

Patient-Provider Communication

Roles for Speech-Language Pathologists and Other Health Care Professionals

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Contents

<i>Preface</i>	<i>vii</i>
<i>Contributors</i>	<i>ix</i>
Chapter 1. Building Bridges to Effective Patient-Provider Communication <i>Sarah W. Blackstone, David R. Beukelman, and Kathryn M. Yorkston</i>	1
Chapter 2. Issues and Challenges in Advancing Effective Patient-Provider Communication <i>Sarah W. Blackstone</i>	9
Chapter 3. Medical Education: Preparing Professionals to Enhance Communication Access in Health Care Settings <i>Kathryn M. Yorkston, Carolyn R. Baylor, Michael I. Burns, Megan A. Morris, and Thomas E. McNalley</i>	37
Chapter 4. Enhancing Communication in Outpatient Medical Clinic Visits <i>Kathryn M. Yorkston, Carolyn R. Baylor, Michael I. Burns, Megan A. Morris, and Thomas E. McNalley</i>	73
Chapter 5. Integrating Emergency and Disaster Resilience Into Your Everyday Practice <i>Sarah W. Blackstone and June Isaacson Kailes</i>	103
Chapter 6. Adult Acute and Intensive Care in Hospitals <i>Richard R. Hurtig, Marci Lee Nilsen, Mary Beth Happ, and Sarah W. Blackstone</i>	139
Chapter 7. Pediatric Acute and Intensive Care in Hospitals <i>John M. Costello, Rachel M. Santiago, and Sarah W. Blackstone</i>	187
Chapter 8. Patient-Provider Communication in Rehabilitation Settings <i>David R. Beukelman and Amy S. Nordness</i>	225
Chapter 9. Residential Long-Term Care <i>David R. Beukelman</i>	247
Chapter 10. Enhancing Communication in Hospice Settings <i>Lisa G. Bardach</i>	271
Chapter 11. Making It Happen: Moving Toward Full Implementation <i>Sarah W. Blackstone, David R. Beukelman, and Kathryn M. Yorkston</i>	303
<i>Index</i>	<i>321</i>

Preface

As we wrote this book, the authors became increasingly aware that patients, health care providers, policy makers, and researchers live in nearly parallel universes with differing incentives, access to data and information, accountability expectations, and time frames for action (see Chapter 1). *Patient-Provider Communication: Roles for Speech-Language Pathologists and Other Health Care Professionals* was written in an effort to bridge the differences between the perspectives of communication vulnerable patients and those who provide their health care services and develop health care policies that guide their care. The clinicians, educators, and researchers who authored chapters in this text have provided strong evidence of the need for effective patient-provider communication across the continuum of health care. This book documents policies and the clinical practices that are currently being implemented to facilitate medical encounters among health care providers, communication vulnerable patients, and family members in doctor's offices/clinics, emergency/disaster scenarios, acute-care hospitals, rehabilitation hospitals, nursing homes, long-term care facilities, and hospice settings. Examples of communication support materials, technologies, and strategies are provided for communication vulnerable patients due to (a) preexisting medical conditions, (b) recent health conditions or interventions, (c) language or cultural differences with health care providers, and (d) limited health literacy.

Individual chapters focus on the challenges and complexities associated with patient-provider communication across health care settings. Chapter 1 highlights the parallel universes of the four groups of people potentially involved in patient-provider communi-

cation—patients, policy makers, researchers, and health care providers. Chapter 2 sets the stage by exploring the inherent complexity of medical encounters, recognizing that each encounter involves not only a patient (as well as family members) who may (or may not) have difficulty communicating, a provider (or perhaps a team of professionals) who may (or may not) have difficulty jointly establishing meaning with patients, and contextual variables that relate specifically to the medical encounter, as well as social, linguistic, cultural, geographical, and other situational factors. Chapter 3 explores issues related to professional education and introduces some exciting new teaching strategies, emphasizing the need for interprofessional practice. It also introduces the need to develop continuing education programs that address patient-provider communication, a theme echoed throughout the book. Chapters 4 through 10 spotlight “communication” issues that occur across medical settings. Authors discuss patient-provider communication in doctor's offices or clinics (Chapter 4); during a medical emergency or disaster (Chapter 5); in an acute care hospital/intensive care unit for adults (Chapter 6) or for children (Chapter 7); in rehabilitation facilities (Chapter 8); in long-term care facilities (Chapter 9); and finally, in hospice settings (Chapter 10). These situational chapters illustrate different communication contexts and how communication interventions may work in each. They also demonstrate the immediate and quantifiably positive impact effective communication interventions have on patient engagement, care, safety, satisfaction, and outcomes. Finally, Chapter 11 looks toward the future and identifies exciting next steps, trends, and opportunities.

