



# Institute for Healthcare Communication - Canada

*Meeting the challenge of providing effective clinician-patient interactions*



IHC-C Faculty Newsletter Volume 6, Issue 1

August, 2011

## Welcome...

**to the Summer, 2011 edition  
of the IHC-C Faculty Newsletter**

The first half of 2011 has been **SO** busy, that we have not even managed to send out formal congratulations to the organizations and faculty who have elected to run Faculty Development programs! Wonderful news for the IHC-C, of course, but perhaps not so good for keeping in touch on other matters!

Due to the extraordinary numbers of faculty trained so far in 2011, you will find this newsletter a bit top heavy in new faculty listings, but we certainly did not want to omit anyone.

The US IHC office has just recently updated its website and introduced a new look and logo for the IHC. Be sure to check it out at <http://healthcarecomm.org/>.



I am thrilled to be working with CFPC IT and graphics personnel to also re-launch the IHC-Canada website as well. We expect to complete the new look sometime this fall.

There have been a number of faculty across the country who have recently added a certification designation to their training. Congratulations to the Vancouver Health Authority and Alberta Health Services for supporting this effort and a full listing of newly certified faculty will be posted in the next edition of this newsletter, and thank you for your patience!

*From the IHC-C office, we hope you enjoy a lovely finale to your summer!*

**New training opportunity**

## *Team and Patient-Centered Communication:*

*Patient-Centered Medical Home (PCMH) Focus*

*See details and further information on Page 2.*

### INSIDE THIS ISSUE

- 2 NEW Faculty Training Fall, 2011:  
*Team and Patient-Centered Communication*
- 3 Ajax, ON - NEWS  
Congratulations to new IHC-C **C&C** faculty
- 4 Calgary, AB - NEWS  
Congratulations to new IHC-C **CARE** faculty
- 5 Calgary, AB - NEWS  
Congratulations to new IHC-C **DUMO** faculty
- 6 Toronto, ON - NEWS  
Congratulations to new IHC-C **C&C** faculty
- 7 Vancouver, BC - NEWS  
Congratulations to new IHC-C **DUMO** faculty
- 8 Hamilton, ON - NEWS  
Congratulations to new IHC-C **C&C** faculty
- 9 You may be interested in reading ...  
*"Giving Medical Receptionists Their Due"*
- 10 You may be interested in reading ... *continued*
- 11 You may be interested in reading...  
*"Medical-Home Model Puts Premium on  
Communication Skills"*
- 12 Spotlight on...."Strangers in Crisis" in BC
- 13 Resources / IHC-C Advisory Council



News from IHC in New Haven, CT...

**IHC Patient-Centered Communication Series:**

*Team & Patient-Centered Communication: PCMH Focus*

Train-the-Trainer Program - October 18-21, 2011

New Haven, Connecticut

**WHAT**

Participate in this highly experiential training to become an IHC faculty member to teach IHC's newly developed CME/CE workshop that addresses healthcare team communication needs and demands. Training includes faculty preparation, all curriculum materials/resources, simulation practice, coaching and feedback, and plans for practice application.

Goals of this team and patient-centered communication training:

1. Help **all** members of your healthcare teams understand, embrace and develop effective communication skills required for PCMH
2. Improve patient care and satisfaction
3. Increase patient adherence and self-management
4. Increase healthcare team satisfaction
5. Reduce medical error and liability risk



**WHO**

All healthcare professionals and educators interested in teaching skill-building communication workshops to their colleagues and healthcare team members.

**WHEN**

Tuesday, October 18-Friday, October 21, 2011. Program begins at 8:00 a.m. on Tuesday and end at noon on Friday.

**WHERE**

New Haven, Connecticut (accessible from Bradley International Airport, New York/New Jersey Airports, Tweed New Haven Airport). Autumn in New England is beautiful!!

**COST**

Tuition for the 3.5-day training is \$3,500.00 and includes all educational materials and resources to teach IHC's team and patient-centered communication workshop.

**TESTIMONIAL**

*"The 3 1/2 day course gave me the opportunity to learn the research evidence behind the workshop and to feel competent when teaching it at my facility. I also found the skills practice time with actors helped me be more aware and sensitive to my patient's needs. I gained more confidence in my skills when having difficult conversations with my patients or my healthcare team." - 2010 PCMH Trainee*

**SPECIAL TRAINING for Clinician-Patient Communication (CPC) trained FACULTY**

*We will also be conducting a shortened (1.75-day) faculty course for CPC-trained faculty who are interested in adding IHC's PCMH communication training to your teaching repertoire!*

**This course will be held in Denver on December 1-2, 2011.**

**Please contact the IHC-C office for details if you are interested in attending.**



**REMINDER: Workshop Follow-up Survey**



**Don't forget to assess the impact of your workshop presentations...**



We now have a course-specific follow up survey mechanism in place to gather data to assess the impact of workshop techniques and skills on the subsequent clinical interactions of your learners.

