2021

Digging Deeper: Improving Health Communication with Patients

Jennifer Ko
Chapman University, jeko@chapman.edu

Miranda Steinkopf
Pacific University

Abby A. Kahaleh
Roosevelt University

Sharon Connor
University of Pittsburgh

Recommended Citation

Ko J, Steinkopf M, Kahaleh AA, Connor SE. Chapter 30: Digging deeper: improving health communication with patients. In: Covvey JR, Arya V, DiPietro Mager N, Gilman N, Herring M, Ochs L, Waddington L, eds. *Public health in pharmacy practice: a casebook*. 2nd ed. Geneseo, NY: Milne Open Textbooks; 2021. https://milnepublishing.geneseo.edu/publichealthforpharmacy/chapter/digging-deeper-improving-health-communication-with-patients/

Public Health in Pharmacy Practice: A Casebook

PUBLIC HEALTH IN PHARMACY PRACTICE: A CASEBOOK

2nd Edition

JORDAN R COVVEY, VIBHUTI ARYA, NATALIE DIPIETRO MAGER, NEYDA GILMAN, MARANDA HERRING, LESLIE OCHS, AND LINDSAY WADDINGTON

ISBN: 978-1-942341-84-0

Published by Milne Open Textbooks
Milne Library
State University of New York at Geneseo
Geneseo, NY 14454

30.

DIGGING DEEPER: IMPROVING HEALTH COMMUNICATION WITH PATIENTS

Jennifer Ko, PharmD, MPH, BCACP

Miranda Steinkopf, PharmD

Abby A. Kahaleh, PhD, MS, BPharm, MPH, FAACP

Sharon Connor, PharmD

Topic Area

Health literacy/communication

Learning Objectives

At the end of this activity, students will be able to:

- Identify five theories and models that can be used to facilitate the patient-provider health communication process
- Describe opportunities to optimize communication with patients in healthcare set-

tings
- Apply health communication theories within patient care, providing specific approaches and language to utilize

Introduction

Effective communication is a critical component of healthcare. At a broader scale, it can help disseminate important public health messages, such as frequent handwashing or consistently wearing masks, as seen during the COVID-19 pandemic. On an interpersonal level, effective communication helps healthcare professionals establish rapport with patients, increase patient understanding of their health, and encourage healthy behaviors. The communication that occurs between patients and healthcare professionals includes written, verbal, and nonverbal information and is impacted by health literacy. The prominence of health communication has been widely recognized and is included in the *Healthy People 2030* goals.[1] Overall, the ability to communicate effectively is essential to enhancing health and well-being.

The consequences of poor or inadequate health communication can impact patient care and health outcomes. When information is complex and difficult to understand, patients may become disengaged. For example, if a healthcare professional uses medical jargon to explain the mechanism of action of chemotherapy, patients may stop engaging because they do not understand the information presented. Patients may not always ask for clarification or may unknowingly misinterpret the information that was communicated. Additionally, when patients are not properly engaged, healthcare professionals may miss opportunities to learn about important health beliefs of the patient that are impactful to the patient's care but seldomly volunteered. For example, patients may have spiritual beliefs that influence the medications or other therapies they are willing to take/receive (i.e., gelatin in capsules, blood products), or they may prefer alternative methods to Western medicine. Further probing is often needed to have a complete picture of the patient's perceptions about their health, preferences on their care, spiritual beliefs that impact their care, and their health goals. Effective communication can also be used to empower patients to make lifestyle changes. These missed opportunities can result in incorrectly labeling patients who are resistant to adopting lifestyle changes and/or are non-adherent to their medications as "stubborn," "difficult," "forgetful," or "negligent." Communication is not a one-way interaction and should allow for shared decision making, patient-centered care, and patient empowerment.[2-5]

Health communication models and theories have been developed to improve communication among healthcare professionals, patients, and populations on micro and macro levels. These include, but are not limited to the Health Belief Model, motivational interviewing, the Transtheoretical Model, the Patient Explanatory Model, and the HOPE questions. A specific goal under *Healthy People 2030* (Health Communication objectives) is to "*increase the proportion of adults who report their health care provider always asked them to describe how they will follow instructions*."[1] This goal highlights the importance of ensuring patient understanding, and for providers to proactively confirm this understanding with patients. One of the recommended strategies is the teach-back method, which asks patients to describe how they will follow the instructions provided.[6] Other *Healthy People 2030* Health Communication objectives include to "*decrease the proportion of adults who report poor communication with their health care provider*" and "*increase the proportion of adults whose health care providers involved them in decisions as much as they wanted*."[1] These two goals may require knowing and applying these health behavior theories and models to facilitate health communication in practice. These strategies or techniques enhance patient-professional interactions by engaging patients in their care.

Case

Scenario

You are a student pharmacist who works at the dispensary of a community-based health center.

