The 38th Forum for Behavioral Science in Family Medicine

The Evolving Role of Patients' Voices in Residency Communication Curriculums

Daniel Hargraves, MSW
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Chris White, MD, JD, MHA

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Disclosures

This presentation is based in part on funded research provided by the Health Resources and Services Administration (HRSA) and the MedTAPP program (a partnership with the Ohio Department of Medicaid). Grant funds provided salary support during the research but no private commercial support.

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Goals and Objectives

1. Upon completion, the participant will be able to describe the use of audio recording as a means to assess learner competency in hearing the patient's voice.
2. Upon completion, the participant will be able to describe the role of Patient Family Advisory Councils as a means of enhancing patient engagement in Family Medicine Residency Programs.
3. Upon completion, the participant will be able to demonstrate some means of how to incorporate note sharing and secure messaging into communication curriculum for resident learners.

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To whom are you listening…

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Who are you…..

How many of you…

- Have/direct a formal communication curriculum?
- Currently using audio/video recording?
- Currently have a PFAC?
- Currently share notes with patients?
- Currently have secure messaging curriculum?

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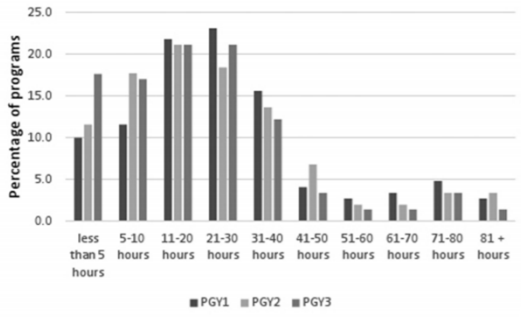
Communication Curriculum Background

Figure 3: Distribution of the Number of Hours Dedicated to Communication Education by Year of Training



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Overview

Effective Communication Curriculum (ECC) Audio Recordings

1. Review of a resident curriculum in effective communication during a patient encounter
2. Incorporating Kalamazoo's seven essential communication tasks into a self-evaluation form for the 15-minute visit
3. Live exercise in self-evaluation
4. Review of quantitative results from residents' self evaluations
5. Identify qualitative themes in residents' self evaluations, faculty feedback, and the audio recording experience

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Effective Communication Curriculum (ECC): The Audio Recording Experience

- **Dual Family Medicine and Psychiatry program**

  In program year cohorts 1-3:
  - 5 Family Medicine residents
  - 2 Dual Family Medicine and Psych residents (5 year residency)

  Total: 25 residents

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The Residency Program

- **Partnership with The Christ Hospital and the University of Cincinnati**
  - Resident clinical time in Christ Hospital's Family Medicine Center
  - FM residents (PGY2) and FM Psych residents (PGY4) also placed in one of three 2-year longitudinal clinical sites for 4-12 hours per month

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ECC Audio Recording Curriculum:

T[illegible]al

To equip family medicine resid[illegible]e communication skills to teach and inform peer learners, [illegible]akeholders, and vulnerable populations about the dete[illegible]th and burden of disease in vuln[illegible]tions.

The Need

Address barriers to effective communication, especially with our most vulnerable patient populations.

Better communication will improve care for all

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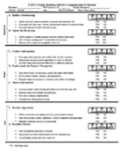
The Audio Recording Curriculum:
Timeline

Literature Background | Video Module | Audio Recording | Self-Evaluation | Faculty Feedback



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The Audio Recording Curriculum:
Literature Background

Patient-Centered Communication: Basic Skills
Provides recommended sequence for medical interviewing including rapport building, agenda setting, and summarizing.
Focus: The patient perspective

The Art of Medicine: 7 Skills that Promote Mastery
Literature review by family medicine faculty member
Describes "the Magnificent Seven" behaviors in medicine that includes focus on empathy and rapport;
Focus: 'human' side of patient interactions

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The Audio Recording Curriculum:

Video Module

Effective Communication: Basics

40 minute video module delivered asynchronously

Provides models of basic communication including verbal and nonverbal cues

Patient-centered communication tenets:

Examples:
- Open-ended questions
- Reflective/empathetic listening
- Teach-back method

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The Audio Recording Curriculum:

Video Module

The 15 Minute Model

Opening

Icebreaking Setting the stage → **Building Rapport** → **Negotiating Agenda**

Middle

Working Agenda | **Clinical Component** | **Maintaining Rapport**

Closure

Summarization

Assessing Understanding

Satisfaction – Provider & Patient

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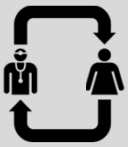
The Audio Recording Curriculum:

Audio Recording

Each resident **completes at least 4 recordings** each program year



Recordings can be completed at Family Medicine Center or longitudinal clinical placements

Scripted consent for patient encounter recording

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The Audio Recording Curriculum:

Self Evaluation Form

Adapted from the Kalamazoo Essential Elements Communication Checklist

- Emerged from Kalamazoo consensus statement

7 essential sets of communication tasks identified:

1. Build the doctor-patient relationship
2. Open the discussion
3. Gather information
4. Understand the patient's perspective
5. Share information
6. Reach agreement on problems and plans
7. Provide closure

Makoul G. **Essential elements of communication in medical encounters: the Kalamazoo consensus statement.** *Acad Med.* 2001 Apr;76(4):390-3.

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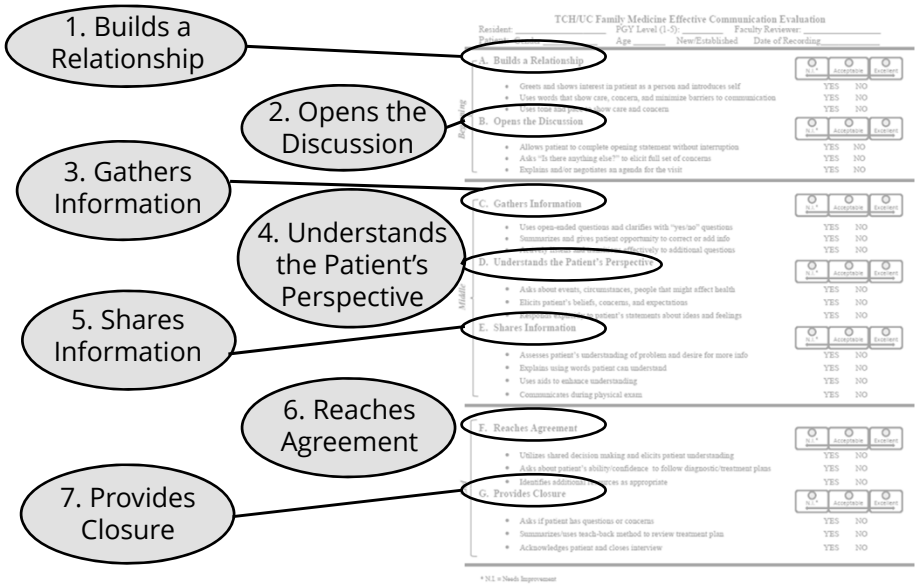

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The Opening

Beginning

A. Builds a Relationship

	N.I.*	Acceptable	Excellent
• Greets and shows interest in patient as a person and introduces self	YES	NO	
• Uses words that show care, concern, and minimize barriers to communication	YES	NO	
• Uses tone and pace to show care and concern	YES	NO	

B. Opens the Discussion

	N.I.*	Acceptable	Excellent
• Allows patient to complete opening statement without interruption	YES	NO	
• Asks "Is there anything else?" to elicit full set of concerns	YES	NO	
• Explains and/or negotiates an agenda for the visit	YES	NO	

Family Medicine ACGME Communication Milestones

C-1 Develops meaningful, therapeutic relationships with patients and families		
Level 2	**Level 3**	**Level 4**
Creates safe environment to engage pts to share information and perspectives	Effectively builds rapport Respects pts' autonomy in decisions and clarifies goals for care consistent with values	Connects with pts/families in continuous manner fostering respect, trust, understanding

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The Middle

Middle

C. Gathers Information

N.I.* | Acceptable | Excellent

- Uses open-ended questions and clarifies with "yes/no" questions — YES NO
- Summarizes and gives patient opportunity to correct or add info — YES NO
- Actively listens and transitions effectively to additional questions — YES NO