Please contact the IHC-C office for more information and / or to get started today!

**FACULTY DEVELOPMENT**



**Congratulations to new "Choices & Changes" Faculty**

January 17<sup>th</sup> - 20<sup>th</sup>, 2011 - 4 day FACULTY COURSE - Ajax, ON

Sponsored by: Central East CCAC, Peterborough Regional Health Centre, Ontario Shores Centre for Mental Health Sciences, Lakeridge Health Corporation, Kawartha Lakes CHC

IHC Faculty Team members: Michele Nanchoff-Glatt, Cecile Carson, Heather Coburn

<b>Ceilia Ayotte</b> , RN, CDE, CPT	Registered Nurse, Adult Diabetes Education Centre Peterborough Regional Health Centre
<b>Natasha Beckles</b> , BScN, RN, CPMHN(C)	Case Manager Central East CCAC
<b>Kim Cearns</b> , BScN (Hon), MHScN	Clinical Education Leader Ontario Shores Centre for Mental Health Sciences
<b>Sandra Chen</b> , BScN, MN, CPMHN(C)	Clinical Education Leader Ontario Shores Centre for Mental Health Sciences
<b>Yassamin Gharai</b> , BSc, MSc, RD, CDE	Registered Dietitian Lakeridge Health Corporation
<b>Clint Gunn</b> , BScN (Hon), MScN, RN	Nurse Educator Scarborough General Hospital
<b>Paul Hutcheson</b> , B Recreation & Leisure Studies	Therapeutic Recreationist (STEP Program), Prof. Practice Leader inTR Ontario Shores Centre for Mental Health Sciences
<b>Paulette Lewis</b> , BHScN, MScN, ACNP	Nurse Practitioner (adult) Scarborough General Hospital
<b>Tammy Purdy</b> , MSW, RSW, ICADC	Social Worker / Addictions Counsellor Ontario Shores Centre for Mental Health Sciences
<b>Yvette Roy</b> , BScN, RN	Registered Nurse Community Health Centre
<b>Parnaz Sadighi</b> , MSc, RD, CDE	Manager, Community Diabetes Program Scarborough Centre for Healthy Communities
<b>Janice Stringham</b> , BSc, RD, CDE	Registered Dietitian, Adult Diabetes Education Centre Peterborough Regional Health Centre

Congratulations to new  
**“Treating Patients with C.A.R.E.”** Faculty

March 7<sup>th</sup> to 9<sup>th</sup>, 2011 - 3 day FACULTY COURSE - Calgary, AB

Sponsored by: **HEALTH QUALITY COUNCIL OF ALBERTA**

IHC Faculty Team members:

Michele Nanchoff-Glatt, Heather Coburn, Sandy Reifsteck

<b>Reeshma Bhura</b> , BScOT	Occupational Therapist, Integrated Supportive Living Personal Care Homes
<b>Verdeen Bueckert</b> , BScN	Clinical Nurse Educator Foothills Medical Centre – Acute Medicine
<b>Veronika Chalupova</b> , RN	Registered Nurse Rockyview Hospital
<b>Katrina Davis</b> , BScN, RN	Registered Nurse Rockyview Hospital
<b>Rachel Downie</b> , BA, BN, RN	Registered Nurse Foothills Medical Centre – Acute Medicine
<b>Val Gaukel</b> , RN	Registered Nurse Integrated Supportive Living
<b>Gurleen Gill</b> , BSc, LPN	Director of Care, Assistant GM Whitehorn Village
<b>Kelly Hill</b> , RN	Registered Nurse Rockyview Hospital
<b>Lisa Johnson</b> , RN, BSc, MEd	Clinical Nurse Educator Foothills Medical Centre – Acute Medicine
<b>Yun Kim</b> , RN	Registered Nurse Foothills Medical Centre – Acute Medicine
<b>Alison Lock</b> , RN	Clinician, Day Medicine Unit Rockyview Hospital
<b>Kristen Meyer</b> , BN	Registered Nurse Rockyview Hospital
<b>Salima Mulji</b>	Area Manager Seniors Central Homecare
<b>Stacy Oke</b> , BN, MScN	Clinical Educator Integrated Supportive Living
<b>Cherie Wilson</b> , MSN	Clinical Nurse Educator Foothills Medical Centre – Acute Medicine

See also...  
 Newsletter Pages 8-9  
 for ...