CC: "I'm just here to pick up my meds."

Patient: TS is a 68-year-old white female (64 in, 78 kg) who arrives at the dispensary today to pick up her medication for pain.

HPI: TS infrequently visits the dispensary to pick up her medications, with months long stretches between visits. You notice that the patient has two other medications on her profile, amlodipine, and Spiriva. The patient filled each of these prescriptions one time about four months ago. She is sometimes heaving or breathing heavily as she waits for her medications.

PMH:

- Osteoarthritis (diagnosed five years ago)

- COPD (diagnosed 10 years ago)
- HTN (diagnosed 15 years ago)

FH:

- Father: deceased (MI)
- Mother: deceased (lung cancer)
- Children: two daughters (44 years old and 38 years old); alive and well
- Grandchildren: four granddaughters and two grandsons

SH:

- Drinks 1-2 alcoholic beverages per weekend
- Smokes one pack of cigarettes per day (since 16 years old)
    - Typically purchases Newport brand cigarettes but prefers menthol cigarettes
    - Previously tried to quit smoking by using nicotine patches about four years ago but stopped after using them for a few days due to local itching
- Denies illicit drug use

Medications:

- Naproxen 220 mg BID prn pain
    - States this is the only medication that works for her
- Spiriva Respimat 2.5 mcg/actuation two inhalations once daily
- Amlodipine 5 mg daily

Immunizations:

- Td: three years ago
- MMR: six years ago

Allergies: NKDA

SDH: TS is widowed and has lived with one of her daughters since the loss of her husband 10 years ago. She completed high school and used to work in a factory. She is not working now but she cares for her young grandchildren several days a week. Her daughter provides her a weekly allowance, the majority of which she spends on a carton of cigarettes, which costs her about $8 per pack.

Interaction: You observe the conversation the pharmacist is having with the patient as she is picking up her medications.

- **Pharmacist**: "Do you need refills for your other medications, amlodipine and Spiriva?"
- **TS**: "No thank you, I don't take those medications because they don't help me."
- **Pharmacist**: "What do you mean they don't help you?"
- **TS**: "I just mean that I'm able to manage without the meds. Besides, I feel fine so why would I take anything that might make me feel worse?"
- **Pharmacist**: "You were prescribed these medications by your doctor for a reason."
- **TS**: "Yeah, my doctor gave me an inhaler too, because I smoke, but I'm not planning to quit smoking, so I don't need that either. They also said something about getting the pneumonia shot. Why would I get that? I have never gotten pneumonia and pneumonia is pretty much harmless anyways. I don't want to put any chemicals in my body that I don't need to. God made us without those chemicals in our bodies for a reason."
- **Pharmacist**: "Alright, so you don't want to quit smoking?"
- **TS**: "No way. I mean at one point I did, but I've been smoking for a long time, and I've been fine so far. My mom used to smoke too. I remember she would always have a cigarette in her hand as she cooked dinner. I guess she ended up getting lung cancer but that doesn't happen to everyone. My friend's been smoking for longer than I have, and she is healthier than me! I will tell you one thing; those companies sure charge a lot for a pack of smokes. They get you hooked, and they drain your money."
- **Pharmacist**: "Okay. Do you take the amlodipine?"
- **TS**: "Not really, they also told me I've got high blood pressure, but I don't see how that's a problem. I mean I don't feel anything. I figure, I'm 68 years old, what can happen to me now? If I can just relax and stay at home, my blood pressure will be fine. It's just the stress and being busy with the little ones that gets my pressure up. I bet if they checked my blood pressure when I don't have the little ones running around it'd be fine. But I wouldn't change it for the world, my grandkids are my pride and joy."
- **Pharmacist**: "Okay that's your choice… Let us know when you're interested in quitting. Thank you for stopping by and have a great day."
- **TS**: "Sure. See you next time."

Case Questions

1. Identify which of the health communication models or theories is most appropriate to use to answer each of the following questions (listed in **Table 1**):

According to TS, what did she think her health problem was? What did she think caused her health problem? How can this impact her willingness to take her medications?

2. How susceptible did TS feel she was for the consequences of smoking and pneumonia? How severe did she think the consequences of smoking and pneumonia are? How does this impact the patient's willingness to quit smoking and get the pneumococcal vaccine?

3. What is TS's stage of change? What is an example of an appropriate way to approach patients at this stage of change?

4. What are some ways that the pharmacist could have used motivational interviewing when TS expressed resistance to smoking cessation?

5. What are ways to ask about TS's spiritual beliefs and engage these beliefs as a source of motivation to take her medications, quit smoking and become vaccinated?