D. Understands the Patient's Perspective

N.I.* | Acceptable | Excellent

- Asks about events, circumstances, people that might affect health — YES NO
- Elicits patient's beliefs, concerns, and expectations — YES NO
- Responds explicitly to patient's statements about ideas and feelings — YES NO

E. Shares Information

N.I.* | Acceptable | Excellent

- Assesses patient's understanding of problem and desire for more info — YES NO
- Explains using words patient can understand — YES NO
- Uses aids to enhance understanding — YES NO
- Communicates during physical exam — YES NO

Family Medicine ACGME Communication Milestones

C-2 Communicates effectively with patients, families, and the public	
Level 3	**Level 4**
Engages patients' perspectives in shared decision making	Educates and counsels patients and families in disease mgmt. and health promotion skills Focus on patient-centeredness and integrates all aspects of patient care to meet patient's needs

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The Closure

End

F. Reaches Agreement

N.I.* | Acceptable | Excellent

- Utilizes shared decision making and elicits patient understanding — YES NO
- Asks about patient's ability/confidence to follow diagnostic/treatment plans — YES NO
- Identifies additional resources as appropriate — YES NO

G. Provides Closure

N.I.* | Acceptable | Excellent

- Asks if patient has questions or concerns — YES NO
- Summarizes/uses teach-back method to review treatment plan — YES NO
- Acknowledges patient and closes interview — YES NO

Family Medicine ACGME Communication Milestones

C-2 Communicates effectively with patients, families, and the public	
Level 3	**Level 4**
Engages pts' perspectives in shared decision making	Educates and counsels pts and families in disease mgmt. and health promotion skills Focus on patient-centeredness and integrates all aspects of pt care to meet patient's needs

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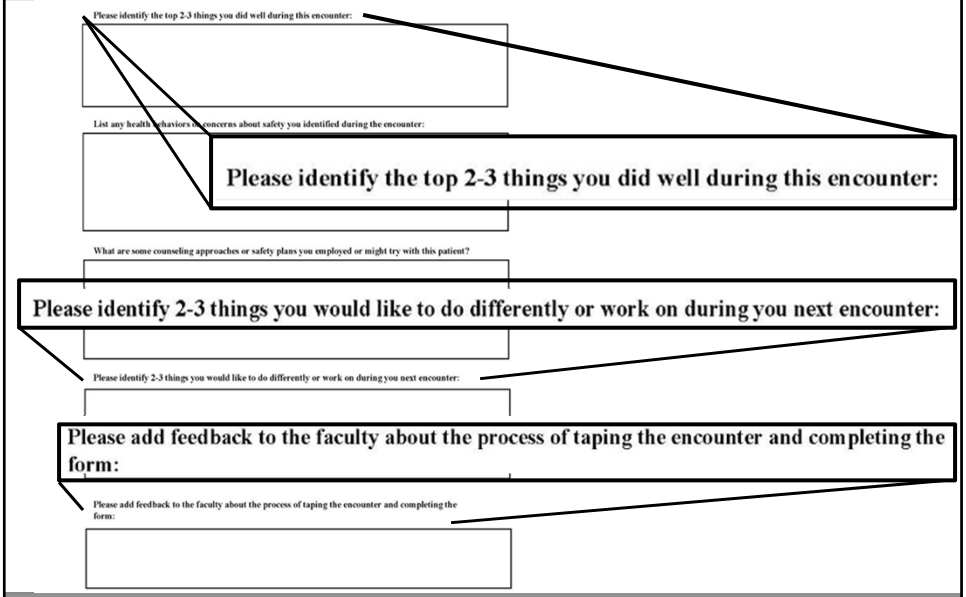

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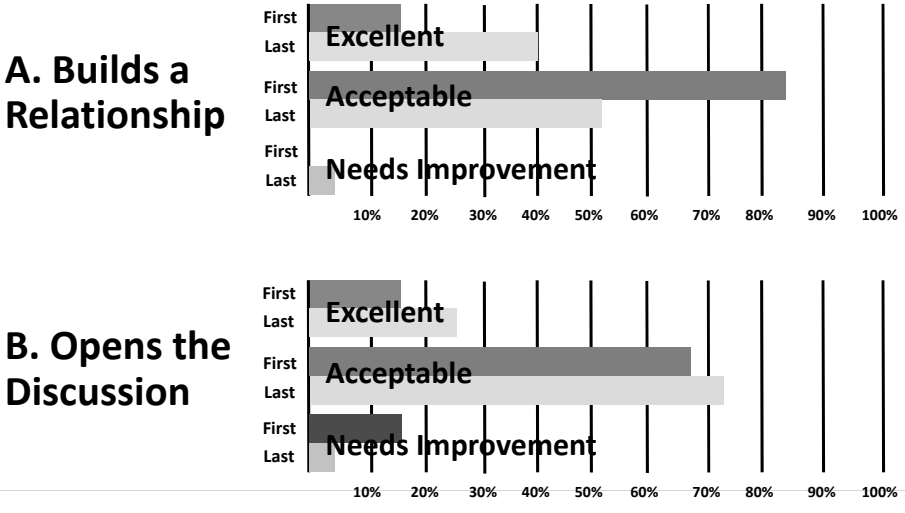
Opening: Self Evaluation Results (n=25 residents)



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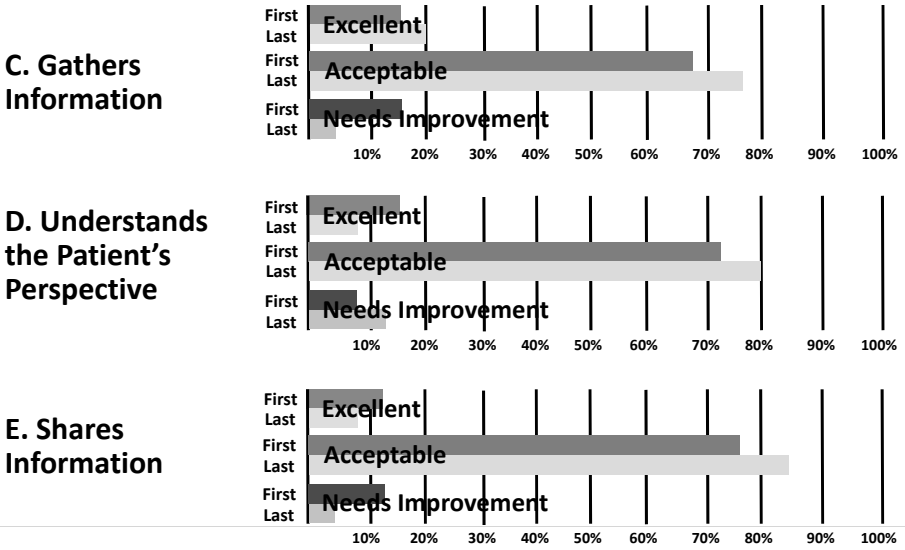
Middle: Self Evaluation Results (n=25 residents)



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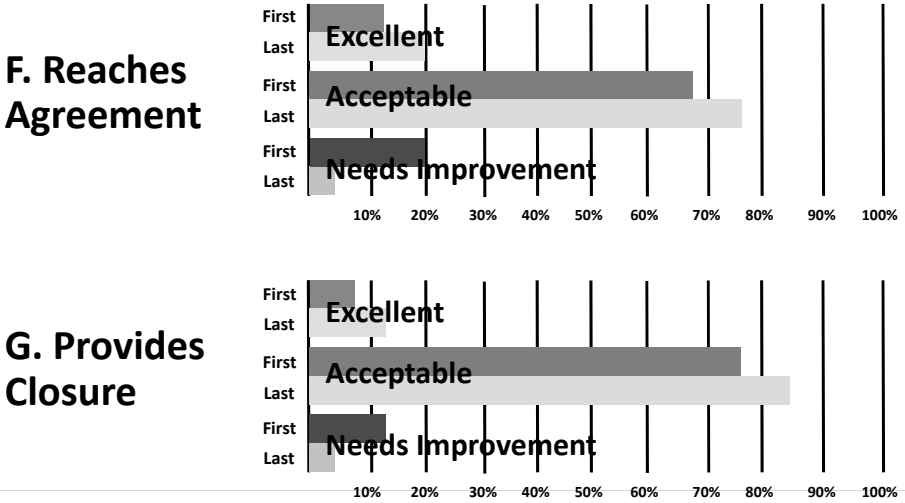
Closing: Self Evaluation Results (n=25 residents)



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Themes from Open-Ended Questions:

What did residents feel they did well?