*Thank you...*



*IHC-Canada would like to express our sincerest thanks to the Health Quality Council of Alberta for their ongoing support of the “Treating Patient with C.A.R.E.” program and the “CARE” faculty members in Alberta.*



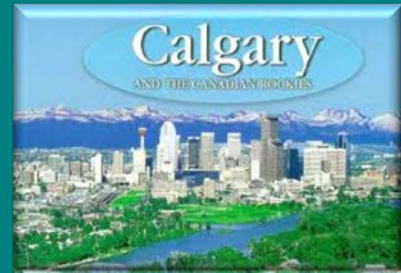
## Updated DUMO Curriculum for Alberta ...

### DISCLOSING UNANTICIPATED MEDICAL OUTCOMES

March 16<sup>th</sup> to 18<sup>th</sup>, 2011 - 3 day FACULTY COURSE - Calgary, AB

Sponsored by: Alberta Health Services

IHC Faculty Team: Dan O'Connell, Bruce MacLeod, Michele Nanchoff-Glatt, Kristin Edmiston and Margot Harvie



### Congratulation to new DUMO Faculty!

AHS Zone	New DUMO Faculty	Position
AHS - Calgary Zone	Elaine Beierbach	QSET
	Conny Betuzzi	Manager Neurosciences/Palliative Care/Rotary Flames House ACH
	Mei Lan Liem-Beckett, BScKin, Cert Occ H&S	Clinical Safety Leader (Patient Safety) Quality Performance Improvement Dept
	Donna MacFarlane	Senior Clinical Safety Specialist
	Linda Mastronardi, EMT-P, BAppBus:ES	Manager, Quality and Patient Safety, Emergency Medical Services
	Mikie Mork, BKin, MSc	Director, Patient Safety South, Acting Executive Director, Patient Safety
	Denise Taylor, RN, MN	Clinical Safety Leader, Alberta Children's Hospital
AHS - Central Zone	Ann Chiovetti, RN, BN, MHSC, MSCN	Quality Consultant - Central Zone
	Celina Colegrave, BSP, MSc	Quality Consultant Rimbey Community Health Centre
	Sylvia Simmons, BSc, MSc Health Prom.	Quality Consultant
AHS - Edmonton Zone	Linda Cawthorn, RN, MN	Quality Consultant , Quality and Healthcare Improvement Community and Rural Hospitals - Edmonton Zone
	Susan Chesney	Site Manager , Health First Strathcona Urgent Care
	Lesa Fee, RN, MN	Clinical Safety Leader, RAH
	Paul Fulbrook, EMT-P	Supervisor, IFT South, Emergency Medical Services
	Chad Jeschke, EMT-P	Clinical Educator (Field Trainer), Emergency Medical Services
	Susan King, RN, BScN	Education Consultant, Quality / Safety Education & Training Quality & Healthcare Improvement
	Deb Michalyk	Senior Clinical Safety Specialist
	Sandy Nickel, R.SLP, M.SLP, S-LP (C)	Manager, Clinical Support Systems, Public Health
AHS - North Zone	Anthony Brannen, RPN, B.Comm, MHSA	Quality Consultant
	Shannon DeGroot, RN	Clinical Nurse Educator, Cold Lake Healthcare Center
AHS - South Zone	Brenda Findlay, RN, Cert Health Care Admin	Manager, Acute & LTC Vulcan Community Centre/Little Bow Continuing Care Centre
	Laurel Stretch, BScPT, MBA	Clinical Quality Consultant, Medicine Hat Regional Hospital

