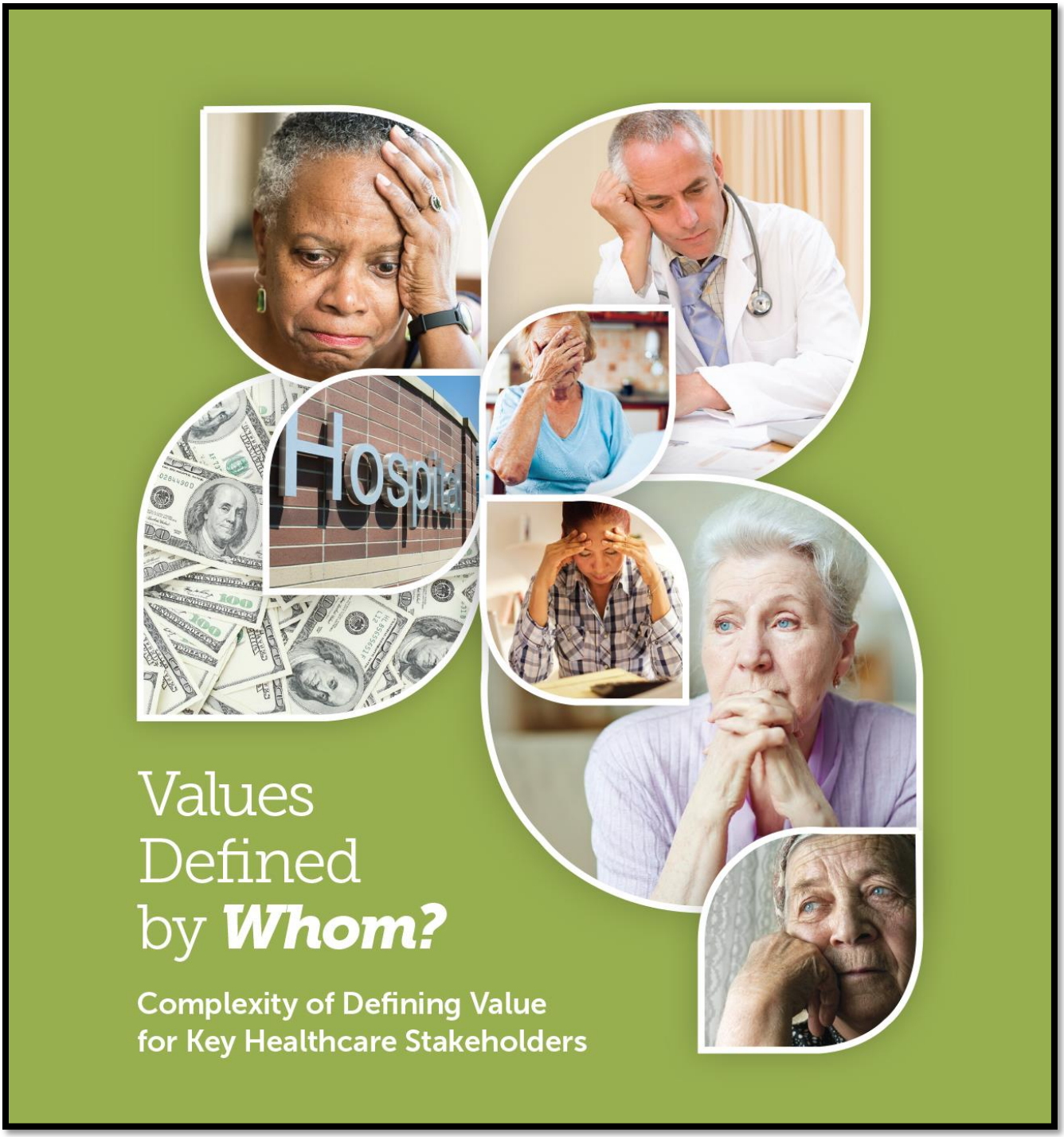
movement is life™
Catalyst for Change

Adding Value to Your Patient Encounters

Value Discussion Guide



Values Defined by ***Whom?***

Complexity of Defining Value for Key Healthcare Stakeholders

The Movement Is Life ™ monograph, “Values Defined by *Whom*? Complexity of Defining Value for Key Healthcare Stakeholders” explores the relationship between how health care is paid for and contrasts what the key constituents (patients, providers, policy makers and payers) find valuable.