Theme 1. Building and maintaining long-lasting, trusting relationships

I have a good relationship with the patient. We have created a comfortable space where he is safe to share whatever is on his mind.

Over time, we have built a trusting relationship, and I feel I have been able to connect with her. This has been a process with this patient.

Brought up some topics that we discussed in the past-vacation plans, caring for her cat. It helps me not only establish rapport, but also helps me assess how she is doing functionally.

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Themes from Open-Ended Questions:

What did residents feel they did well?

Theme 2. Empathy and caring for the patient

I felt as though I was able to match her energy, understand how difficult this is to her.

I allow her to voice her concerns and even vent about her life at visits.

I kept the focus on his diabetes while also showing compassion for his chronic cramping, reassuring him he's getting the care he needs.

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Themes from Open-Ended Questions:

What did residents feel they did well?

Theme 3. Eliciting the patient's concerns

I was patient enough to let him push my ideas aside and come to his own ideas he was motivated to make.

Good job of allowing the patient to lead some of the discussion.

Let her have open-ended answers to questions and have time to talk.

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Themes from Open-Ended Questions:

What would residents like to do differently?

Theme 1. More pre-visit prep and history taking

Get a more complete history, not double and triple check/reiterate facts. It made me look unprepared and where to go next.

I need to do more prep work for visits so I have a better grasp on his diabetes and can keep the conversation moving more quickly and smoothly.

I could have been more organized in my history taking. I asked the same questions repeatedly a couple times.

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Themes from Open-Ended Questions:

What would residents like to do differently?

Theme 2. Capitalize on teaching moments and sharing resources

I could have done more teaching opportunities like going into further detail about things to eat instead of just referring him to a diabetic counselor.

I could have given the patient more specific reasons for follow-up with her PCP regarding BP, stress, and smoking.

I forgot to give her a handout on stress urinary incontinence and like the previous encounter, the teach-back method would have been good given her level of health literacy.

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Themes from Open-Ended Questions:

What would residents like to do differently?

Theme 3. Keeping the visit and agenda on track

I need to be better at steering the conversation, sometimes letting the patient go too long for a 15 minute visit.

She skips around all over the place and at times gives such off the wall answers that I find myself distracted and difficult to come up with a plan right away.

I want to listen and show empathy but at the same time I need help on how to get the conversation back on track when the patient starts going off on tangents.

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What do faculty think? Themes from feedback on strengths

Theme1. Building and maintaining long-lasting, trusting relationships

The greatest strength in this recording was the relationship you had with the patient. Clearly you two were on the same page and talking in shorthand.

It was refreshing to hear you and the patient chit chat in such a comfortable and natural style. She clearly felt comfortable with you.

After 30 years with another provider, after one visit the patient asking your name and more about who you are is the greatest sign of confidence in your abilities as a physician.

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What do faculty think? Themes from feedback on strengths

Theme 2. Keeping the visit and agenda on track

A very efficient visit while maintaining a nice pace and caring/non-judgmental demeanor.

Not only were you interactive with the patient and his partner, you did great teaching, came up with specific follow up steps, triaged a new complaint, made small talk all in 15 minutes and they sounded very satisfied.

The strength was remaining focused on immediate safety issues and getting triage questions down in a very efficient manner yet also working to attend to this new patient and keep some rapport going.

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What do faculty think? Themes from feedback on strengths

Theme 3. Educating and engaging while remaining patient-centered

You always do a nice job of being jargon free and explaining things to the patient.

You do a good job of trying to teach as you go along with the visit and remained jargon free.

You allowed her to do the overwhelming part of the talking as supportive counseling as you both worked to prioritize her wellness through her troubled personal relationship.

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ECC Audio Recording Process Feedback from Residents

The form is very easy to complete and helps me focus on my strengths and weaknesses.

Taping is awkward and another time suck during a busy clinic day.

Completing this form is interesting for me because I consider my self a good communicator but I am still missing some key points.

I would not have let this encounter go on this long if I did not know that I was being recorded.

Always feel it's a worthwhile exercise after I actually do the recordings.

Various issues with the physical handheld recorder and remembering to do the assignment.

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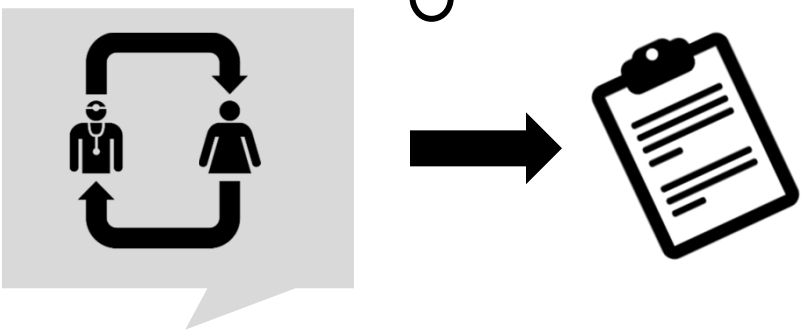
Activity:
An Exercise in Self-Evaluation



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A Patient and Family Advisory Council:

our journey

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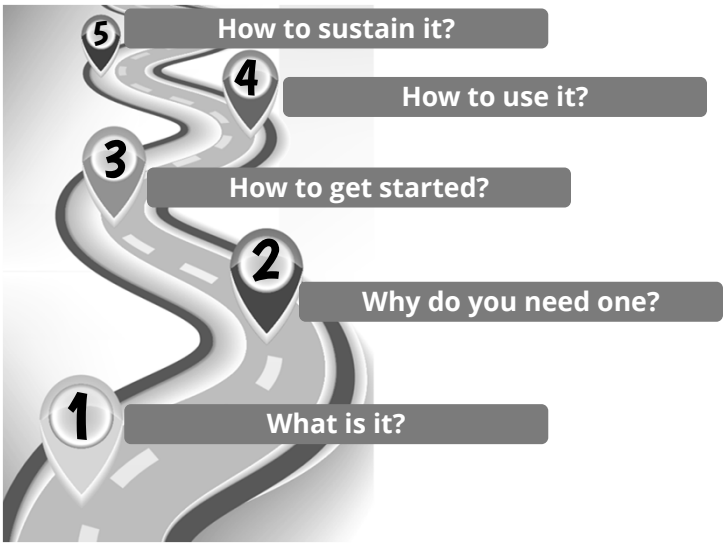

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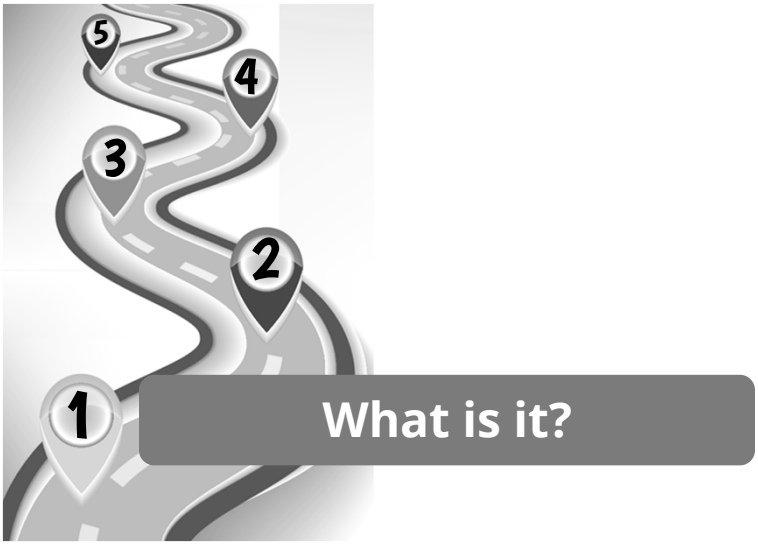

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The Foundation:
Patient- and Family Centered Care

Patient- and family-centered care is working **"with"** patients and families, rather than just doing something "to" or "for" them.