Congratulations to new "Choices & Changes" Faculty

**TORONTO-based COURSES**



**March 28<sup>th</sup> to 31<sup>st</sup>, 2011 - 4 day FACULTY COURSE**

**Sponsored by: Ontario Association of Community Care Access Centres (OACCAC)**

**IHC Faculty Team: Michele Nanchoff-Glatt, Heather Coburn, Sandy Reifsteck**

<b>Mary Lou Anderson, RN</b>	Case Manager, Champlain CCAC
<b>Beatrix Argeropoulos, BScOT</b>	Client Services Educator, Mississauga Halton CCAC
<b>Mary Bergin, Diploma in Nursing, BScN</b>	Case Management Educator, HNHB CCAC
<b>Cindy Brunelle, BScN</b>	Professional Practice Lead & Client Safety, North Simcoe Muskoka CCAC
<b>Pam Burford, RN, BScN</b>	Education Facilitator, Erie St. Clair CCAC
<b>Margaret Cheung, Bachelor of Human Ecology</b>	Registered Dietician, Trillium Health Center
<b>Youanne Lam, RN, BScN</b>	Orientation Coordinator, Central CCAC
<b>Vickie Lewis, MEd, BScN, BA</b>	Education Lead, OACCAC
<b>Barbara Newport, RN, BScN, MPA</b>	Manager, Client Services, Champlain CCAC
<b>Lorelei Parrenas, BScN</b>	Adult Educator Orientation Coordinator, Central CCAC
<b>Marion Ratzlaff, RN, BScN</b>	Case Management Educator, HNHB CCAC
<b>Megan Suddergaard, BHSc, BHScPT</b>	MPA Project Manager, Mississauga Halton Self-Management

**April 18<sup>th</sup> to 21<sup>st</sup>, 2011 - 4 day FACULTY COURSE**

**Sponsored by: Toronto Central CCAC, Central CCAC, Central East CCAC, Central West CCAC**

**IHC Faculty Team: Michele Nanchoff-Glatt, Wayne Weston, Sandy Reifsteck**

<b>Gaya Amirthavasar</b>	Health Information Analyst, Diabetes Regional Coordination Centre, HNHB LHIN
<b>Leigh Caplan, RN, BSc, MA, CDE</b>	Diabetes Nurse Educator, Toronto Central CCAC
<b>Faiza Damji, RD, BSc (Hon)</b>	Registered Dietitian, The Scarborough Hospital, Central East CCAC
<b>Nora Dixon, RN, MN, CDE</b>	Clinical Nurse Specialist, The Scarborough Hospital, Central East CCAC
<b>Bo Fusek</b>	Clinical Nurse Specialist, Diabetes Regional Coordination Centre, HNHB LHIN
<b>Susan Himel, BA (Hon), MES</b>	Strategy Lead, LiveWell! Bridgepoint Health, Toronto Central CCAC
<b>Annie Hoang, HBSc, RD</b>	Registered Dietitian, Etobicoke Medical Centre Family Health Team
<b>Kathryn MacDonald, BAA, RD, CDE</b>	Diabetes Outreach Coordinator, Central West Diabetes Regional Coordination Centre
<b>Julie Matthews, BKin</b>	Project Coordinator, Southlake Regional Health Centre, Central CCAC
<b>Carlene McLean, RN, BSc (in progress)</b>	Registered Nurse, The Scarborough Hospital, Central East CCAC
<b>Sandra Raisman, BAppSc</b>	Registered Dietitian, Diabetes Educator, South Riverdale CHC, Toronto Central CCAC



Updated DUMO Curriculum for BC...

## DISCLOSING UNANTICIPATED MEDICAL OUTCOMES (DUMO):

*Disclosing & Resolving Adverse Outcomes with Patients and Families*



June 6<sup>th</sup> to 8<sup>th</sup>, 2011 - 3 day FACULTY COURSE  
 UBC, Vancouver, BC

Sponsored by: BC Patient Safety & Quality Council

IHC Faculty Team members: Dan O'Connell, Christina Krause  
 Michele Nanchoff-Glatt, Glenn McRae, Camille Ciarniello

**Congratulation to new DUMO Faculty!**

ORGANIZATION	New DUMO Faculty	Position
Vancouver Coastal Health	<b>Bob Chapman</b> , MSW	Director Client Relations, Risk Management and Patient Care Quality Office
	<b>Lois Keen</b> , B Soc Sc (N), MEd	Client Relations and Risk Management Manager, Special Projects for Quality & Patient Safety
	<b>Dermot Kelly</b> , MSc, CEBT	Director, Quality & Patient Safety / Infection Prevention & Control
	<b>Kellé Payne</b> , BScN, MA, RN, CPHRM, DHA	Director, Clinical Quality & Patient Safety Coastal HSDA
	<b>Kim Sinclair</b> , MA, RCC, DOHN, BScN, RN	Patient Care Quality Office Director, Client Relations & Risk Management Med. Affairs
Fraser Health Authority	<b>Ali Gregory</b> , Hon BA, MSc	Quality Improvement & Patient Safety Consultant FHA Critical Care Program
	<b>Kelly Madigan</b> , BA, MSW	Patient Care Quality Officer, Fraser Health Quality Improvement & Patient Safety
	<b>Bonnie McGinnis</b>	Patient Care Quality Officer Supporting Surgical Services Program and RCH Site
	<b>Marianne Southwell</b> , BSN	QI and Patient Safety Consultant
	<b>Karim Suleman</b> , BSc, MBA	Consultant, Quality Improvement & Patient Safety
Providence Health Care	<b>Wallace Robinson</b> , BA, MSW	Project Manager & Social Worker
	<b>Teresa Robitaille</b> , BA, BSW, MSW	Social Worker
Vancouver Island Health Authority	<b>Graham L Sanderson</b> , BA	Corporate Director, Risk Management
Interior Health	<b>Debbie Smith</b> , BScN, Health Admin Dip	Residential Health Service Administrator
Provincial Health Services Authority	<b>Catherine Syms</b>	Corporate Director, Risk Management