Policy makers typically view the costs of health care to be excessive and unsustainable. The traditional “fee for service” payment model values volume of care over value, and is felt to be responsible for waste and “low value care”.

Payers (the federal government and private insurers) have proposed alternatives to fee-for-service that purport to improve quality of care while saving money. These alternative payment models have created unintended consequences for patients, including barriers to care, time and production pressures for providers, and failures to address patient concerns.

Patients consistently value effective communication, professionalism, and competence in their providers. Many system factors (IT, EMR, and institutional policies) may be outside a provider’s control and can work to impede effective patient-provider encounters.

Fortunately, communication and respectful treatment are within all providers’ capabilities. These case studies, based on patient reports in focus groups, highlight specific concerns and address strategies to make your interactions with patients more effective and valuable for your patients, and your practice.

The Movement is Life ™ Value Work Group gratefully acknowledges contributions by the scholars and mentors of Nth Dimensions, an organization founded in 2004 By orthopaedic surgeons with the desire to see women and minorities advance in the field of orthopaedics. http://www.nthdimensions.org.

Value Case Studies

Value Case Study 1

Patients in the Movement is Life ™ focus groups reported communication failures related to the electronic medical record:

"I had one doctor who came in and turned his back to me on the computer, never looked at me."

"The doctors no longer even look at us, they're just at the computer. It's frustrating!"

"The technology, instead of helping, is hurting us. Because they no longer pay any attention to us, when they used to before."

The electronic medical record has been a consistent source of frustration for both patients and their health care providers. Both patients and providers note the loss of human connection created by the computer in their midst.

In the Cleveland Clinic's "relationship-based care" program, the first step is to "invest in the beginning" – also referred to as "honoring first contact". A consistent greeting routine allows you to focus on the patient. When you sit at appropriate social distance, patients perceive that you have spent more time with them even though visit length does not lengthen, and may actually shorten. Patients expect to be addressed by their names, and that providers introduce themselves and their role in the health care team. They expect appropriate "social" touch (traditionally a handshake, but during pandemic times, a "fist bump" or an "elbow bump" usually suffices). With a few exceptions, they expect eye contact and attentive listening. Patients consistently value being treated with respect above other aspects of provider communication. (1)

During a virtual visit, the computer is not intruding. Touch, of course, can only be simulated during a video visit. Eye contact can be lost in the virtual setting because we look at the patient's image rather than the camera lens. We may be unaware of the camera angle, and the patient may see only part of our face.

However, in a face to face visit the computer presents a physical barrier which magnifies the distance between the provider and patient. Eye contact is typically lost while the provider enters data in the EMR. Listening with intent to understand requires that you not try to enter data at the same time. While eliciting the patient's agenda (the reason for the visit), avoid looking at the screen, your phone, or anything other than the patient.

An open-ended question such as:

- "What can I/we do for you today?" or
- "How can I/we help you today?

should be followed by uninterrupted listening for a minute. If the patient has multiple concerns, they must be prioritized:

- "For you, what's the most important thing we need to take care of today?" (2)

A respectful approach is to ask permission to enter data in the EMR only after you have agreed upon the agenda.

Clinical empathy depends upon both verbal and non-verbal cues. Nonverbal cues tend to be more powerful but less specific than verbal cues, so it's really important to maintain eye contact so you can pick up on nonverbal cues such as posture and facial expressions (grimacing, rolling eyes). Clinical empathy requires both recognition of emotional content and acknowledgement of the cue: (3)

- "I noticed that you rolled your eyes just now. Please tell me what you're thinking."

If you notice a patient becoming tearful, stop talking. Offer a tissue; say something like:

- "I can see this is hard for you. Take your time."

Maintaining "connection" while dealing with the EMR requires work, but maintaining that connection is critical to a satisfactory outcome of any clinical visit.

References:

1. Quigley DD et al. Specialties Differ in Which Aspects of Doctor Communication Predict Overall Physician Ratings. J Gen Intern Med 29(3):447–54

2. Rodriguez HP et al. Can teaching agenda-setting skills to physicians improve clinical interaction quality? A controlled intervention. BMC Medical Education 2008, 8:3

3. Platt FW and Gordon GH. Field Guide to the Difficult Patient Interview Second Edition. 2004. Lippincott, Williams and Wilkins. P. 21

Value Case Study 2

A member of the African American focus group reported this interaction:

Patient: "With my family history, you want me to come back to your office in six months?"