The Christ Hospital defines family as:

"Family refers to two or more people related in any way, **biologically, legally, or emotionally.**

The Christ Hospital allows patients to *define who family is to them*."

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4 Principles of Patient- and Family-Centered Care (PFCC):

Dignity and Respect	Information Sharing	Participation	Collaboration

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A PFAC is a group of patients/family members, office staff, residents and physicians working together to improve care.

Our council at The Christ Hospital Family Medicine Center includes **18 members** consisting of:

- 8 patient/family advisors
- 4 staff advisors
- 4 resident advisors
- 2 physician advisors

Key leadership, including the Medical Director and Office Manager, *are present at our meetings.*

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Why do you need one?

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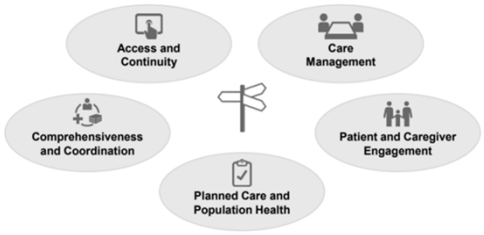
CPC+ Practice Care Delivery Requirements:



Practices will organize a Patient and Family Advisory Council (PFAC) to help them understand the perspective of patients and caregivers on the organization and delivery of care, as well as its ongoing transformation through CPC+.

Practices will use the recommendations from the PFAC to help them improve their care and ensure its continued patient-centeredness.

https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf

Why do you need one?

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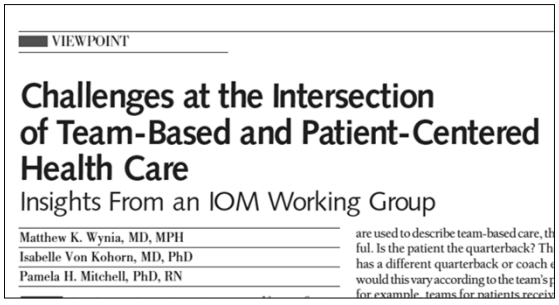
"In high-functioning health care teams, patients are ***members*** of the team; not simply ***objects*** of the team's attention; they are the ***reason*** the team exists and the ***drivers*** of all that happens."



VIEWPOINT

Challenges at the Intersection of Team-Based and Patient-Centered Health Care

Insights From an IOM Working Group

Matthew K. Wynia, MD, MPH
Isabelle Von Kohorn, MD, PhD
Pamela H. Mitchell, PhD, RN

are used to describe team-based care, th
ful. Is the patient the quarterback? Th
has a different quarterback or coach
would this vary according to the team's
for example, teams for patients receiv

Wynia MK, Von Kohorn I, Mitchell PH. Challenges at the Intersection of Team-Based and Patient-Centered Health Care Insights From an IOM Working Group. JAMA. 2012;308(13):1327–1328. doi:10.1001/jama.2012.1260*

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Why do you need one?

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In a growing number of instances where truly ***stunning levels of improvement have been achieved***, **organizations have asked patients and families to be directly involved in the process.**

And those organizations' leaders often ***cite this change*** **—putting patients in a position of real power and influence, using their wisdom and experience to redesign and improve care systems** — ***as being the single most powerful transformational change in their history.***

Reinertsen, Bisagnano, & Pugh. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care, 2nd Edition, IHI Innovation Series, 2008. Available at www.ihi.org.

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Everyone—patients and staff alike—embraces the concept, yet ***no one knows how to truly hear the patient's voice***.

Given the proper resources and leadership, PFAC programs have tremendous potential and can enable institutions to hear the patient's voice.

PFACs are powerful tools for ***hearing the patient's voice and identifying the needs of a patient population.***

Niehaus K. Using a Patient and Family Advisory Council as a Mechanism to Hear the Patient's Voice. J Oncol Pract. 2017 Aug;13(8):509-511. doi: 10.1200/JOP.2017.024240. Epub 2017 Jul 13. PubMed PMID: 28704122.

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Benefits of the Patient Voice

1. HC professionals ***make fewer assumptions*** about what patients and family members want
2. Patient advisors have a ***different lens*** and can help identify "blind spots"
3. Advisors challenge ***what is possible***
4. Patients are a ***key stakeholder*** in healthcare

Adapted from Collaborating with Patients and Families in Quality Improvement Webinar, Institute for Patient and Family Centered Care (IPFCC)

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How to get started?

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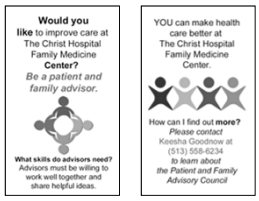
Recruitment Strategies

Our best recruitment strategy is the use of a ***"pocket card" –***



Physicians **personally invite patients** to become part of our council and give them a card with details and contact information.

We also rely on patient/family advisor recommendations, word of mouth, brochures, and posters to invite our patients to join.

How to get started?

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Recruitment Process

Medical Director ***screens and calls*** potential candidates

Coordinator calls, provides ***detailed information*** and completes a ***phone interview***

Patients submit an ***application***

Complete a ***background check***

Attend an ***orientation***

Commit to ***one-year term***

How to get started?

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Sample Agenda

AGENDA:

- Ice Breaker or Sharing Segment
- "Educational Moment"
- Real Time Clinic Issue Discussion
- Quality Improvement Update
- Patient & Family Priorities

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How to use it?

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Sample Meeting Content

- Patient- and Family-Centered Care Principles
- Roles & Responsibilities of Advisors
- How to Share your Story
- Communication Basics
- Plan-Do-Study-Act (PDSA) Cycles for Quality Improvement
- Discussion of Real Time Clinic Issues
- "Walk About" Experience as QI Tool
- Identification of QI Projects and ongoing feedback

How to get started?

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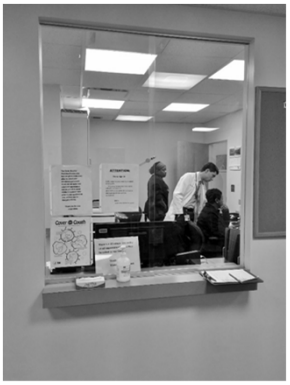
Walkabout



How to use it?

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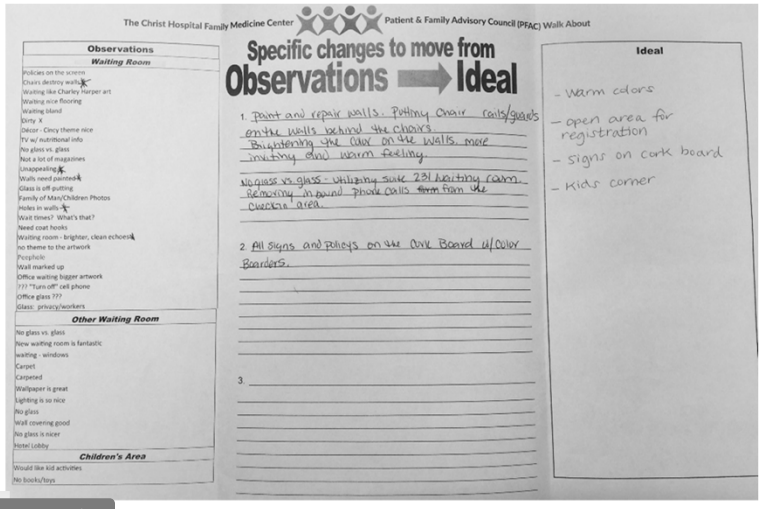

The Christ Hospital Family Medicine Center — Patient & Family Advisory Council (PFAC) Walk About

Observations

Waiting Room

Policies on the screen
Chairs destroy walls
Waiting like Charley Harper art
Waiting nice flooring
Waiting bland
Dirty X
Décor - Cincy theme nice
TV w/ nutritional info
No glass vs. glass
Not a lot of magazines
Unappealing
Walls need painted
Glass is off putting
Family of Man/Children Photos
Holes in walls
Wait times? What's that?
Need coat hooks
Waiting room - brighter, clean echoes
no theme to the artwork
Prophalic
Wall marked up
Office waiting bigger artwork
??? "Turn off" cell phone
Office glass ???
Glass: privacy/workers

Other Waiting Room

No glass vs. glass
New waiting room is fantastic
waiting - windows
Carpet
Carpeted
Wallpaper is great
Lighting is so nice
No glass
Wall covering good
No glass is nicer
Hotel Lobby

Children's Area

Would like kid activities
No books/toys

Specific changes to move from Observations ➡ Ideal

1. Paint and repair walls. Putting chair rails/guards on the walls behind the chairs. Brightening the color on the walls. more inviting and warm feeling.