## Congratulations to new “Choices & Changes” Faculty

June 20<sup>th</sup> to 23<sup>rd</sup>, 2011 - 4 day FACULTY COURSE – Hamilton, ON

Sponsored by: Mississauga Halton, Hamilton Niagara Haldimand Brant (HNHB), North West CCAC,  
Central CCAC, Dufferin Area Family Health Team

IHC Faculty Team: Michele Nanchoff-Glatt, Heather Coburn, Cecile Carson, Sandy Reifsteck

<b>Susan Anderson</b> , BASC, MScA, RD, CDE	Self-Management Coordinator, Hamilton Health Sciences , HNHB
<b>Azeb Ayele</b>	Support Coordinator, Support & Housing, Mississauga-Halton
<b>Susan Bird</b> , BA	Activation/Volunteer Manager, Oakville Senior Citizens Res., Mississauga-Halton
<b>Carolyn Bornstein</b> , BScPhm	Pharmacist, Southlake Regional Health Centre, Central LHIN
<b>Mary Durnford</b> , BHSC, MEd	Dietitian, Brant Community Health Care System, HNHB
<b>Shawn Goodman</b> , BSc, BSc Pharm, Pharm D, RPh	Pharmacist, Etobicoke Medical Centre Family Health Team, Mississauga-Halton
<b>Melissa Koch</b> , BASC, RD	Registered Dietitian, North Hamilton Community Health Centre, HNHB
<b>Edith Lam</b> , BA	Program Director, Carefirst Seniors & Community Services Association, Central
<b>Jenya LoRi</b> , BScN (H)	SSCM, Mississauga Halton CCAC
<b>Kathryn MacIsaac</b> , BScN, BA	Intake Case Manager, Central West
<b>Mary Ellen McGeachie</b> , BEd, HBA	Rec. Therapist / Coordinator CDSMP-Journey into Wellbeing, North York Gen.Hosp., Central
<b>Lisa Orasanin</b> , BScN, MN, RN	Diabetes Clinical Nurse Specialist, Hamilton Health Sciences, HNHB
<b>Amy Peters</b> , BSCAHN, RD	Registered Dietitian, HNHB
<b>Kathy Theroux</b> , RN Diploma, BScN	COPD Coordinator, Halton Healthcare Services – Oakville Site, Mississauga-Halton
<b>Gladys Wong Chan</b> , MTS, MSW	Social Worker, Yee Hong Centre , Mississauga-Halton
<b>Alana Young</b> , BA, MA	Health Promoter, Dufferin Area Family Health Team

You may be interested in reading...



NEW YORK TIMES - June 30, 2011, 10:41 am

### ***Giving Medical Receptionists Their Due***

By PAULINE W. CHEN, M.D.

Not long ago, the receptionist on the hospital floor where I work went on a family leave. Calm and with a wisecracking wit that she attributes to her New Jersey roots, she had worked at the hospital for years and knew better than anyone how to make things happen in the system.

What doctors and nurses missed most when she was gone, though, was her ability to soothe emotional family members, intuit medical emergencies on the phone and cut off rude doctors — then tirelessly repeat that good work dozens of times over the course of a day. *Continued on page 9...*

## Continued from page 8... *Giving Medical Receptionists Their Due*

When she got back from her leave, I told her how much all of us had missed her. "There are some doctors and nurses who don't think much of what people like me do," she laughed. "But we are the first ones to see and take care of everything."

While much has been written about the role of doctors, nurses and other clinicians in the care of patients and their families, little attention has been paid to those individuals who make up the very front lines of health care. In almost every clinical practice, office receptionists and the professionals who do comparable work in hospitals, the ward clerks and unit secretaries, are the first people patients see. But serious research on their interactions with patients has been sparse at best.

On the importance of...

"Treating Patients  
with C.A.R.E."



Now the journal *Social Science and Medicine* has published a new study on the work of this group of professionals. Despite the stereotype that many receptionists bear as mere "gatekeepers" or even "the dragon behind the desk," the study found that their responsibilities extend far beyond administrative duties. Ward clerks and office receptionists are a vital part of patient care.