Provider: "Yes. You should be more concerned about your grocery bill than you are about this lump."

(The patient had a positive diagnosis of breast cancer)

This interaction is an example of "empathic blocking" (1). The provider invalidates the patient's concern and offers premature reassurance, probably in hopes of staying on schedule.

When there is disagreement on the plan for treatment or follow up, a reflective statement followed by an open-ended question might work better:

> *Provider: "I'm hearing you say that you're uncomfortable with waiting six months for our next visit. What are your thoughts about where we should go from here?"*
>
> OR:
>
> *Provider: "I can see that following up on this lump is a real concern for you. What would make more sense for you?"*

DO NOT engage in "deflective listening":

- Interrupt or finish the patient's sentences
- Challenge the patient's feelings
- Speak in a manner that sounds biased, patronizing, or uncaring.
- Describe what the patient ought to think or feel
- Fail to acknowledge patient emotion by changing the topic and proceeding with medical questions

Shared decision making requires an invitation to the patient from the provider. These responses would serve as starters for shared decisions or, in the "DO NOT" case, shut down any chance of reaching a shared decision.

The reference to the "grocery bill" may reflect unconscious bias toward a patient with obesity or the patient's socioeconomic status. In any case, it is presumptuous and disrespectful. The provider assumes that he/she knows more about the patient's life and context than the patient does. This is a variant of the dreadful "you be the patient and let me be the doctor" or "I

understand that…" utterances. These are paternalistic at best and arrogant at worst. The patient is the expert on herself.

In a larger sense, this interaction demonstrates a failure of agenda setting. Failing to elicit the patient's agenda (2) and concerns (3) is counterproductive – and a strong driver of patient dissatisfaction. Ideally, the conversation would start something like this:

Provider: "How can I help you today?"

Patient: (states concern)

Provider: "What else?" (and repeat if further concerns, until you have the whole list)

With multiple concerns:

Provider: "For you, what is most important for us to get done today?"

If the patient's agenda is not elicited, it often pops up again just when you think the visit is over. This is called the "doorknob phenomenon" because it occurs as your hand is on the doorknob as you're trying to exit the room. (4)

Failing to address a patient's concerns often ends up with the patient repeating them, costing you time. One study showed that office visits where concerns or empathic "clues" were ignored took longer than visits in which concerns and clues were addressed as they occurred (5).

References:

1. Maguire P and Pitceathly C (2002). Key communication skills and how to acquire them. BMJ (Clinical Research Ed) 325 (7366) 697-700.

2. Rodriguez H et al (2008). Can teaching agenda-setting skills to physicians improve clinical interaction quality? A controlled intervention. BMC Medical Education 2008, 8:3

3. Levinson W, Hudak P, Tricco AC (2013). A systematic review of surgeon-patient communication: Strengths and Opportunities for Improvement. Patient Education and Counseling, 93:3-17.

4. Rodondi PY et al (2009). Physician response to "By the way" syndrome in primary care. Journal of General Internal Medicine, 24(6): 739-741.

5. Levinson W et al (2000). A study of patient clues and physician responses in primary care and surgical settings. JAMA: The Journal of the American Medical Association, 284(8) 1021-1027.

Value: Case Study 3

A patient from one of the Movement is Life ™ focus groups recounted this experience:

> ***"He (the doctor) said, 'Have you ever been addicted to pain medicine?'…he just automatically wrote me off as a drug addict…it was so degrading to me."***

Musculoskeletal pain is a primary focus of Movement is Life ™. Painful hip and knee joints contribute to the "vicious cycle" of inactivity leading to obesity, type 2 diabetes, and heart disease. This vicious cycle is particularly difficult for patients in disadvantaged groups.

At the same time, the "opioid epidemic" has wrought havoc on the entire United States. Pain evaluation and management are more problematic now than ever.

We are familiar with "drug seeking" behavior (seeing multiple providers, obtaining multiple prescriptions, "lost" prescriptions, and so on). A patient who mentions pain as a concern puts us on the defensive, and unfortunately we often assume the worst. Unconscious biases may cause us to suspect Latinx and Black patients, even though either is no more likely than white patients to exhibit drug seeking behavior – or to be addicted to opioids. (1) The literature has shown that women, Latinx and Black patients were consistently undertreated for fracture pain even before the opioid epidemic (2). This ironically seems to have protected Black patients from prescription drug addiction. (2)

The doctor's question is frankly disrespectful. Respect for each patient's human dignity demands that we "take a history", which requires much more than just inquiring about addiction. This "Yes/No" (closed ended) question seems to cut off or "block" the chance of getting any other information. Implying that the patient might be an addict at an early stage of the visit makes it unlikely that either you or the patient will be satisfied at the end.