No glass vs glass - Utilizing suite 231 waiting room. Removing in-wall phone calls from from the checkin area.

2. All signs and policys on the one Board w/color Boarders.

3.

Ideal

- Warm colors
- open area for registration
- signs on cork board
- Kids corner

How to use it?

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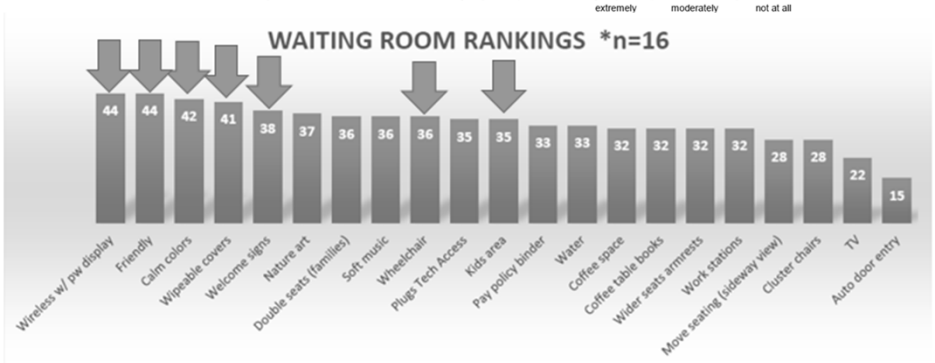
The Christ Hosptial Family Medicine Center — Patient Family Advisory Council — Quality Improvement: Best Practice Rankings

Please check the importantce of each factor: 1 = extremely important, 2 = moderately important, 3 = not at all important



Automatic Entry Door	☐	☐	☐

How to use it?

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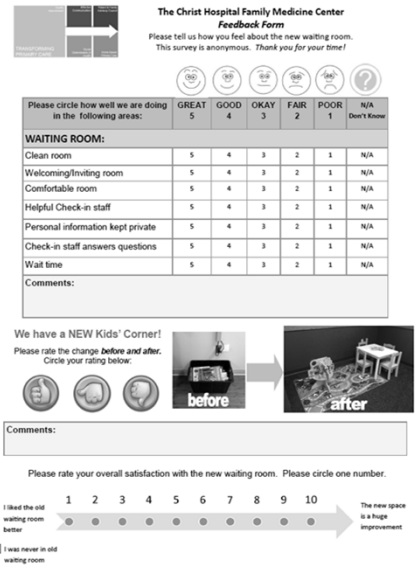

The Christ Hospital Family Medicine Center
Feedback Form
Please tell us how you feel about the new waiting room.
This survey is anonymous. *Thank you for your time!*

Please circle how well we are doing in the following areas:	GREAT 5	GOOD 4	OKAY 3	FAIR 2	POOR 1	N/A Don't Know
WAITING ROOM:						
Clean room	5	4	3	2	1	N/A
Welcoming/Inviting room	5	4	3	2	1	N/A
Comfortable room	5	4	3	2	1	N/A
Helpful Check-in staff	5	4	3	2	1	N/A
Personal information kept private	5	4	3	2	1	N/A
Check-in staff answers questions	5	4	3	2	1	N/A
Wait time	5	4	3	2	1	N/A
Comments:						

We have a NEW Kids' Corner!
Please rate the change ***before and after.***
Circle your rating below:

Comments:

Please rate your overall satisfaction with the new waiting room. Please circle one number.

I liked the old waiting room better — 1 2 3 4 5 6 7 8 9 10 — The new space is a huge improvement

☐ I was never in old waiting room

How to use it?

TOOLKIT

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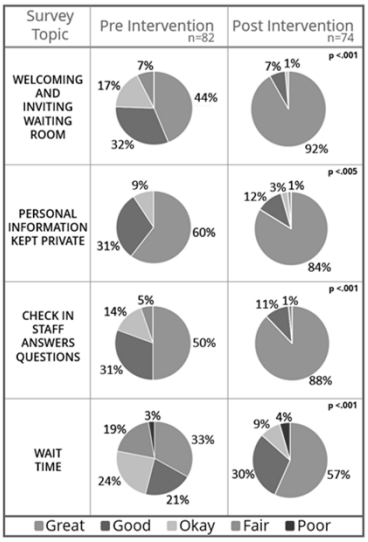

Survey Topic	Pre Intervention n=82	Post Intervention n=74
WELCOMING AND INVITING WAITING ROOM	7%, 17%, 44%, 32%	p <.001: 7%, 1%, 92%
PERSONAL INFORMATION KEPT PRIVATE	9%, 31%, 60%	p <.005: 12%, 3%, 1%, 84%
CHECK IN STAFF ANSWERS QUESTIONS	5%, 14%, 31%, 50%	p <.001: 11%, 1%, 88%
WAIT TIME	3%, 19%, 33%, 24%, 21%	p <.001: 9%, 4%, 30%, 57%

Great Good Okay Fair Poor

While cleanliness, inviting atmosphere, and comfort were all expected to improve, ***patient perception of wait time and helpfulness of office staff improved,*** even though we made no staff or process changes

How to use it?

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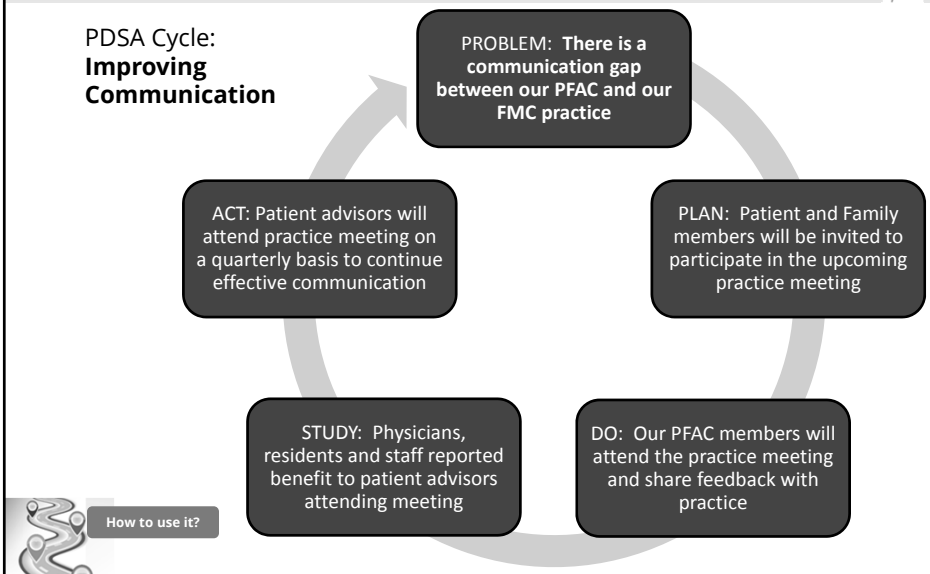
PDSA Cycle:
Improving Communication



How to use it?

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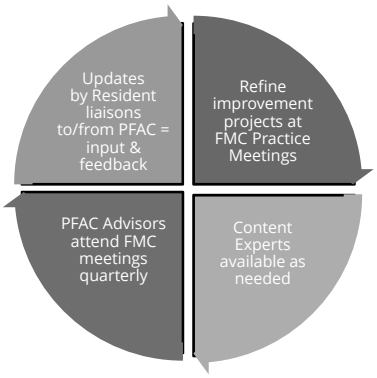
The PFAC is the ***driver for QI***

The Family Medicine Center weekly practice meeting is the ***dissemination vehicle***



How to use it?