Over the course of three years, Jenna Ward, lead author of the study and a lecturer in organization studies at the York Management School of the University of York in England, embedded herself in general practice offices and observed and interviewed nearly 30 office receptionists. She found that in addition to their administrative work, receptionists had to deal directly with as many as 70 people during a single day. Their emotionally challenging work ranged from confirming a prescription with an angry patient, to congratulating a new mother, to consoling a man whose wife had just died, to helping a mentally ill patient make an appointment.

The demands changed from minute to minute and were often unpredictable. But one thing was certain: A significant portion of their work involved managing the emotions and care of patients and families.

"Receptionists are a key part of the relationship between patients and doctors," Dr. Ward said. "We should be thinking of the relationship not as a two-way one between doctor and patient or nurse and patient, but as a three-way relationship among clinician, patient and receptionist."

Dr. Ward observed that the most experienced and successful receptionists could rapidly change emotions to meet the patient's needs. For example, seconds after one of the receptionists confided to another how sad she was about the accidental death of a young patient, the office telephone rang. The receptionist immediately collected herself, then answered the phone in a warm and cheery way. During a mix-up over appointment times, another receptionist responded calmly to an elderly patient who had begun shouting racial epithets, helping to defuse the situation.

"It's not that the receptionists don't feel anything; it's just that they may be mirroring the kind of 'objective' behavior that doctors are taught in order to protect themselves," Dr. Ward said.

But this detachment can also backfire. In an effort to protect doctors from being inundated with patient visits and requests, many of the receptionists relied on emotional distancing to deal with upset patients, a strategy that sometimes only angered patients further. "In a lot of people's minds, the receptionist is barring access to primary care," Dr. Ward said. "But the receptionists see themselves in the very difficult position of having to deal with all the emotions of the patients while remaining responsible for the practice and protecting their practitioners."

Dr. Ward believes that with more recognition and support for the emotional work receptionists do, such misunderstandings and antagonistic interactions could be avoided. Practices, for example, could make more explicit the fact that any requests to see a clinician would be fulfilled within 72 hours rather than 24. Moreover, those who become receptionists could receive training on handling not only the administrative but also the emotional aspects of their work.

"Right now, when you employ people as receptionists, it's kind of a Russian roulette as to how much emphasis they place on the emotional work," Dr. Ward said. "If it were more integrated into the culture — health care as being doctors, nurses and administrative staff — we might encourage people to perform these emotional tasks well."

"Patient care is a holistic social process," Dr. Ward added. "And those on the front line can be a crucial part of that holistic treatment"



You may be interested in reading (*continued*) ...

### ***A randomized controlled trial of communication training with primary care providers to improve patient-centeredness and health risk communication.***

Helitzer DL, Lanoue M, Wilson B, de Hernandez BU, Warner T, Roter D.

[Patient Educ Couns.](#) 2011 Jan;82(1):21-9. Epub 2010 Mar 12.

**Source:** Department of Family and Community Medicine, University of New Mexico, Albuquerque, NM

#### **ABSTRACT**

##### **OBJECTIVE:**

To determine the efficacy and effectiveness of training to improve primary care providers' patient-centered communication skills and proficiency in discussing their patients' health risks.

##### **METHODS:**

Twenty-eight primary care providers participated in a baseline simulated patient interaction and were subsequently randomized into intervention and control groups. Intervention providers participated in training focused on patient-centered communication about behavioral risk factors. Immediate efficacy of training was evaluated by comparing the two groups. Over the next 3 years, all providers participated in two more sets of interactions with patients. Longer term effectiveness was assessed using the interaction data collected at 6 and 18 months post-training.

##### **RESULTS:**

The intervention providers significantly improved in patient-centered communication and communication proficiencies immediately post-training and at both follow-up time points.

##### **CONCLUSIONS:**

This study suggests that the brief training produced significant and large differences in the intervention group providers which persisted 2 years after the training.

##### **PRACTICE IMPLICATIONS:**

The results of this study suggest that primary care providers can be trained to achieve and maintain gains in patient-centered communication, communication skills and discussion of adverse childhood events as root causes of chronic disease.

### ***Communication Discrepancies Between Physicians and Hospitalized Patients***

Douglas P. Olson, MD; Donna M. Windish, MD, MPH

*Arch Intern Med.* 2010;170(15):1302-1307

#### **BACKGROUND:**

Hospital surveys indicate lack of patient awareness of diagnoses and treatments, yet physicians report they effectively communicate with patients. Gaps in understanding and communication could result in decreased quality of care. We sought to assess patient knowledge and perspectives of inpatient care and determine differences from physician assessments.

