HQRM Report HEALTHCARE QUALITY & RISK MANAGEMENT

PART I: COMMUNICATE, COMMUNICATE, COMMUNICATE

INTRODUCTION:

Most providers more than likely believe that they are effective communicators. After all, they are highly educated and more than likely would not be in the positions they are in now if unable to effectively communicate. However, studies have shown that there is a direct relationship between the medical malpractice claims and poor communication between providers and patients.[1,2] Most if not all providers want to effectively communicate but find it increasingly difficult to find the time to talk to their patients as healthcare becomes more complicated and regulated. In addition, there are new ways for providers to communicate with patients such as through email, texting and patient portals that should help improve communication but also can create new challenges.

The purpose of this two part article is to assist providers in improving their relationships with patients through effective communication. Part I will focus on establishing a rapport with patients, how to take an effective patient history and providing information to patients during and after an exam and patient follow-up, all essential building blocks for a successful patient-physician relationship. Part II will be published in the next HQRM Newsletter and will focus on hand-off communication, communicating difficult news, such as an adverse outcome and communicating in difficult patient situations.

A. SOME STATISTICS:

Many patients sue because they want answers or because they feel like the health care professionals did not listen to what they were saying. Research shows that basic interpersonal skills such as listening and showing respect are just as important as clinical skill.[3] In fact, a study that looked at the incidence of adverse events in hospitalized patients revealed that about 1% of patients developed significant injury related to negligence, but less than 3% of that 1% sued, demonstrating the fact that not all patients who suffer an unexpected adverse event will sue.[4] In a study that involved the review of plaintiff (patient) depositions in medical malpractice cases, “problematic relationship issues” were identified in 71% of the cases .[5] The bottom line is that if a patient experiences an unexpected outcome due to negligence but has a good relationship with the provider, there is a very good chance that the provider will avoid being sued.

B. ESTABLISHING RAPPORT:

A provider must establish a good first impression. In the office setting, especially when seeing a patient for an initial visit, the first person that the patient will more than likely come into contact with will be the provider’s front office personnel. Providers should listen very closely to what their staff members say to patients when talking to them on the telephone or checking them in at the front desk. Unfortunately, if a patient has a bad

experience with the provider's staff, the provider may be unable to establish or maintain a good rapport with that patient. The staff member should be pleasant, friendly, greet the patient with a smile and should be sufficiently trained so that the patient's first impression of you, the provider, is favorable. There are several tools a provider can use to make a first good impression. The key is for the "physician to convey kindness, compassion, intelligence, confidence, and commitment to the well-being of a new patient…"[6] Dr. Beeson outlines several basic, but extremely effective, behaviors that can help a provider create a positive first impression: [6]

1. **Knock on the door before entering.** Aside from being courteous, this gives the patient time to prepare for your entrance.
2. **Smile, introduce yourself, and shake the patient's hand.** A smile places the patient at ease, conveys friendliness and reduces the patient's anxiety. Be sure to introduce others that may enter the room with you.
3. **Sit and maintain eye contact.** When you sit down, the patient's perception will be that you spent more time with him/her than if you stood.
4. **Use consistent opening comments.** Especially when seeing a patient for the first time, a non-medical dialogue is effective in placing the patient at ease and showing that you care. You can also ask if the patient had any problems setting the appointment or checking in; this is a quick way to evaluate how the patient has perceived your staff. For any patient visit, if you are running behind, apologize and thank the patient for waiting.

Certainly, the above techniques, revised as necessary to meet the circumstances, are very effective when seeing patients with whom the provider has an established relationship.

C. Taking an Effective Patient History

As health care continues to move towards being more patient-centered, it is important for a provider to create an atmosphere of collaboration with the patient but at the same time maintain appropriate control over the initial interview. Dr. Beeson offers the following techniques to assist a provider in preparing for a patient exam[6]:

1. **Be Prepared.** Whether you are seeing a new or existing patient, take the time to review the patient's chart. "What you know when you enter the patient exam room will drive the efficiency of clinical care, and can instill or rattle confidence in you as the treating physician." [6]
2. **Allow the patient's major health concerns and questions to drive the agenda of the visit.** Typically, the nurse or other designated personnel will first ask the patient about the purpose of the visit. The information gleaned from this interview will set the agenda for your visit. It is important that staff be trained in the appropriate way to conduct this interview, and many of the same behaviors outlined above under "Establishing Rapport" apply here as well. Once you enter the room, be sure to acknowledge the information that was collected earlier when you begin to ask the patient questions. This demonstrates

collaboration among healthcare team members in your office.