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How to sustain it?

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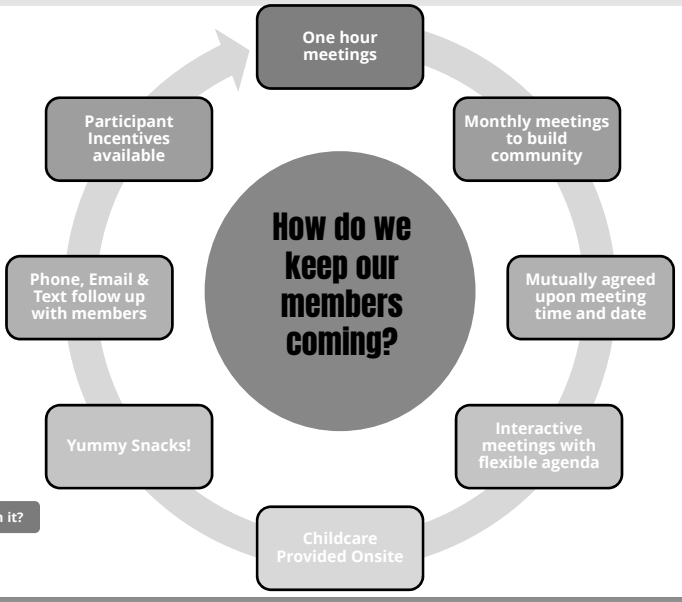

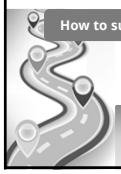

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Key Take Aways:

1. ***Don't be too polished:*** Patients want to see the human side of you
2. ***Speak a common language:*** Leave the acronyms and abbreviations at the door
3. ***Avoid information overload:*** Teach concepts and strategies in "Educational Moments"
4. ***Pause….:*** Intentional silence encourages the patient voice

How to sustain it?

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- Articles/Publications
- Implementation Guides
- Sample Forms

Why do you need one?

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Effective Communication: **Note Sharing**

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The OpenNotes Study

Box 1: OpenNotes study[6]

12 month study in primary care practices at three sites

- Beth Israel Deaconess Medical Center, a large teaching hospital offering primary care in Boston, and affiliated suburban practices
- Geisinger Health System, an integrated system with clinics scattered through rural Pennsylvania
- Harborview Medical Center, a safety net hospital in the University of Washington health system in Seattle

Participants

- 105 primary care physicians completed the study; 143 declined to participate
- Physicians; notes were opened to >19 000 patients who were registered for their institution's portal; patients were notified by secure portal message that their notes would be available during the study
- Participating doctors were allowed to exclude patients from the study; 1023 were excluded at Harborview (mainly patients with major mental illness or substance misuse), 158 were excluded at Beth Israel Deaconess, and 139 at Geisinger

How it worked

- After a visit, the doctor's electronic signature triggered a secure message notifying the patient the note was available
- The patient could log in to the institution's secure portal and read the note
- Before the next scheduled visit, another secure message encouraged the patient to review the note to prepare for the visit
- Notes written before the study were not available online

Evaluation

- Surveys of patients and doctors before and after the intervention
- Analysis of email volume and portal use

Patient results

- >80% of patients opened at least one note
- Over two thirds reported better understanding of their health and medical conditions, taking better care of themselves, doing better with taking their medications, or feeling more in control of their care
- Few (1-8% at the three sites) were confused, worried, or offended by what they read
- About 20% shared a note with someone else
- >85% said availability of notes would influence future choice of providers

Doctor results

- Only 3% spent more time answering patient questions outside of visits, 11% spent more time writing or editing notes; email volume did not change
- About 20% reported changing the way they wrote about cancer, mental health, substance misuse, or obesity

- Research and demonstration project
- **105 PCPs and 20,000 patients**:
  - Boston (BIDMC)
  - Rural Pennsylvania (Geisinger)
  - Seattle Inner City (Harborview)
- Today = **80+** Health systems share notes

BMJ 2015; 350 doi: https://doi.org/10.1136/bmj.g7785 (Published 10 February 2015)

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Go to: **https://www.opennotes.org/join/map/**

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Patients who read notes…

- Have a ***better understanding*** of their health and medical conditions
- Feel more ***in control*** of their health
- Can identify inaccuracies in the record and ***play a role in the safety*** of care
- ***Feel comfortable*** sharing notes with care partners and others involved in their care
- ***Can communicate more clearly***, helping to strengthen the partnership between themselves and their health care team

Delbanco, Walker et al. Inviting Patients to Read Their Doctors' Notes. Ann Intern Med 2012;157(7):461-470. DOI: 10.7326/0003-4819-157-7-201210020-00002

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Doctor-Patient Relationships

99% — **Patients** felt better (37%) or the same (62%) about their doctor after reading one or more notes.

7% — **Patients** reported contacting their doctor about concerns in their note.

>50% — **Doctors** believed shared notes increased patient satisfaction and trust.

0% — **Doctors** reported ordering more tests or referrals.

Bell SK, Mejilla R, Anselmo M, et al. BMJ Qual Saf Published Online First: doi:10.1136/bmjqs-2015-004697

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Why do patients read notes?

1. To know about my health
2. To be sure I understood what the doctor said
3. I was curious
4. To know what my doctor was thinking
5. To remember the visit
6. To check if the notes were right

Bell SK, Gerard M, Fossa A, et al A patient feedback reporting tool for OpenNotes: implications for patient-clinician safety and quality partnerships. BMJ Qual Saf Published Online First: 13 December 2016. doi: 10.1136/bmjqs-2016-006020

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Potential Barriers

- Concerns about errors
- Offending language
- More questions
- More time

Potential Benefits

- Enhanced patient engagement
- Better awareness of care plan
- Better information & ability to share with family
- Increased patient satisfaction
- Increased patient safety
- More open discussion about difficult topics

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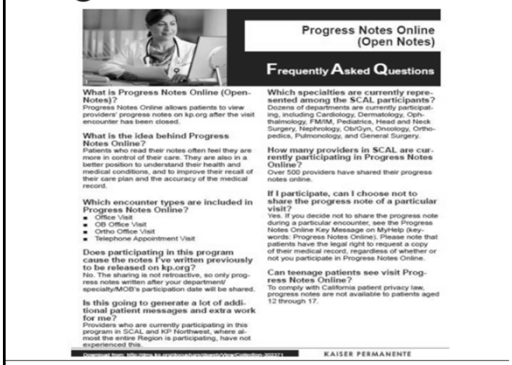
Progress Notes Online FAQs



IPFCC Webinar: OpenNotes the Power of Knowing, September 6, 2017

https://www.opennotes.org/tools-resources/for-patients/patient-faqs/

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I remember this history when I hear doctors object to making lab reports or visit notes available to patients because they may cause pain and anxiety. No doubt they will in some cases, but then pain and anxiety are part of the human condition and are as likely to be produced by a sense of ignorance and powerlessness as by knowledge. The difference turns on who decides. People have myriad ways of protecting themselves from things they don't want to know. Making information freely available doesn't necessarily mean that patients will be forced to learn what they'd rather ignore. The Internet is a model here: Some people devour the plethora of medical information; others avoid it like the plague. If any generalization suffices, to treat patients like adults requires that we, not a well-meaning professional, make the choice between more and less knowledge.