6. What are ways that you could leverage social support to cue TS to action?

7. What are some ways to increase TS's self-efficacy for getting her HTN under control and quitting smoking?

Author Commentary

Pharmacists often focus on optimizing drug therapy instead of patient behavioral change. Additionally, pharmacists may overlook the patient's perceptions of disease, susceptibility, and optimal treatment. This contributes to missed opportunities to motivate patients to make the necessary changes to improve their health and to assumptions healthcare providers make regarding patients' health beliefs. For example, it has been reported that only 26.6% of adults reported that a healthcare provider utilized the teach-back method with them.[1] Patients who do not understand health information are known to be less likely to get preventative healthcare and more likely to have health problems.[1] Also, only 52.8% of adults reported their healthcare providers always involved them in decisions about their healthcare as much as they wanted.[1] Patients want to engage in decision-making about their health, so it is important that pharmacists attempt to engage patients using communication techniques as often as possible to improve relationships and ultimately the health of patients.[1]

Beyond communicating with patients directly at the individual level, pharmacists can also impact health communication on the macro level. This includes collaboration with other healthcare providers. Having effective communication is essential for enhancing collaboration and closing

the health disparities gaps that often exist due to the social determinants of health among underserved patient populations. However, behavior change cannot be sustained without recognizing the different levels of influence that impact health communication. Unfortunately, health communication alone cannot repair insufficient access to health care or unhealthy living environments. To close the gaps that cause health disparities, pharmacists should seek expansive ways to utilize health communication strategies and develop interventions that have multi-level influences.[7] Ultimately pharmacists are integral members of high-performing health care teams. Effective communication and collaboration among health care professionals and across multiple levels will help meet the goals and objectives of *Healthy People 2030*.

Patient Approaches and Opportunities

Effective health communication includes patient-centered care which emphasizes the inclusion of the patient in decision-making regarding treatment. Shared decision-making allows for a discussion about the evidence for various treatment strategies and may lead to enhanced provider-patient relationships. One model of shared decision-making described by Elwyn and colleagues,[5] utilizes patient deliberation and emphasizes respect for patients' choices and as individuals. We must tailor the therapy to individuals.

Pharmacists can motivate patients to adopt healthy behaviors by utilizing effective communication methods. Pharmacists can also assure appropriate understanding by taking the time to assess patients' beliefs regarding their health. Patient-provider interactions should always involve a bidirectional transfer of information. **Table 1** includes five theories and models that can be used in practice to improve health communication, which is necessary to establish constructive patient-pharmacist relationships.

Table 1: Health Communication Theories and Models

Theory/Model	Application	Examples
Health Belief Model:[8] A theoretical model that is used to explain and predict changes in health behaviors. The key factors that influence health behaviors include: Perceived susceptibility Perceived severity	Conduct a health needs assessment to determine who is at risk and the population that should be targeted Convey the consequences of the health issues and risk behaviors	What is the likelihood or susceptibility of getting infected with the flu? How severe is a flu infection among this patient population? What are the potential benefits for giving pharmacists "provider status"?

Theory/Model	Application	Examples
Perceived benefits of action Perceived barriers to action Cues to action Self-efficacy	Explain how, where, and when to take action and what the potential positive results will be Offer reassurance, incentives, and assistance; correct misinformation Provide "how to" information, promote awareness, employ reminder systems Provide training and guidance in performing action; use progressive goal setting	What are the barriers for achieving this legislative milestone for the pharmacy profession? What is the level of self-efficacy among pharmacists to assume provider status? What is the role of internal and external stakeholders in this initiative for cues to action? How does the media perceive the role of pharmacists in public health?
Motivational Interviewing:[9] A technique that centers on patients' ability to exercise free choice and change in a process of self-actualization. The five principles include: **R:** Roll with resistance **E:** Express empathy **D:** Develop discrepancy **S:** Support self-efficacy	**R:** Avoid argument and direct confrontation. Adjust to patient's resistance rather than opposing it directly **E:** Exercise reflective listening **D:** Develop discrepancy between patient's goals or values and their current behavior **S:** Actively listen for patient's strengths and values and reflect these back in an affirming manner	Open-ended questions: *Start questions with "what", "when", "how" instead of "do"* Affirming: *"Sounds like this is challenging. No wonder you feel overwhelmed."* Reflective listening: *"What I hear you say is..."* Summarizing: *Recap what the patient said*
The Transtheoretical Model (Stages of Change):[10] A model of intentional change that assumes that people change behavior through a continuous, cyclical process. The six stages of change include:	Raise patient's awareness of the problem and the possibility of change without giving prescriptive advice Address ambivalence and discuss reasons and	Patient may deny there is a problem and see no need for change. Minimization, blaming, and resistance are likely present Patient may acknowledge that a problem exists and considers change, but also rejects it.