#### **METHODS:**

Two validated questionnaires assessed the experiences of inpatients treated by house staff from October 10, 2008, through June 23, 2009. We surveyed corresponding internal medicine resident and attending physicians, asking them to report on their care of hospitalized patients and their understanding of their patients' perspectives on the care received.

#### **RESULTS:**

Eighty-nine patients and 43 physicians participated. Although 73% of patients thought there was 1 main physician, 18% correctly named that physician, compared with 67% of physicians who thought patients knew their names ( $P<.001$ ). Most physicians (77%) believed patients knew their diagnosis; however, 57% of patients did ( $P<.001$ ). A total of 58% of patients thought that physicians always explained things in a comprehensible way, compared with 21% of physicians who stated they always provided explanations of some kind ( $P<.001$ ). Two thirds of patients reported receiving a new medication in the hospital, yet 90% noted never being told of any adverse effects of these medications. Nearly all physicians (98%) stated that they at least sometimes discussed their patients' fears and anxieties, compared with 54% of patients who said their physicians never did this ( $P=.001$ ).

#### **CONCLUSIONS:**

Significant differences exist between patients' and physicians' impressions about patient knowledge and inpatient care received. Steps to improve patient physician communication should be identified and implemented.



You may be interested in reading (*continued*) ...

From [Medscape Medical News](#)

### ***Medical-Home Model Puts Premium on Communication Skills***

Robert Lowes

July 9, 2010 — How can a patient-centered medical home live up to its name — and potential — if physicians do not even make eye contact with their patients?

This question is implicit in an article appearing in the July issue of *Health Affairs* that advocates more intensified communication training for physicians in the era of the patient-centered medical home.

The medical home is a model for primary care in which a physician-lead team provides continuous, coordinated, and holistic care that, theoretically at least, leads to better outcomes and lower costs. It is little wonder, then, that the new healthcare reform law calls for pilot projects to test the model's effectiveness.

For medical homes to succeed, however, physicians must do a better job at talking with patients, according to lead author Wendy Levinson, MD, chair of the Department of Medicine at the University of Toronto, Canada, and colleagues. Fortunately, skills such as asking open-ended questions, listening attentively, negotiating treatment plans, and responding to a patient with empathy can be taught at all levels of medical education, including continuing medical education (CME) for practicing physicians.

Right now, most physicians receive limited training in this area, according to the authors. They credit medical schools with teaching communication skills to first-year and second-year students but fault them for often neglecting the subject during the third and fourth years, when students need this training the most as they engage patients during clinical rotations.

The picture worsens during residency training. "Most training programs after medical school do not include communication skills in their curricula," the authors write, although there are some exceptions in the primary care realm.

#### **More Pay for Breaking Bad News?**

In contrast, various medical societies and large group practices have put greater stress on physician-patient communications in CME for practicing physicians during the past decade. Such courses rely on role play, standardized patients, and review of videotaped encounters with actual patients.

The authors note several barriers to physicians taking advantage of this training. One is the time taken away from revenue-generating patient care. Another is the misconception that patient-centered communication means longer visits. "In fact, effective communication may result in shorter, more efficient visits," write the authors.

One driver for more CME on the talking side of medicine, they write, is the recent decision by the American Board of Medical Specialties to make assessment of communication skills a requirement for recertification by individual specialty boards. Physicians must undergo these evaluations, beginning with patient surveys in 2010 and peer surveys in 2012. Each kind of survey must be conducted at least every 5 years.

Money also has a way of changing physician behavior. The authors note that Medicare and other third-party payers could devise reimbursement strategies that reward physicians for having good conversations with patients, and not just for performing procedures. Payers could base payment on patient survey scores and documentation of patient education and counselling, including discussions of specific topics such as advance directives. "Complicated conversations, such as breaking bad news or disclosing medical errors, could be reimbursed as 'complex procedures,'" the authors suggest.

"Although health reform has inspired new momentum for patient-centered care, making this vision a reality will require sizable investments in improving the skill set of our physician workforce — including appropriate communication skills," the authors write. "The necessary changes will not overcome overnight, but neither are they out of reach."

"We have a moral imperative to meet this challenge, because doing so will improve the quality of care."