Meltsner M. A Patient's View of OpenNotes. Ann Intern Med. 2012;157:523–524. doi: 10.7326/0003-4819-157-7-201210020-00012

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OpenNotes®

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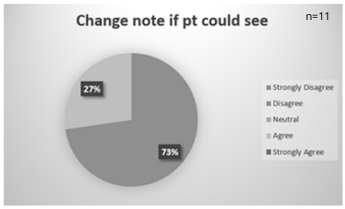
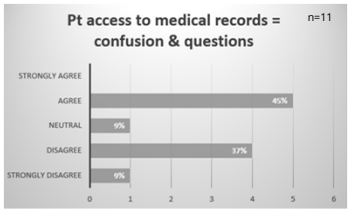
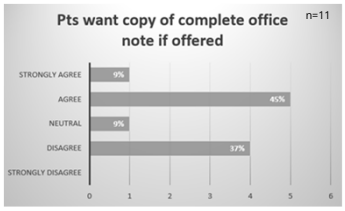
Resident Attitude Surveys







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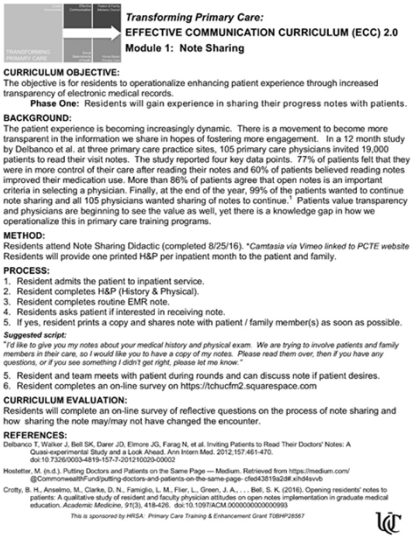

Transforming Primary Care:
EFFECTIVE COMMUNICATION CURRICULUM (ECC) 2.0
Module 1: Note Sharing

CURRICULUM OBJECTIVE:
The objective is for residents to operationalize enhancing patient experience through increased transparency of electronic medical records.
Phase One: Residents will gain experience in sharing their progress notes with patients.

BACKGROUND:
The patient experience is becoming increasingly dynamic. There is a movement to become more transparent in the information we share in hopes of fostering more engagement. In a 12 month study by Delbanco et al. at three primary care practice sites, 105 primary care physicians invited 19,000 patients to read their visit notes. The study reported four key data points. 77% of patients felt that they were in more control of their care after reading their notes and 60% of patients believed reading notes improved their medication use. More than 86% of patients agree that open notes is an important criteria in selecting a physician. Finally, at the end of the year, 99% of the patients wanted to continue note sharing and all 105 physicians wanted sharing of notes to continue.[1] Patients value transparency and physicians are beginning to see the value as well, yet there is a knowledge gap in how we operationalize this in primary care training programs.

METHOD:
Residents attend Note Sharing Didactic (completed 8/25/16). **Camtasia via Vimeo linked to PCTE website*
Residents will provide one printed H&P per inpatient month to the patient and family.

PROCESS:
1. Resident admits the patient to inpatient service.
2. Resident completes H&P (History & Physical).
3. Resident completes routine EMR note.
4. Residents asks patient if interested in receiving note.
5. If yes, resident prints a copy and shares note with patient / family member(s) as soon as possible.

Suggested script:
"I'd like to give you my notes about your medical history and physical exam. We are trying to involve patients and family members in their care, so I would like you to have a copy of my notes. Please read them over, then if you have any questions, or if you see something I didn't get right, please let me know."

5. Resident and team meets with patient during rounds and can discuss note if patient desires.
6. Resident completes an on-line survey on https://tchucfm2.squarespace.com

CURRICULUM EVALUATION:
Residents will complete an on-line survey of reflective questions on the process of note sharing and how sharing the note may/may not have changed the encounter.

REFERENCES:
Delbanco T, Walker J, Bell SK, Darer JD, Elmore JG, Farag N, et al. Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead. Ann Intern Med. 2012;157:461-470. doi:10.7326/0003-4819-157-7-201210020-00002

Hostetter, M. (n.d.). Putting Doctors and Patients on the Same Page — Medium. Retrieved from https://medium.com/@CommonwealthFund/putting-doctors-and-patients-on-the-same-page- cfbd43819a2d#.xhd4evvb

Crotty, B. H., Anselmo, M., Clarke, D. N., Famiglio, L. M., Flier, L., Green, J. A., . . . Bell, S. K. (2016). Opening residents' notes to patients: A qualitative study of resident and faculty physician attitudes on open notes implementation in graduate medical education. *Academic Medicine*, *91*(3), 418-426. doi:10.1097/ACM.0000000000000993

This is sponsored by HRSA: Primary Care Training & Enhancement Grant T08HP28567

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ECC 2.0: Module 1 Note Sharing Module Evaluation

Resident Name | PGY Level | Faculty

How comfortable were you sharing your note with this patient?
- very comfortable
- somewhat comfortable
- somewhat uncomfortable
- very uncomfortable

Did you change the content (change/omit information in the note) or the language (simpler language, used non-medical jargon) of the note since you knew it was going to the patient?
- changed/omitted content
- changed/omitted language
- changed both
- changed neither

After sharing the note, did the patient have questions, clarifications, or comments about your note?
- No questions
- Yes, but it had nothing to do with the note.
- Yes, and the note helped promote better communication
- Yes, but the note was a hindrance to the process

Were there any changes suggested by the patient? Check all that apply.
- Nothing
- Minor Typo
- History
- Medications
- Physical
- Diagnostic Assessment
- Treatment Plan
- Other

Why did you pick this patient?

Having shared your note, would you consider sharing your note more often?
- Yes, for inpatient
- Yes, for outpatient
- Both
- Neither

Why?

Submit

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Note Sharing Project

n=18

100% comfortable	How comfortable were you sharing your note with the patient?
89% changed neither	Did you change the content or language of the note since you knew it was going to the patient?
78% no questions	After sharing the note, did the patient have questions, clarifications, or comments about your note?
61% would share	Having shared your note, would you consider sharing your note more often?

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Effective Communication: **Secure Messaging**

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

E-Health

E-mail in patient–provider communication: A systematic review

Jiali Ye*, George Rust*, Yvonne Fry-Johnson*, Harry Strothers*

ABSTRACT

1. Introduction

2. Methods

24 studies reviewed

- Reviewed content (6 studies)
- Patient perceptions (14 studies)
- Provider perceptions (13 studies)

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Effective Communication: **Secure Messaging**

Journal of the American Board of Family Medicine

Enhancing Doctor-Patient Communication Using Email: A Pilot Study

Shou Ling Leong, MD; Dennis Gingrich, MD; Peter R. Lewis, MD; David T. Mauger, PhD; John H. George, PhD

Disclosures

J Am Board Fam Med. 2005;18(3):180-188.

Comment Print

References

Abstract and Introduction

Background: The doctor-patient relationship has been eroded by many factors. Would e-mail enhance communication and address some of the barriers inherent to our medical practices?

Methods: Of our study population, 4 physicians offered e-mail communication to participating patients and 4 did not. Both patients and physicians completed questionnaires regarding satisfaction, perceived quality, convenience, and promptness of the communication.

Results: Patient satisfaction significantly increased in the e-mail group compared with the control group in the areas of convenience ($P < .0001$) and the amount of time spent contacting their physician ($P < .0001$). Physician satisfaction in the e-mail group increased regarding convenience, amount of time spent on messages, and volume of messages. The response time was longer with e-mail. When asked if patients should be able to e-mail their physicians, most patients in the e-mail group and all but 2 of the physicians in the non-e-mail group responded "yes."

Conclusion: E-mail communication was found to be a more convenient form of communication. Satisfaction by both patients and physicians improved in the e-mail group. The volume of messages and the time spent answering messages for the e-mail group physicians was not increased. E-mail has the potential to improve the doctor-patient relationship as a result of better communication.