Theory/Model	Application	Examples
Precontemplation: Patients do not intend to take action within the next 6 months **Contemplation**: Patients are intending to start the healthy behavior within the next 6 months **Preparation**: Patients are ready to take action in the next 30 days **Action**: Patients have recently started changing their behavior (within the past 6 months) **Maintenance**: Patients have sustained their behavior changes for more than 6 months **Termination**: Patients have no desire to return to their unhealthy behavior	benefits for change and the consequences of inaction Help identify the best actions to take for change and support motivation Help implement a change strategy and identify available sources of support Identify triggers and develop coping strategies to prevent relapse	Patient has decided to change and wants to do something about the problem Patient takes steps to change and engages in specific actions to bring about change Patient actively works on sustaining the changes made. The challenge is to prevent relapse
Patient Explanatory Model:[11] Theory that individuals and groups can have vastly different notions about health and disease. Assesses patients' health beliefs and explanation of illness.	The eight questions include: *What do you call the problem?* *What do you think has caused the problem?* *What do you think the sickness does? How does it work?* *How severe is the sickness? Will it have a short course?* *What kind of treatment do you think the patient should receive?* *What are the chief problems the sickness has caused?* *What do you fear most about the sickness?* *What are the most important results you hope to get from treatment?*	
HOPE Questions:[12] A teaching tool developed to help incorporate a spiritual assessment into a patient interview.	**H:** Source of hope, meaning, comfort, strength, connection **O:** Organized religion **P:** Personal spirituality and practices	**H:** "*What are your sources of hope, strength, comfort and peace?*" **O:** "*Are you part of a religious or spiritual community? Does it help you? How?*"

Theory/Model	Application	Examples
	E: Effects on medical care and end-of-life issues	**P:** "*Do you have personal spiritual beliefs that are independent of organized religion? What are they?*" **E:** "*Are there any specific practices or restrictions I should know about in providing your medical care?*"

Important Resources

Related chapters of interest:

- Communicating health information: hidden barriers and practical approaches
- Smoke in mirrors: the continuing problem of tobacco use
- Getting to the point: importance of immunizations for public health
- Saying what you mean doesn't always mean what you say: cross-cultural communication
- Uncrossed wires: working with non-English speaking patient populations
- Laying the foundation for public health priorities: Healthy People 2030

External resources:

- Websites:
    - *Healthy People 2030*. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication
    - Centers for Disease Control and Prevention. Gateway to health communication. https://www.cdc.gov/healthcommunication/
    - Food and Drug Administration. Risk communication. https://www.fda.gov/science-research/science-and-research-special-topics/risk-communication
    - Agency for Healthcare Research and Quality. The SHARE Approach – essential steps of shared decision making: quick reference guide. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tools/resource-1.html
    - Agency for Healthcare Research and Quality. The SHARE Approach – a

model for shared decision making. https://www.ahrq.gov/sites/default/files/publications/files/share-approach_factsheet.pdf

- Book chapters and journal articles:
    - Kahaleh AA, Youmans SL, Bresette JL, Truong HA. Health behavior theories and models: frameworks for health promotion and health education programs. In: Truong HA, Bresette JL, Sellers JA, eds. *The pharmacist in public health: education, applications, and opportunities.* American Pharmacists Association; 2010.
    - Pringle JL, Boyer A, Conklin MH, Mccullough JW, Aldridge A. The Pennsylvania Project: pharmacist intervention improved medication adherence and reduced health care costs. *Health Affairs* 2014;33(8):1444-52.

References

1. *Healthy People 2030*. Health communication. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication. Accessed February 17, 2021.
2. Agency for Healthcare Research and Quality. Strategy 6I: Shared decision making. https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html. Accessed March 21, 2021.
3. NEJM Catalyst. What is patient-centered care? https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559. Accessed March 21, 2021.
4. Sindhu T. Why patient empowerment matters. https://www.wolterskluwer.com/en/expert-insights/why-patient-empowerment-matters. Accessed on March 21, 2021.
5. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. *J Gen Intern Med* 2012;27(10):1361-1367.

6. Agency for Healthcare Research and Quality. Health literacy universal precautions toolkit, 2nd edition: use the teach-back method: Tool #5. https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html. Accessed February 17, 2021.
7. Freimuth VS, Quinn SC. The contributions of health communication to eliminating health disparities. *Am J Public Health* 2004;94(12):2053-5.
8. Hochbaum G, Rosenstock I, Kegels S. *Health belief model*. Washington, DC: US Public Health Service, 1952.
9. Miller WR, Rollnick S. *Motivational interviewing: preparing people to change addictive behavior*. New York: Guilford Press, 1991.
10. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *Am J Health Promot* 1997;12(1):38-48.
11. Kleinman, A, Eisenberg, L, Good, B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978;88(2):251-8.
12. Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician* 2001;63(1):81-9.

Glossary and Abbreviations

- Glossary
- Abbreviations