Building a Better Care Relationship with Effective Doctor-Patient Communication

BY MICHAEL L. MILLENSON

In the era of accountable care organizations, patient-centered medical homes, and online report cards, effective communication between doctors and patients can have a significant impact on reimbursement, patient relationships, and community reputation.

The Better Health Conversations[SM] program was developed as an evidence-based, consumer- and physician-friendly means of integrating better communication into the office visit routine to improve care and satisfaction. The program's centerpiece is the Care Card[SM], which patients bring with them into the doctor's office, share, and then take home.

The wording of the Care Card and the doctor-patient interaction involved in using it are carefully designed to help patients more efficiently and effectively express what they want to accomplish and help doctors consistently collaborate with them in doing so. The formal name for this type of effort is "agenda setting."

In a pilot program at three diverse medical groups, the program prompted a positive response from both patients and veteran physicians who might not have been aware that their own communication practices could be improved. As one physician participant acknowledged, "It changed my way of starting conversations with patients."

Communication Comes to the Fore

In 2001, the Institute of Medicine listed "patient-centered care" as one of six aims of the U.S. healthcare system. Since then, measurement of how effectively clinicians communicate with Medicare patients has become part of "report cards" shared with the public and community through the H-CAHPS survey (Hospital Consumer Assessment of Healthcare Providers and Systems). Similar report cards are planned using a clinician and medical group survey (known as CG-CAHPS). Meanwhile, patient-centeredness measures are linked to reimbursement for Medicare's accountable care organizations, in the patient-centered medical home, and in other new payment models from private and public payers.

While there are multiple questions, what lies at the heart of all these surveys are the conversations that take place between physician and patient.

The average physician conducts more than 150,000 interviews during a practice lifetime, making the patient interview potentially "the most powerful, sensitive, and versatile instrument available."[1] It does not always fulfill that potential: one oft-quoted study showed that physicians interrupt the patient's initial description of his or her problem after just 18-23 seconds.[2]

Done right, however, effective communication skills build a better relationship that has a powerful impact on doctors and patients alike. Better communication enables physicians to improve patients'

understanding of their illnesses, improve patient adherence to treatment regimens, use time efficiently, avoid professional burnout, and increase professional fulfillment.[3] Studies show "unequivocal and significant relationships" between various aspects of communication and such health outcomes as psychological and functional status, symptom recovery, and recovery from emotional problems.[4,5]

On the other hand, physicians who communicate poorly not only miss out on a chance to help their patients, but also run an increased risk of being sued.[6]

The spread of consumer-oriented medical websites, third-party payer incentives related to patient satisfaction, and changed societal expectations have made effective communication even more important. Yet the nuts-and-bolts components of clinical communication, such as information sharing and relationship building, are inevitably stressful and challenging for both patient and physician.[7] That's why both sides need new tools that will allow them to move forward together.

Improving on Improvement Tools

Health Quality Advisors LLC, a consulting firm on quality of care and patient empowerment, began by assembling an expert advisory board to develop an intervention that would be effective in the group practice environment. We included patient advocates along with physicians and academic researchers. We also worked closely with the American Medical Group Association in conjunction with the pharmaceutical company Daiichi Sankyo, Inc. to ensure that the intervention would be effective "in the trenches."

In addition, we set out to learn from what had been done before by reviewing the medical literature on physician-patient communication and assessing similar initiatives offered by others. We also learned along the way: the expert advisory board provided continual feedback, which was then shared with focus groups conducted with AMGA member executives and doctors.

There are already health literacy programs for patients, encouraging them to ask several specific questions, and training programs for physicians to improve communication skills. What distinguished Better Health Conversations was our decision to make improving communication a responsibility shared by clinicians and patients. That joint approach, the focus on one specific area (agenda setting), and the warm and friendly "look/feel" of all the program materials set it apart.

Two caveats came through loud and clear from AMGA members: "What's in it for me?" had to be immediately apparent to doctors, and the program had to fit seamlessly into a very busy office workflow.

Three diverse groups volunteered to help refine the materials and conduct a four-week pilot in the summer of 2011: Crystal Run Healthcare of Warwick, New York, serving a suburban and rural population; Holzer Clinic in Gallipolis, Ohio, serving a rural population; and University of Utah Health Care, Salt Lake City, serving primarily an urban and suburban population.

Developing Program Materials

While the Better Health Conversations materials are anchored in the medical literature, they have a consumer-oriented look and an engaging style of writing that signals patient and doctor alike that this is not typical "educational" materials. The different components include:

- A Program Guide for the Group Practice that welcomes providers, describes the program, and contains references and other information
- Agenda Setting: A Practical Guide, supplementing hands-on coaching at the program launch
- Folder with Welcome Letter, including an overview for physicians and office staff and a Frequently Asked Questions page
- Waiting Room Display, alerting patients to the program and engaging them
- Care Card for the patient to fill out and share with the physician

The Care Card is central to the program. It directly addresses patients at the point of care, asking them to write down health concerns before seeing the physician and then take the card into the exam room to share with the doctor. There are three separate lines for the first three concerns, followed by lines for "Additional Concerns." However, the concerns were deliberately not numbered so as not to require (or suggest) prioritization; joint agreement on prioritization is at the heart of the clinical conversation. The request to the patient to fill out the card is phrased as a way to help "us" provide better care; that is, it implicitly gives permission to the patient to become a partner.