Empathic communication sets the stage for more effective history taking. Acknowledging (without judging) the difficulty of pain with an empathic statement helps to develop trust:

- "It sounds like this pain is really interfering with things you need (want) to do"

The location, nature, frequency, and quality of the patient's pain should be assessed. Previous treatments and outcomes are important to know.

The patient's ideas, concerns, and expectations ("ICE") for treatment help us to understand the patient's situation.

- “What are your thoughts about what is causing this pain?”
- “Tell me about your concerns with the medication”
- “What do you want to be able to do that you can’t now?” (3)

Asking permission before talking about your recommendation is respectful.

- “Would it be OK if I tell you how I treat pain?”

Using these techniques will make it more likely that you and the patient will reach a satisfactory agreement on treatment.

If you conclude that the patient is “drug seeking” you can now set limits. Policies for opioid prescriptions should be established in your practice. You can explain the policy without implying judgment. Referral can be offered when appropriate.

References:

1. Patrick Radden Keefe. Empire of Pain: The Secret History of the Sackler Dynasty. 2021, Doubleday. Page 320.

2. A.A. White III MD. Seeing Patients: Unconscious Bias in Health Care. 2011. Harvard University Press.

3. Matthys J et al. Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. Br J Gen Pract. 2009 Jan;59(558):29-36.

Value Case Study 4

In a focus group of Latina women sponsored by Operation Change, one mother recalled hearing this while she watched her son (a gang member) die in the Emergency Room:

> ***"My son was covered in blood, his head open. I heard the nurse when she said 'a gang member more, a gang member less'".***

Expressing such thoughts in a setting where you are likely to be overheard (one common place is in an elevator) is risky and when overheard they lead to mistrust, HIPAA violations, or worse (violence).

In the Emergency Room setting, time pressure and production pressure contribute to cynicism among staff. "Compassion fatigue" is a real phenomenon and a real risk for health care providers in high pressure situations. Many providers feel that they may be "opening Pandora's box" by expressing empathy. Empathy is "blocked" (Maguire) because of concerns about time pressure and compassion fatigue. These all can lead to the "burnout triad" – depersonalization, feelings of loss of control, and feelings of ineffectiveness. (2 – general burnout reference)

Empathic communication is a powerful tool for care givers. Clinical empathy (being able to imagine another's feeling and express that understanding) is often confused with sympathy (an expression of your own feelings). Paradoxically, one can express empathy even in a situation where you might not feel any sympathy. However, starting in the third-year medical school and subsequent residency training, empathy is lost.

Empathy may be verbal or non-verbal. Verbal statements such as:

- "I can't imagine how hard this must be for you" (reflective)
- "As parents, we're always worried about our children" (self-disclosure)
- "Anyone would be upset having to go through this" (normalization)

    - would be appropriate in this setting.

Nonverbal empathic clues include facial expressions, vocal tone, posture, and gestures. In this situation, offering the grieving parent a box of Kleenex is a powerful gesture. It indicates that you sense the other person's distress and want to help.

One must avoid the temptation to:

- Interrupt or finish the patient's sentences
- Challenge the patient's feelings
- Speak in a manner that sounds biased, patronizing, or uncaring.

- Describe what the patient ought to think or feel
- Fail to acknowledge patient emotion by changing the topic and proceeding with medical questions (5)

Empathy creates a human connection and, for providers, is an important antidote to burnout.

References:

1. Values: Defined By Whom? Complexity of Defining Value for Key Healthcare Stakeholders. Movement is Life TM 2019.

2. Drummond, D: Stop Physician Burnout. 2014

3. Maguire P and Pitceathly C. Key Communication Skills and How to Acquire Them. BMJ 325: 28, September 2002

4. Holmes CL et al. (Almost) forgetting to care: an unanticipated source of empathy loss in clerkship. Med Educ. 2017 Jul;51(7):732-739.

