerabilities and identifying points of resilience
2. Identify clinical benefits of identifying vulnerabilities and resilience through case study
3. Understand the impact therapeutic relationships have on patient outcomes and clinician burn out
4. Address frequently asked questions when developing therapeutic relationships
General Training Objectives

1. Learn and practice eliciting the patient’s narrative while at the same time, attending to their patient’s medical concerns

2. Identify and ask open ended questions about common vulnerabilities and resilience points in their patients. Practice reflective and active listening through role play.

3. Communicate the linkage between physical health outcomes and social determinants to their patients.

4. Identify and problem solve with their peers around challenges in developing strong therapeutic relationships with their patients.

5. Practice using empathic statements under time pressure in visits with your patients.
Disclosures

Some of the content of this talk come from a textbook of the care of vulnerable patients that I am a co-author of (Schillinger)
Vulnerable Populations Defined

Vulnerable Populations are subgroups of the larger population that, *because of social, economic, political, structural and historical forces*, are exposed to “greater risk of risks”, and are thereby at a disadvantage with respect to their health and health care.
Exemplar Case

- Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.

- Question for you is WHY?
Common Social Vulnerabilities

- Violence and trauma
- Uninsured
- Literacy and Language
- Neglect
- Economic hardship/food insecurity
- Race/ethnic discordance, discrimination
- Addiction
- Brain disorders, e.g. depression, dementia
- Immigrant
- Legal status
- Isolation/Informal caregiving burden
- Transportation problems
- Illness Model
- Yes and Ears
- Shelter
What are We Up Against?
Reversing The Inverse Care Law

“Access to and quality of healthcare is inversely proportional to the needs of the population”

- Tudor-Hart, 1971
“Somebody has to do something, and it's just incredibly pathetic that it has to be us.”

Jerry Garcia
3 Mechanisms By Which Social Vulnerabilities Affect Healthcare Outcomes

Finding the Sweet Spot for Effective Intervention with Vulnerable Patients

This approach uniformly allows a clinician to navigate the social distance and create the human connection that underlies therapeutic relationships.

Eliciting the Patient’s Story: Reveals Hidden Treasures that Humanize
Finding Resilience

R eligion
E xpertise/Employment
S ocial support & Network
I ntimates
L aughter
I nstitutions
E nergy & Enthusiasm
N avigate Life’s Difficulties
C ultural Assets
E ntertainment/Enjoyment
Common Social Vulnerabilities

Violence and trauma
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Illness Model
Eyes and Ears
Shelter
What is Health Literacy?

- “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make [informed] health decisions.”

- 3 domains: oral (speaking, listening); written (reading, writing); numerical (quantitative)

- ?Web? Patient portals?

- Capacity/Preparedness ↔ Demand Mismatch
Limited Health Literacy Patients Experience More Serious Hypoglycemia/year \( N>14,000 \)

![Bar chart showing percentage of patients with limited and adequate health literacy experiencing different problems.](image)

- Problems learning: Limited 14%, Adequate 8%
- Help reading: Limited 14%, Adequate 8%
- Not confident with forms: Limited 14%, Adequate 8%

\( P \) for all < 0.001

Sarkar, Adler, Schillinger, JGIM 2010
Exemplar Case:
Clearly this was Limited Health Literacy, right?

Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents to you for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.
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Food Insecurity

- The limited or uncertain availability of nutritionally adequate and safe foods or
- ability to acquire acceptable foods in socially acceptable ways
Cycles of Food Adequacy & Inadequacy Wreak Havoc

Hyperglycemia

Compensatory Strategies during Food Adequacy
- Avoidance of food waste
- Systematic overconsumption

Compensatory Strategies during Food Shortage
- Skipped meals
- Reduced caloric intake

Hypoglycemia

Cycles of Food Adequacy & Inadequacy Wreak Havoc

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What is intimate partner violence (IPV)?

**PATTERN of abusive behaviors**

- including physical, sexual, verbal, emotional, economic, and/or psychological abuse
- Includes interfering with medical care
- used by adults or adolescents
- against current or former intimate partners, and sometimes against other family members
- in ANY intimate relationship: LGBTQ/straight/all gender identities
Exemplar Case: Clearly this was Intimate Partner Violence, right?

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A (Very) Brief History of History-Taking

1816

1939

2017
What’s wrong with this picture?
In 2017, is “Very Good Care” good enough?

The IOM asserted in this highly cited monograph that patient/relationship-centered care was one of six domains that define quality. The others are: safety, effectiveness, timeliness, efficiency, and equity.
Breaking News: Medical Error 3rd Leading Cause of Death in the US

- Cancer: 585k
- Medical error: 251k
- Heart disease: 611k
- COPD: 149k
- Suicide: 41k
- Motor vehicles: 34k
- Firearms: 34k

All causes: 2,597k

However, we’re not even counting this - medical error is not recorded on US death certificates.

http://bmi.co.mederr
The IOM documented vulnerable gaps in care

- 44,000-98,000 of these gaps led to preventable deaths
- Many more were considered “near misses” Many of these could be traced back to breakdowns in communication and relationships
- 80% of all adverse outcomes in hospital settings are related to poor communication during handoffs
Relationship Between Physician Communication and Medical Malpractice Risk

![Bar graph showing the number of utterances per 15-minute visit for different physician communication processes.](image)

- **Facilitation**:
  - No Claims: 19.4
  - Claims: 11.9

- **Orientation**:
  - No Claims: 14.5
  - Claims: 11.2

Source: Levinson et al. JAMA 1997; 277:553-559.
Elapsed Time of Visit

Visit Duration

<table>
<thead>
<tr>
<th>Elapsed Time in Minutes</th>
<th>No Claims</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
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</tbody>
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## Four Habits of Highly Effective Physicians

<table>
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<th>Habit</th>
<th>Skills</th>
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<tr>
<td>Invest in the Beginning</td>
<td>Create rapport quickly; elicit the patient’s concerns; let the patient know what to expect</td>
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<tr>
<td>Elicit the Patient’s Perspective</td>
<td>Ask for patient’s ideas; determine patient’s specific request or goal; explore the impact on patient’s life</td>
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<tr>
<td>Demonstrate Empathy</td>
<td>Be open to the patient’s emotions; make empathetic statements; convey empathy nonverbally (pause, touch, facial expression)</td>
</tr>
<tr>
<td>Invest in the End</td>
<td>Deliver diagnosis in terms of original concern; explain rationale for tests and treatments; monitor for adherence, summarize visit and review next steps</td>
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FAQs

1. With 30 min new patient appts and 15-20 minute F/U appts, is there really enough time to build relationships with patients this way?

2. By using this approach with my patients who have so many needs, won’t I be creating a cycle of dependency, or co-dependency?

3. What is the use of searching for vulnerabilities if my clinic does not have the social services to address my patient's complex needs?

4. If I start uncovering these vulnerabilities, and being a witness to things beyond my control, will I experience secondary (so-called vicarious) trauma?
Workshop Overview

September 7, 9:30 am – 4:00 pm

Objective: Learn and apply techniques to discover and identify patient vulnerabilities and resilience through eliciting patient narratives and developing shared care plans

Open To: Clinicians, members of their care team and other health center staff doing work related to health communication

Register here
Limited spots available.
Contact Information

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• Dean Schillinger, dean.schillinger@ucsf.edu

Please remember to fill out the post-webinar survey!

Thank you!