The unique roles of speech-language pathologists in the provision of communication support services are described throughout the book. These communication support interventions are illustrated with numerous reports of patient experiences in various medical settings. The identity of these patients is protected in that their names have been changed, and a few of the descriptions are composite case reports to illustrate the experiences of patients with similar communication vulnerabilities. We wish to thank those patients whose personal stories illustrate a wide range of patient-provider communication barriers and solutions.

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CHAPTER 2

Issues and Challenges in Advancing Effective Patient-Provider Communication

Sarah W. Blackstone

Introduction

Communication between patients and providers is a core component of patient-centered and value-based health care. In Chapter 1 we noted that policy makers, administrators, researchers, and providers across the continuum of health care are beginning to address this component more fully, forcefully, and systematically. Research shows that communication breakdowns can lead to negative health outcomes, increased costs, lack of adherence to provider recommendations, longer stays in intensive care units (ICUs), longer hospital stays, increased hospital readmissions, an increase in sentinel events, and reduced patient satisfaction (Bartlett, Blais, & Tamblyn, 2008; The Joint Commission, 2013). Evidence also reveals that successful patient-provider communication correlates positively with patient safety and satisfaction, better health outcomes, adherence to recommended treatment, self-management of disease, and lower costs (Bartlett, Blais, & Tamblyn, 2008; Divi, Koss, Schmaltz, & Loeb, 2007; Wilson-Stronks & Galvez, 2007; Wolf, Lehman, Quinlin, Zullo, & Hoffman, 2008). In this chapter, we dis-

cuss the nature of communication between patients and providers across the continuum of health care, identify populations who are “communication vulnerable,” discuss opportunities for speech-language pathologists and other providers to improve patient-provider communication across health care settings, and give examples of promising practices during medical encounters. This chapter sets the stage for more detailed discussions of specific health care settings in later chapters.

Given the diversity of patients, providers, medical encounters, and health care settings, as well as the complexity of the messages that need to be conveyed, successful communication between patients and providers is not easily achieved. “Communication access” is, nevertheless, mandated by law, policy, and regulations in the United States and other Western nations. This means that health care systems and the professionals who work in them need to develop a better understanding of factors that influence successful patient-provider communication so they can prevent or ameliorate communication breakdowns. Communication access involves consideration of face-to-face interactions between two people or in a group situation; telephone communication;

reading and handling text and print materials; use of the Internet, e-communications and social media; and written communication (Collier, Blackstone, & Taylor, 2012).

Defining Communication

Communication is so embedded in our everyday lives that we rarely think about how complex it truly is. Theoretical constructs of communication (whether or not they are explicitly understood, known, or stated) help shape our daily practice and research and influence what constitutes best practice, what is considered relevant evidence, and how evidence is interpreted (Blackstone, Wilkins, & Williams, 2007).

An early construct of the human communication process was the “sender-receiver” model of communication (Shannon & Weaver, 1949). This widely held and persistent theory conceptualized human communication as consisting of a sender, a channel, and a receiver. As applied within the context of health care, the sender-receiver model led to expectations that a provider (e.g., a physician or a speech-language pathologist) “sends” information to a patient during a medical encounter (e.g., an office visit, at bedside) and then assumes the patient has understood/“received” the information conveyed, which may or may not be the case. Interference from the “channel” during face-to-face communication is often illustrated by the “telephone game” wherein a message is whispered in the ear of one person after another, clearly demonstrating how easily messages can be distorted without either the sender or receiver being aware. As George Bernard Shaw pointed out, “the single biggest problem with communication is the illusion that it has taken place.”

The sender-receiver model is far too simplistic a view of human communication. For starters, face-to-face interaction involves mul-

iple channels (e.g., information is transmitted nonverbally as well as verbally). A more robust and workable construct also requires recognition that human communication is part of an interactive, dynamic social process and thus necessitates consideration of factors that go beyond the individuals involved, taking into account underlying cultural components and key aspects of the environment.