5. AMA. Practice transformation series: listening with empathy. 2016.

Value Case Study 5

A focus group member shared this experience:

> ***"I was diagnosed with breast cancer. I had surgery and treatment. I went to see this new primary doctor…I'm tired and she's telling me to go workout and you won't be tired. Lady, I can barely go to work! I go to work and I come home and I don't even make it to the bedroom – I make it to the couch."***

Although Movement Is Life ™ is a tireless advocate for physical activity to break the "vicious cycle" of joint pain, we are painfully aware of the obstacles members of historically disenfranchised groups face in trying to exercise.

Social determinants of health are important: is the patient's neighborhood safe for walking? Do the patient's work schedule and family responsibilities allow time for exercise? Recent changes in the AMA ICD 10 coding guidelines allow for upcoding to a higher visit level if SDOH are documented:

Social Determinants of Health Z Code categories from Chapter 21 of ICD-10-CM: Persons with Potential health hazards related to socioeconomic and psychosocial circumstances

Z56 – Problems related to employment and unemployment
o Changing of job, losing job, no job, stressful work schedule, discord w boss/co-workers, bad working conditions

Z59 – Problems related to housing and economic circumstances
o Homeless, inadequate housing, discord with neighbors/landlord, problems w residential living, lack of adequate food/safe drinking water, poverty, low income, insufficient social insurance/welfare support

Fatigue may be a symptom of illness. After cancer treatment which included surgery and chemotherapy, anemia is common as is depression (many of the Focus Group members felt that their providers seemed to be unable or unwilling to diagnose depression.)

A non-specific recommendation to "go work out" is unlikely to be helpful unless the provider has explored the patient's situation ("context") and found a mutually agreeable strategy for exercise. Review of pertinent medical history and lab tests is appropriate.

Without this background information, the "go work out" recommendation is an example of "empathic blocking" (this has also been called "deflective listening") (1,3), defined as responding to emotional cues with strategies that block further disclosure. Examples might include:

- Offering advice and reassurance before the main problems have been identified
- Explaining away distress as normal
- Attending to physical aspects only
- Switching the topic
- "Jollying" patients along

An empathic cue offers a hint of the patient's context. An empathic response might be:

- "I hear you saying that you're so tired that you can barely get through the day" (reflective statement)
- "This is really worrying you"

Empathic responses help to build trust, and set the stage for shared decision making.

A shared decision requires an invitation to the patient from the provider to participate in decisions about treatment. Exploring the patient's ideas, concerns, and expectations ("ICE") allows a more workable recommendation to be reached.

Using the "ICE" mnemonic and open-ended questions a provider can elicit the patient's concerns:

- "What are your thoughts about this tiredness you're experiencing?"
- "What do you think is going on?"
- "What is worrying/concerning you most about this?"
- "What are you hoping we can accomplish?"

Questions like this help us to understand the patient's perspective, including "self-diagnosis", functional impairment, and goals for treatment. With this information, you're more likely to arrive at a plan the patient can realistically – and willingly - accomplish. (2)

References:

1. Maguire P and Pitceathly C (2002). Key communication skills and how to acquire them. BMJ (Clinical Research Ed) 325 (7366) 697-700.

2. Matthys J et al. Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. Br J Gen Pract. 2009 Jan;59(558):29-36.
3. AMA STEPS Forward: *AMA. Practice transformation series: listening with empathy. 2016.*

Value Case Study 6

A member of the Cleveland focus group had this request:

"If I'm going to the doctor and you're my kids' age, you don't call me by my first name. Don't call me Sweetie."

In one study of CG-CAHPS Physician Communication scores in a multi-specialty clinic (a measure of patient experience in ambulatory settings), patients most valued being "treated with respect." (1)

Part of your greeting "ritual" should be to address older patients as "Mr." or "Mrs." If you have concerns about mispronouncing a patient's surname, ask the patient to help you. You may also want to ask the patient how they prefer to be addressed.

> "Please help me so I don't mess up pronouncing your name."