**Health Affairs. 2010;29:1310-1318.**

# Spotlight on....

## Strangers in Crisis: Communicating with Patients, Families, & Your Team in the ED

The following text is an excerpt from: The Beryl Institute's report:

### **"Improving the Patient Experience in the Emergency Department: A Look at Patient Experience Efforts across British Columbia, Canada"** (March 2011)"

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Full text can be found at <http://www.theberylinstitute.org/?page=ONTHEROAD0311>



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#### *Strangers in Crisis Program*

A program that was shared at many stops on our journey and came up in a number of conversations we had was the communications-focused learning program, Strangers in Crisis. Offered by the Institute for Healthcare Communication, based both in the U.S. and Canada (<http://www.healthcarecomm.org>), the program offers a core set of ideas in communication most effective with patients and families in an ED setting. We had a chance to stop in on the first class being held at Royal Columbian and also speak with Jill Breker, Darin Abbey, and Ev Pollock from the Vancouver Island Health Authority on their leading the implementation of the program in BC.

While I am not one to suggest a training program as a sole solution to improvement efforts, a focused program such as Strangers in Crisis layered on process improvement and organization change efforts can be very successful. The program as described is grounded in evidence-based practices and focuses on four components of communication in an ED setting – engagement, empathy, education and enlistment. I will not attempt to outline the entire program here, but rather will share the passion with which the individuals delivering and participating in the program speak to its value.

An interesting component of the program is its specific customization for hospitals in BC. The customization is based on a 2009 study conducted by the University of British Columbia's Centre for Health Policy and Research (CHSPR) titled, "In pursuit of Quality: Opportunities to improve patient experiences in British Columbian emergency departments". The study found something interesting, that courtesy, above teamwork, availability or even wait times was the most important influencing factor in patient feedback. The study showed that in examining all the influencing factors of quality and experience, the most important factor for those who said their overall quality of care was excellent was the degree to which they considered staff to be courteous. Interestingly enough, similar to those who reported positive experiences, those who reported negative ratings cited staff courtesy as the most important factor as well. The full report is available at <http://www.chspr.ubc.ca/research/patterns/emerg>

Darin touched on this very point in emphasizing a core premise and important point of the program. It is not only that communication matters, as depicted by the findings on courtesy, but also that communication is a procedure like any other conducted in the ED setting. He was clear in supporting the idea that as staff in the ED follow clinical process, they too need to be aware of the processes of communication they follow that can impact patient and family experience. He added, "We need to be patient-centered, but it is equally important that we understand ourselves (as care providers)."

Jill added that the program offers an important lesson for ED staff, while recognizing their unique nature. "It is important we recognize that patients don't come to our emergency department, we work in theirs," she said. "At the same time we must remember in delivering the program that ED nurses get bored easily, they are used to action, so the course must keep moving."

In my visit to UCLA on last month's On the Road both Dr. Feinberg and Dr. Rosenthal suggested that cultures of patient experience were not necessarily based on change, but rather on unearthing and reviving the passion people bring to their work in healthcare. It was evident through our conversation the passion that these individuals brought to and gained from the program. Also, while not yet directly linked to survey outcomes, the interest in the program has spread rapidly across the province as a tool to reignite the passion and communication skills of all staff, from leadership to the front line....



## ADDITIONAL RESOURCES

### HEALTH LITERACY RESOURCE

Some of you may be interested in the following FDA training module:

#### ***Does My Patient Understand? Health Literacy & Best Practices for Health Care Professionals***

<http://pssc.aphanet.org/trainingmodules/FDAdoesmypatientunderstand.htm>

Description/Goal: Provide health care professionals with the knowledge and tools to assess their patient's health literacy and effectively communicate to ensure patient understanding of health related information.

Target Audience: Physicians, Nurses and Pharmacists who educate patients on medication use and management of their medical condition.

#### Learning Objectives:

Upon completion of this activity, participants should be able to:

1. Define health literacy and develop tools for recognizing patient populations at risk for having limited literacy and limited health literacy skills.
2. Discuss the impact of non adherence on patient outcomes and identify barriers to adherence.
3. Identify methods for improving communication skills within your allotted appointment time.
4. Develop skills for recognizing appropriate patient education materials and
5. Identify appropriate FDA OWH publications that can be utilized to improve patient education, compliance, and health outcomes.

### PATIENT VOICES (from *The New York Times* - HEALTH)

Receiving a diagnosis of a chronic disease, mental illness or other health condition, can have an enormous impact on so many aspects of a patient's life.



Patient Voices features first-person accounts of the issues, changes and challenges faced by patients as they negotiate an unfamiliar and uncertain path in learning to cope with various health issues.

[http://www.nytimes.com/interactive/2009/09/10/health/Patient\\_Voices.html](http://www.nytimes.com/interactive/2009/09/10/health/Patient_Voices.html)



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