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Potential Uses of Secure Messaging

- Help patient prepare for a visit
- Enhance visit or phone call
- Follow-up after visit
- Health news sharing
- Answering common questions
- Chronic disease management
- Patient education

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Potential Benefits

Providers:

· **more patients should use the portal** for things such as medication refill requests

· takes **less time** to respond to e-mails than to process incoming calls and route them

· **efficient communication** and reduction of "phone tag" that often results in delays and miscommunication

· messages **are in patients' own words** and not subject to others interpretation, biases, or attention to detail

· potential **economic benefits** for achieving Meaningful Use requirement of 5% patients utilizing web portal

Patients:

· They appreciate the ability to **ask questions** in-between visits and convenience of **requesting medication** and referrals online

· Some **patients select providers** because of the availability of the portal

· **93% of adults would prefer** to go to a doctor that offers email communication

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Potential Challenges

- IT Access
- Managing Passwords
  - Self
  - Family members
- Appropriate issues for e-Communication
- Privacy concerns
- Need to set expectations (time, content, amount)

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BRIEF REPORT

A Tool to Assess Family Medicine Residents' Patient Encounters Using Secure Messaging

Jung G. Kim, BS
Carl G. Morris, MD, MPH
Fred E. Heidrich, MD, MPH

ABSTRACT

Background Secure messages exchanged between patients and family medicine residents via an electronic health record (EHR) could be used to assess residents' clinical and communication skills, but the mechanism is not well understood.

Objective To design and test a secure messaging competency assessment for family medicine residents in a patient-centered medical home (PCMH).

Methods Using the existing literature and evidence-based guidelines, we designed an assessment tool to evaluate secure messaging competency for family medicine residents training in a PCMH. Core faculty performed 2-stage validity and reliability testing (n = 2 and n = 9, respectively). A series of randomly selected EHR secure messages (n = 45) were assessed from a sample of 10 residents across all years of training.

Results The secure message assessment tool provided data on a set of competencies and a framework for resident feedback. Assessment showed 10% (n = 2) of residents at the novice level, 50% (n = 10) as progressing, and 40% (n = 9) as proficient. The most common deficiencies for residents' secure messages related to communication rather than clinical competencies (n = 37 [90%] versus n = 4 [10%]). Interrater reliability testing ranged from 60% to 78% agreement and 20% to 44% disagreement. Disagreement centered on interpersonal communication factors. After 2 stages of testing, the assessment using residents' secure messages was incorporated into our existing evaluation process.

Conclusions Assessing family medicine residents' secure messaging for patient encounters closed an evaluation gap in our family medicine program, and offered residents feedback on their clinical and communication skills in a PCMH.

Kim JG, Morris CG, Heidrich FE. A Tool to Assess Family Medicine Residents' Patient Encounters Using Secure Messaging. *Journal of Graduate Medical Education.* 2015;7(4):649-653. doi:10.4300/JGME-D-14-00558.1.

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Composing Effective, Personal Messages

I was working so hard in school that I didn't get a flu shot yet. I have had two cold symptoms since just before thanksgiving. My symptoms are/were:
- *1 day last week fever of 100+ but less that 101 F*
- *Chest cough - very small amount of mucous*
- *No vomiting or diarrhea*
- *slight headache and nasal congestion*

Question - can I get a flu shot with these symptoms or should I wait? I recently hear CDC advice to get one even if you are sick - not sure if that is a good idea.
Happy New Year to you and your family!!!

Patient email

Start Personally

Demonstrate Empathy

End Personally

Hello ____,
I am sorry you have been sick! It is typically ok to receive the flu shot as long as you don't currently have a fever. It sounds like you may be at the tail end of an illness and it would be ok to receive the flu shot. We have them in our office still, just call and let the front desk know the day you plan to come in so the nurses can have it ready.

Happy New Year to you as well!

Resident email

Used with permission:
Carl G. Morris, MD, MPH; Jung G. Kim
GroupHealth
Family Medicine Residency, Seattle, WA

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Transforming Primary Care:
EFFECTIVE COMMUNICATION CURRICULUM (ECC) 2.0
Module 2: Secure Messaging / EPIC MyChart

CURRICULUM OBJECTIVE:
The objective is for residents to operationalize appropriate use of asynchronous electronic communication in a variety of clinical settings (home visit, FMC, etc)

BACKGROUND:
Successful patient engagement includes using technology to promote collaborative dialogue. Electronic communication between patients and providers is becoming increasingly common. Patients are: accessing online charts for visit summaries and test results; requesting appointments and prescriptions; and asking questions and receiving feedback via secure portals. According to a recent survey of adults age 21 and over, 93% of patients would prefer to go to a doctor that offers email communication. Beyond these patient factors, Meaningful Use stage 2 criteria requires physicians to interact with at least 5% of patients via the web portal. Secure messaging provides an avenue for collaborative dialogue, engaging patients and promoting a genuine partnership. As this trend evolves, physicians will need training and guidelines on using effective asynchronous communication as a means to provide patient centered care.

METHOD:
Residents will view an online Camtasia presentation for Asynchronous Communication reviewing emerging best practices regarding content and format.
Every 6 months, residents will route 2 doctor-patient conversations from their outpatient clinic to faculty through secure site.

PROCESS:
1. Resident encourages patient to communicate via EPIC MyChart. **discuss registration for portal*
2. Resident accesses EPIC MyChart system.
3. Resident composes and sends message to patient.
4. Resident copies/routes conversation to faculty through EPIC.
5. Faculty reviews conversation and uses rubric to evaluate appropriate use of portal messaging.

CURRICULUM EVALUATION:
Faculty will review and evaluate messages tied to milestones using a Secured Messaging Formative Feedback Evaluation Tool. Evaluation team will work with IT to generate reports regarding spectrum of patient usage.

REFERENCES:
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Leong SL, Gingrich D, Lewis PR, Mauger DT, George JH. Enhancing doctor-patient communication using email: a pilot study. J Am Board Fam Pract. 2005 May-Jun;18(3):180-8. PubMed PMID: 15879565.
Paladine HL, Miller K, White B, Feifer C. Study of a novel curriculum on electronic communication in family medicine residencies.Fam Med. 2010 May;42(5):314-21. PubMed PMID: 20455106.

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TOOLKIT

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ECC 2.0: Module 2 Secure Messaging/EPIC MyChart Formative Feedback Evaluation Tool

Resident Name:	PGY:	Date of Message:

C.2 Communicates effectively with patients, families, and the public:
Utilizes optimal communication factors in secure messaging.

Level 1: NOVICE	Level 2: BEGINNER	Level 3: INTERMEDIATE	Level 4: COMPETENT	Level 5: EXPERT
Many missed opportunities; Language lacks clarity, spelling/grammar issues; Limited awareness of messaging components; Significant time gap for response	Relatively few opportunities missed; Language included tone problems or abbreviations and lacked components of effective messaging; Some delay in timing	No major missed opportunities; Language free of spelling/grammar mistakes, includes major components of effective messaging; Response time met standard	Addressed most opportunities; Communicates a transparent message with some empathy; Utilizes most components of effective messaging; Most replies completed at or quicker than time standard	All opportunities addressed; Concise, clear lay language with a positive tone; Expert use of effective messaging criteria; All responses occurred faster than time standard
☐	☐	☐	☐	☐

C.4 Utilizes technology to optimize communication:
Demonstrates appropriate legal and ethical factors in secure messaging.

Level 1: NOVICE	Level 2: BEGINNER	Level 3: INTERMEDIATE	Level 4: COMPETENT	Level 5: EXPERT
Communication with pt risked many ethical and legal challenges secondary to topic, word choice, or communication method	Communication with pt risked some ethical and legal challenges secondary to topic, word choice, or communication method	Communication with pt risked only minor ethical and legal challenges secondary to topic, word choice, or communication method; lacks efficiency	Communication with pt complied with all ethical and legal recommendations and used appropriate communication vehicle; achieves efficiency through chosen communication means	Adopts enhanced opportunities for transparency and optimizes asynchronous communication to engage patients without ethical or legal issues
☐	☐	☐	☐	☐

Comments:

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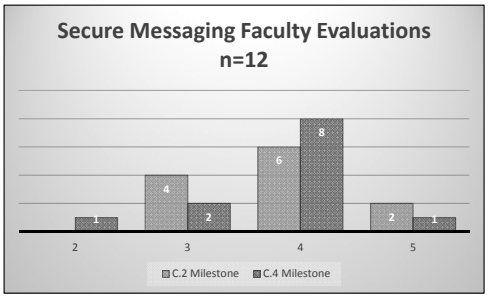

C.2 Communicates effectively with patients, families, and the public:
Utilizes optimal communication factors in secure messaging.

C.4 Utilizes technology to optimize communication:
Demonstrates appropriate legal and ethical factors in secure messaging.

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