Calling a patient by other than their preferred name is a "micro invalidation" of that person's human dignity. (2) Professionalism implies that all patients should be respected equally. Our biases, both conscious and unconscious can be at work when we meet a person for the first time. The Implicit Association Test (IAT) is very helpful for us in learning our own biases so we can consciously work to mitigate any adverse effect on our patients. (3,4)

References:

1. Quigley DD et al. Specialties Differ in Which Aspects of Doctor Communication Predict Overall Physician Ratings. J Gen Intern Med 29(3):447–54 DOI: 10.1007/s11606-013-2663-2

2. Sue, DW et al. Racial Microaggressions in Everyday Life: Implications for Clinical Practice. American Psychologist Vol. 62, No. 4, 271–286 DOI: 10.1037/0003-066X.62.4.271

3. Banaji M, Hardin C and Rothman AJ. Implicit Stereotyping in Person Judgment. Journal of Personal1ty and Social Psychology 1993, VoL 65. No.2. 272-281

4. https://implicit.harvard.edu/implicit/takeatest.html

Strategies to Increase the Effectiveness of Provider-Patient Interactions

COMMUNICATION

Honoring “first contact”. Rationale:

- Physician communication was highlighted as a major concern for patients in the focus groups

Steps (and their benefit) towards better patient communication include:

- Sitting during exam
- Patient perceives this as not being rushed.
- Allows for initial concerns to be expressed.
- Ultimately reduces visit time by 20 seconds

(Zulman et. al. Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter. *JAMA.* 2020;323(1):70–81. doi:10.1001/jama.2019.19003)

Focus on patient immediately upon entering room:

- Sit
- Make eye contact
- Greet by formal name (Ms. or Mr. “X”) [ask for proper pronunciation if necessary]
- Ask open question: “What can I/we do for you today?” Prioritize if there is a list.
- Wait for complete response (NO typing into EHR, NO looking at phone, NO reading chart)
- Repeat patient concern
    - Listen for underlying Patient feelings/needs/values
- Ignore patient communication style
- Recognize that anger/irritation often are manifestations of fear
- Ask open questions (not “yes/no”) until understanding reached
- Express/ demonstrate verbal/ non-verbal empathy.

Listen Intently:

- Lean forward,
- Maintain eye contact
- Don’t interrupt for first minute.
- Patient perception of visit is that more time is/was spent, and concerns were listened to.

Agree on what matters most:

- Answer to question “What can we do for you today?” OR “How can we help you today?”
- Incorporate patient’s concerns into visit and plan.

Connect with patient’s story:

- Acknowledge/ encourage positive efforts

- Consider Social Determinants of Health (SDoH)

Notice, Acknowledge and Explore emotional cues
- "Mirror" back what patient has said.

Clinician-patient communication is a key component of patient care. Patients understand and retain about one-half of what is discussed in clinical encounters.

Do Not Make Assumptions About Language Preferences or Literacy Level.
- Ask patient what their preferred language is.
- DO NOT rely on family members for translation.
- Assume middle school or lower literacy.

Use Plain, Nonmedical, Nontechnical Language.
- Do not use medical jargon that patients do not understand.
- Clinicians should mirror a patient's vocabulary.
- Say "Your leg is *'broken'*, not '*fractured*'"
- Say "1 out of 20", not "5%"
- Use the word "chance" instead of "risk"

Speak Slowly and Break Down Information into Small Steps.
- Limiting the focus of each clinical encounter to 3 key messages increases comprehension of both low- and high-literacy patients.

Confirm Patient Understanding.
- Use the teach-back method. This entails the patients explaining the new information in their own words, allowing the clinician to assess for comprehension.

Empower Patients
- Encourage participation
- "What questions do you have" – NOT "Do you have any questions?"
- Encourage bringing written questions (Limit to 3)
- Encourage bringing an advocate
- Confirm medication understanding
- Confirm method for remembering to take medications.

(Hersh L, Salzman B, Snyderman D. Health Literacy in Primary Care Practice. Am Fam Physician. 2015 Jul 15;92(2):118-24. PMID: 26176370.)

EMPATHIC LISTENING

Be present when listening:

- Listen first, confirm understanding second, THEN ask if you can “write that down” in EHR
- When listening, remove hands from computer (or doorknob), face patient and resume eye contact.

Look for clues to Speak and Listen:

DO

- Use open ended questions
- Use the “ICE” approach; Determine patient Ideas, Concerns, and Expectations

DO NOT

- Interrupt or finish the patient's sentences
- Challenging the patient's feelings
- Speak in a manner that sounds biased, patronizing, or uncaring.
- Describe what the patient ought to think or feel
- Fail to acknowledge patient emotion by changing the topic and proceeding with medical questions.

Rationale:

- Promotes patient – physician bond
- Increases patient satisfaction
- Increases perceived time spent with physician
- Increases in compliance = increases in better outcomes
- Decreases litigation
- Allows for upcoding in 2021 AMA ICD10 if social determinants are discussed.