3. **Let the patient speak without interruption.** The average physician will interrupt a patient 17 seconds during the first part of a conversation when the patient is attempting to describe his/her concerns.[6] The patient will perceive multiple interruptions as a sign that you are not listening to what he/she is trying to tell you.
4. **Use continuers.** Be sure to actively listen; nod your head, continue to maintain eye contact and use terms like "Continue" or "Go on" to convey your interest in what is being said.
5. **Paraphrase the patient's history.** This tactic is very important, especially when the patient has given you a confusing and convoluted account. Summarize in your own words what you believe you heard the patient tell you. The patient will then be more receptive to your recommended plan of care.
6. **Take control when the patient history loses direction.** Very often, a patient will "ramble" or may include insignificant information when giving you a history. Listen without interrupting for a couple of minutes (see tactic #3 above), and if you perceive that you have not heard any information that will help you determine why the patient is there to see you, take control. Say things like, "It seems there are many things bothering you. What is bothering you the most"? This will demonstrate that you are listening but will also help steer the patient in the right direction and save time.
7. **Express empathy.** Recognizing when empathy is appropriate demonstrates a caring and compassionate attitude. "Tactical and honest expression of empathy by physicians supports the most important predictor of patient satisfaction, which is: *Did the physician care about me?"*[6]

If you have a patient who may be difficult to communicate with due to reasons such as dementia or diminished capacity, involve the appropriate family member or care-giver when communicating and examining the patient.

D. The Physician Exam

During the examination of the patient, many providers do not talk as they are concentrating on listening, looking and touching. Before conducting the examination, briefly explain what you are going to do and then as you move through your examination, inform the patient what you will do next. Let the patient know what your findings are, as well. For example, you can say, "I am going to listen to your heart and lungs now. You are moving air well and your lung fields' sounds are clear. Your heart sounds are normal."[6] The patient will be put at ease and will not be surprised when you touch certain areas of his/her body. (NOTE: Be aware of those situations when a chaperone should be present during an exam.) In addition, it conveys your expertise and, especially for those patients who have little of no medical training, such explanations inform the patent how competently and quickly you can gather the information that you need to make a diagnosis. Many patients equate the length of time of the examination with how comprehensive your exam was; the shorter the exam, the less the provider knows. A running dialogue during the exam goes a long in dispelling that misunderstanding.

After the exam, sharing medical information in a manner that the patient understands is crucial. The key is to simplify what you are saying without appearing patronizing to the patient. Dr. Beeson recommends the following simple steps[6]:

1. **Provide a simple explanation; drop the lingo.** Every diagnosis, treatment, medication or lifestyle change should be explained in words the patent understands. For those diagnoses, medications and treatment plans that you use constantly, develop simple, clear and consistent explanations.
2. **Query the patient for understanding.** After providing information to the patient, ask the patient if he/she understands. In addition, ask the patient if he/she needs additional information. Ask the patient to repeat back instructions, for example, to evaluate understanding.
3. **Be specific.** Patients comply with treatment programs when they completely understand what is expected. For example, instead of saying "Get more exercise", say, "Please exercise 5 times a week for 30 minutes at a time."