The reverse side of the card includes space for note taking by the patient or for notes written by the physician. However, the card is deliberately given back to the patient by the doctor so it does not become a formal part of the medical record and possibly subject to privacy regulations.

Launching the Pilot

We knew good materials alone were insufficient. Building a better doctor-patient relationship starts with other relationships. Critical to launching the pilot was buy-in by medical group leaders, who selected a physician champion at each group. They were: Jonathan Nasser, M.D., an internist board-certified in pediatrics and internal medicine, at Crystal Run; Adam Breinig, D.O., a family practice physician, at Holzer; and John Houchins, M.D., a family practice physician, at Utah. All three champions received background information on communication and on physician training.

Training took place face-to-face

for about an hour at a lunch or breakfast meeting onsite with the physicians in each group recruited to try out the program. After a remote presentation by advisory board experts Howard Beckman, M.D., and Richard Frankel, Ph.D., about the science of doctor-patient communication, Health Quality Advisors' team members on site provided information about the goals and structure of the program. Most important of all was an interactive role-playing exercise in which physicians had the opportunity to use the Care Card in clinical scenarios developed by Health Quality Advisors. Switching between the doctor and patient roles provided a personal experience of how the Care Card could work in an actual clinical encounter and gave physicians the opportunity to ask practical (and probing) questions.

The Health Quality Advisors team and the physician champion also spoke with front office staff at each group about their role in helping explain to patients what was being asked of them and helping make the program a smooth-flowing part of the office routine. A regularly scheduled phone call among the physician champions and the Health Quality Advisors team also provided support and feedback.

The Results

A satisfaction survey attached to the Care Card was returned by 1,465 patients during the pilot. A physician satisfaction survey was returned by 14 out of 19 participants and at least 60 percent at each medical group. We also tracked anecdotal reports. While this was not a research study, we submitted the survey results for analysis by an academic consultant.

In sum, signs of the good things the medical literature predicted—albeit difficult to see clearly in a very short pilot—started to appear while the feared negative consequences did not. For example:

- Fears of opening a "Pandora's box" of patient concerns proved unfounded. The most frequent number of concerns listed on the Care Card was one (36.5 percent). Just 12 percent of patients listed more than three concerns.
- Patient satisfaction with how physicians addressed concerns was very high. About 98 percent of patients were "completely" or "very satisfied" with the visit.
- The consistency of satisfaction suggested a program effect. Even when patient expectations were increased by telling them their doctor was interested in what they wrote on the Care Card, those new and higher expectations were met. Had they not been, satisfaction could have taken a dip.
- The Care Card appears to have been a relationship facilitator. Patients seemed to have felt more comfortable sharing concerns. One physician champion said the Care Card got patients talking about problems they wouldn't ordinarily talk about—truly a better health conversation. Others reported some returning patients asked about the Care Card after the pilot ended.

Perhaps in part because of the patient reaction, participating physicians were mostly positive.

- Nearly 80 percent of physicians agreed the program improved agenda setting, both by preparing patients and reminding them of the importance of setting an agenda jointly. When asked to respond to the statement, "My patients were better prepared to discuss their concerns," 11 of 14 physicians agreed somewhat or strongly, two disagreed somewhat or strongly, and one was neutral. When asked whether the Care Card "was a useful reminder to me about agenda setting," 11 physicians agreed somewhat or strongly, three disagreed somewhat or strongly, and none was neutral.
- Physicians generally felt the program was helpful to them in their overall interaction with patients. Sixty-five percent felt "the Care Card was helpful to me in my interaction with patients" and 50 percent agreed "I was more satisfied with my interactions with patients." For a short pilot with a very modest behavioral intervention, that sort of positive impact is striking.
- About two-thirds of physicians favored continued use of the Care Card or were neutral. Fifty-seven percent were positive and 14 percent neutral. Some of those reacting negatively may have been influenced by a technical glitch—the cards were printed on glossy paper that was tough to write on.

This positive reaction stands out even more when one considers that practicing physicians tend to believe they already communicate well; it typically takes videotaping and formal follow-up to suggest otherwise. Two physician champions said they did not fully appreciate the impact of the Care Card on their own practice habits until they stopped using them and saw how they had served as a "prompt" for agenda setting.

Conclusion

Better communication builds better relationships that have positive clinical effects, positive effects on patient satisfaction, and positive effects on clinician worklife satisfaction. We believe the Better Health Conversations pilot to enhance physician-patient communications succeeded for several reasons:

- The program focused on an important problem for medical groups and physicians. As a result, it received strong support from the leadership and individual physician champions.
- The program addressed an individual component of physician-patient communication where it could make a difference in a man-

ner that resonated with doctors and patients alike.

- The program was innovative, collaborative, and flexible. Feedback from participants and Health Quality Advisors' program partners was solicited and acted upon.

As a next step, we are using the feedback received from the pilot to refine the content of materials and the way those materials are used to improve their effectiveness. In today's healthcare environment, with an increasing need to integrate better physician-patient communication into the routine processes of outpatient care at medical groups, a collaboration between doctors and patients is more important than ever. Better Health Conversations seems to provide an evidence-based, consumer- and physician-friendly means of helping that collaboration happen.

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