The communication accommodation theory (Giles & Ogay, 2007) recognizes that speakers and listeners accommodate each other’s communication patterns during social interactions. One interesting application of the theory is consideration of the kinds of “overaccommodations” and “underaccommodations” that can affect interaction. These often occur when one communication partner has a “stereotypical” view of another. For example, overaccommodations abound in residential facilities, as exemplified when staff use a higher pitch and volume, exaggerated intonation, simplified grammatical structures and vocabulary, greater repetition and terms of endearment (honey, lovey) with their elderly residents or with adults with disabilities (Worrall & Hickson, 2007). An example of an underaccommodation is the situation in which a communication partner fails to recognize the signals of another or lacks awareness of cross-cultural issues.

In addition, our interactions have changed dramatically over the past few decades, reflecting advances in information and communication technologies. An increasingly high percentage of human interaction today does not occur face-to-face, but rather asynchronously and across great distances, using text, graphics, photos, avatars, sounds, and other media, as well as spoken language.

The theoretical construct of communication we use in this book is grounded in cognitive science and psycholinguistics, widely supported by research, and links easily to other theoretical constructs that address human interaction and language (Clark,

2005; Goodwin, 2003; Hutchins, 2001). We define communication as the joint establishment of meaning, wherein meaning is jointly established or coconstructed using a variety of strategies, which include the simultaneous use of common modalities (speech, gestures, manual signs, facial expressions, electronic and nonelectronic technologies, etc.) (Blackstone, Wilkins, & Williams, 2007).

The Joint Commission, a health-care accrediting agency in the United States, recently adopted this definition of communication in its standard for hospitals, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Road Map for Hospitals* (The Joint Commission, 2010), applying it specifically to interactions between patients and providers:

Effective communication is the successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care. (The Joint Commission, 2010, p.1)

Communication Challenges During Medical Encounters

Patients and providers share a common goal—the patient’s health; however, making progress

toward that goal usually requires that patient and provider be able to communicate effectively. Medical encounters are often high-stakes interactions and may be stressful and time constrained. Thus, although successful communication is a critical component of each encounter, it can be very difficult to achieve for a myriad of reasons. For example, interactions between patients and providers often involve individuals who are not familiar with one another, may have very different views about the world, and even speak different languages. Patients (or providers) may have difficulty hearing, speaking, understanding, or remembering what is being said. Family members may be present, and when they are, can influence patient-provider communication, making it easier or, in some cases, more difficult. Also, interactants may be distracted by concerns that have absolutely nothing to do with the situation at hand, such as worrying about a sick child left at home, what to make for dinner, or an argument with a spouse. Finally, many significant issues are too rarely acknowledged or understood, including socioeconomic issues, educational background, culture and religion, race, ethnicity, sexual orientation, gender identity, age and other personal characteristics or beliefs. Some of these can function as “the elephant in the room.”

As LaPointe (1996) pointed out, health care professionals need to guard against the routineness of their procedures and practices. Reflecting on his own experience as a patient, LaPointe recalls a nurse who greeted him for a scheduled medical procedure saying, “So you’re the cysto.” He writes, “I’m a bit more than ‘the cysto.’ I am a person that is scared at the moment and worried about my future and a bit more complex than a shorthand name for a medical procedure” (LaPointe, 2011). He reminds providers of the need to explain procedures in a way that the patient can understand, to reveal and clarify rationales, to answer questions, and to calm fears. Providers

should find ways for patients to express their concerns, describe their symptoms, talk about what might be bothering them, ask questions, and get their needs met. This information is essential to receiving an accurate diagnosis, appropriate treatment, and adequate follow-up, and experiencing better health. One available model is Dr. Arthur Kleinman's Nine Questions, a clinical tool designed to bring out a patient's health beliefs (U.S. Department of Health and Human Services Office of Minority Health, 2014). In short, to preserve the individuality and dignity of each person and do their jobs well and in a timely fashion, providers need to have the communication skills required to treat all their patients, including those with communication challenges.