E. Patient Follow-up

After the examination, it is important that the provider clearly articulates the next steps. The following fundamental issues should be communicated to the patient before the end of the visit[6]:

1. **When or if you need to see the patient again.** If a follow-up appointment is necessary, tell the patient reason why and the exact time-frame when you would like to see the patient again. If possible, ask your staff to set the appointment before the patient leaves, and give the patient a document that contains the appointment information.
2. **Informing of test results.** Your office must have a process of informing patients of laboratory and diagnostic test results. Inform the patient as to when to expect the results and how he/she will receive those results. For those tests that evaluate patients for serious conditions, it is preferable if the provider call the patient directly to discuss the results. Exercise caution if utilizing the nurse or other staff person to communicate abnormal results; you do not want to place that staff person in the position of having to handle questions that might be beyond his/her expertise. Certain results such as abnormal biopsy results should be communicated directly by the physician to the patient. One other consideration is to determine when certain abnormal results should be communicated in person rather than over the telephone or through electronic means. These conversations are better face-to-face since most patients will have many questions, and the provider will also need to explain a treatment plan going forward. If you plan to communicate via email or other electronic means, please be sure to obtain the written consent of the patient, and be sure that you are communicating via approved secure and encrypted systems. Finally, maintain all emails and document all telephone calls in the patient's medical record.

4. **Establishing follow-up with specialty physicians**. If the patient requires a referral to another specialist, be sure to explain why it is necessary to be referred, the expertise that physician has and the fact that you will stay involved in the case and receive regular reports. It is also a good practice to give the patient an idea of how urgent it may or may not be to see the specialist.
5. **Finish the appointment.** Be sure to end your visit by giving the opportunity to the patient to ask final questions. Close the appointment with a handshake and a smile and a request to call your office if they think of additional questions after leaving the office.

F. SUMMARY

Effectively communicating with patients not only improves the quality of care for that patient, but it also creates a positive and collaborative relationship between the patient and the physician. If the patient then experiences an adverse outcome, he/she may think twice before filing a lawsuit against the provider or, if a lawsuit is filed, damages may be significantly mitigated.

QUALITY MANAGEMENT - AUDITS OF THE EMR

The Quality Management ("QM") Department conducts biannual audits of the UNTHealth electronic medical record ("EMR") to monitor adherence with documentation guidelines and to promote patient safety. In the audits, the QM department monitors compliance with the Texas Medical Board ("TMB") standards for contents of a medical record and Joint Commission and CMS documentation standards. The audits measure such things as organization of the record, patient identification, consent to treat, chief complaint or reason for visit, date and legible identity of the observer, chronic conditions, history of present illness, past medical/surgical history, history and physical, assessment and plan, education, treatments and procedures, medications, and allergies. Each provider receives an individualized report after every audit outlining results and recommendations for improving documentation, as applicable. As part of UNT Health's Clinical Quality Improvement Program, audit results are reported to the Continuous Quality Improvement ("CQI") committees, the Quality, Patient Safety and Services Committee and, ultimately, the UNTHealth Board. All CQI information generated through the Clinical Quality Improvement Program is subject to the privilege and confidentiality protections available under state and federal laws.

The audits also monitor other quality and patient safety measures based on evidence-based best practice guidelines such as documentation of a pain assessment, height and weight, BMI assessment including a plan of care with a follow up, alcohol assessment, tobacco assessment and cessation counseling when indicated, preventive screening, care of the diabetic patient and other measures.

At UNTHealth, the Final Master document is the formal "legal" note in the EMR for each patient visit, so it must contain all of the necessary documentation elements of a patient's visit to be considered complete. The QM department will look at only the Final Master document when auditing, therefore, providers must document

completely and accurately in the EMR in order for the proper information to carry over to the Final Master document.

In addition, it is crucial that providers electronically authenticate their visit notes. If a visit note is not authenticated, the QM department will consider that note incomplete for auditing purposes, and the provider will receive no credit for any documentation of that patient visit.

Please direct any questions about the QM audits to Jan Stanton, R.N. by calling 817.735.0228 or by email at Jan.Stanton@UNTHSC.edu.

Thank you for your commitment to providing quality health care to our patients.

INTRANET SITE

Healthcare Quality and Risk Management has a new intranet website! To find more information regarding our department please visit:

http://intranet.hsc.unt.edu/Sites/HealthcareQualityandRiskManagement/.

You may find policies and procedures, our incident report form and our patient complaint form here as well as past newsletters. We have also posted the contact information for the staff in the department.

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