Kleinman's Questions (adapted from *A Physician's Practical Guide to Culturally Competent Care*. Available at: <https://cccm.thinkculturalhealth.hhs.gov/>):

1. What do you call your problem?
What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you?
How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive?
9. What are the most important results you hope to receive from the treatment?

Breakdowns in health care communication can occur at any time (during regis-

tration, at an office visit, at discharge, in a therapy session, before or after surgery), in any place (doctor's office, emergency room, hospital, skilled nursing facility), and be experienced by anyone (patients, family members, health care providers, other workers). No one is immune. In fact, it is quite surprising that so many medical encounters are successful, and that even when problems occur, most communication partners find ways to circumvent barriers by making adjustments to their own behavior, or by managing to negotiate a solution with their communication partner. For example, interactants may vary the modes of communication they use, decide to change their position (e.g., sit down or stand up), modify their nonverbal or verbal behaviors, rephrase the content of their message, or alter some aspect of the environment. A nurse who observes an agitated patient who is intubated may present the patient with a communication display and say, "Please show me what's wrong." A speech-language pathologist who needs to talk with a patient with limited English proficiency about a swallowing assessment and treatment options may request a medical interpreter.

Most professional training programs recognize the importance of teaching students effective communication skills, and while the amount of time directed to communication training in medical and allied health educational programs is often quite limited, most professionals are well aware of issues that cause communication breakdowns. For example, professional preparation programs teach general information, such as the importance of speaking with patients and families in a respectful manner, using "plain language," reducing rate of speech, and listening closely. Many professionals also learn to use evidence-based techniques, such as teach-back, a strategy that aims to help ensure patients have understood critical information (Dinh, Clark, Bonner, & Hines, 2013; Jager & Wynia, 2012). More

specific information about medical education programs is featured in Chapter 3.

Communication Vulnerable Populations

“Vulnerable” is a term used to refer to groups that are at high risk. Health care, emergency management, education, economics, sociology, and psychology often describe “vulnerable populations” as groups that are at increased risk because of poverty, health disparities, disabilities, limited health literacy, incarceration, limited social networks, and so on. Vulnerability is not only related to something inherent to an individual, but in fact, far more often reflects barriers people experience when denied access to social and material resources (Miller et al., 2010).

We define “communication vulnerability” as the diminished capacity of an individual to speak, hear, understand, read, remember, or write due to factors that are

- inherent to the individual (e.g., disabilities related to receptive and expressive language skills, hearing, vision, speech, cognition, memory, as well as language spoken, lifestyle, belief system, etc.) or
- related to the context or situation (e.g., a noisy environment, being intubated in an intensive care unit after surgery, suffering injury while traveling in a foreign country, having cultural practices, lifestyles, or religious beliefs that are not understood or accepted by providers).

Earlier definitions of communication vulnerability tended to omit entire groups of people and ignore or de-emphasize factors external to the patient. For example, the

Ethical Force Program Consensus Report (American Medical Association, 2006) stated that communication vulnerable populations are those “whose members have limited or no English proficiency, a culture that is not well understood by personnel in the organization, and/or limited health literacy skills” (p. 9). This definition does not include people with communication disabilities. Costello, Patak, and Pritchard (2010) aimed to correct this oversight by defining communication vulnerable individuals as having “diminished capacity in expressive and/or receptive communication abilities” (pp. 289–290), which inadvertently overlooks factors external to the individual. The Joint Commission’s (2010) definition of communication quoted earlier corrects these narrower interpretations.

We identify five patient groups as “communication vulnerable” in Figure 2–1.

People With Disabilities Affecting Communication (Speaking, Hearing, Seeing, Understanding, Reading, Remembering, and Writing)

Nearly one in five people in the United States has a disability (U.S. Census Bureau, 2012). A substantial number of individuals have communication disabilities (American Speech-Language-Hearing Association, 2011). Approximately 27 million people have difficulty hearing or are deaf (Berke, 2010; American Speech-Language-Hearing Association, 2008a, 2010a). As many as 46 million adults and children have some type of disorder that affects their ability to speak and/or understand language (American Speech-Language-Hearing Association, 2008a, 2008b, 2010a; National Institute on Deafness and Other Communication Disorders, 2011; U.S. Department of Education, 2006). Recently, Collier and colleagues (2012) surveyed adults with communication disabilities and their disability service providers in Canada to identify areas