Annotated Bibliography

Patient-Centered Communication Series:

Team and Patient-Centered Communication Skills for the Patient Medical Home

Institute for Healthcare Communication

The Patient Medical Home

American College of Physicians. (2008). How is a shortage of primary care physicians affecting the quality and cost of medical care? A Comprehensive Evidence Review. A White Paper. Accessed from http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf

> The evidence for the value of primary care is clear: better quality of life, more productive longevity, and lower costs as a result of reduced hospitalization improved prevention and better coordination of chronic disease care. The nation must take immediate steps to address the issues that threaten primary care's survival. ACP calls on the federal government, large employers and other purchasers, health plans, and the medical profession itself to take immediate action to create a comprehensive national health care workforce policy with a focus on primary care (2); adopt a patient-centered physician guided model of health care delivery to provide Americans with optimal care (3); and restructure payment policies to support the value of care provided by primary care physicians (4). The consequences of failing to act will be higher costs, greater inefficiency, lower quality, more uninsured persons, and growing patient and physician dissatisfaction. Averting the collapse of primary care is the best cure for an ailing health care system.

American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. January 2006. Accessed from http://www.hhs.gov/healthit/ahic/materials/meeting03/cc/ACP_Initiative.pdf

> This policy monograph highlights some of the major problems with the health care system in the United States today and proposes a fundamental change in the way that principal – or primary care – is delivered and financed. It recommends voluntary certification and recognition of primary care and specialty medical practices that: provide patient-centered care based on the principles of the Chronic Care Model; use evidence-based guidelines; apply appropriate health information technology; and demonstrate the use of "best practices" to consistently and reliably meet the needs of patients while being accountable for the quality and value of care provided. The American College of Physicians introduces the term "Advanced Medical Home" to distinguish these practices and calls for consideration and testing of this model of care. The issues identified and positions offered in this monograph address major concerns about the status of the U.S. health care system.

American College of Physicians. A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care. January 2007.

> The guiding philosophy of these recommendations is that patient needs are best met through the delivery of patient-centered, longitudinal, coordinated care. This is the model of care that primary care providers and other physicians who provide principal care are trained and well-suited to deliver yet has been historically unrecognized or under-recognized by the payment system. The College believes that these proposals will improve the quality and effectiveness of care provided in this country and facilitate a sustainable environment in which physicians are provided adequate incentives for furnishing care appropriate to the patient population.

Ballantyne JC (2009). Patient –centered healthcare: are opioids a special case? *The Spine Journal, 9*:770-772.

> The author cites research studies that demonstrate high levels of patient satisfaction with pain care even if treatment is of marginal benefit, provided that the patient a) Feels complaints are validated b) Perceives a strong patient-provider relationship, and c) Feels confident that the best available treatment has been offered.

Bechtel C & Ness DL. (2010). If you build it, will they come? Designing truly patient-centered health care. *Health Affairs,* 29(5):914-20.

> As the United States debates how to reorganize its health care system, policy makers must ask what patients really want and need from their primary care providers. There is often a disconnect between

what patients say they want and what other providers or payers think patients want. Our research at the National Partnership for Women and Families suggests that a truly patient-centered health care system must be designed to incorporate features that matter to patients—including "whole person" care, comprehensive communication and coordination, patient support and empowerment, and ready access. Without these features, and without consumer input into the design, ongoing practice, and evaluation of new models, patients may reject new approaches such as medical homes and accountable care organizations.

Bernstein, SJ. (2008). A new model for chronic care delivery. *Frontiers of Health Services Management;* Winter; 25, 2: 31.

Ultimately, the chronic care model, the medical home concept, and community engagement will be judged on whether these programs lead to improved continuity of care, patient and provider satisfaction, quality of care, clinical outcomes and, especially with the increasing financial burden of health care, reduced healthcare costs. Many previous panaceas have been proposed to solve the healthcare conundrum yet they have not withstood critical examination. We must be able to provide evidence of the effectiveness of these interventions rather than merely implementing them based on our beliefs.

Center for Policy Studies in Family Medicine and Primary Care. (2007). The Patient Centered Medical Home *History, Seven Core Features, Evidence and Transformational Change.*

This paper provides evidence that is foundational to the concept of patient centered medical home model. It is also an effort to identify key elements of a medical home for delivering a patient-centered experience. And finally,it will revisit some of the reasons for managed care's failure lest the patient centered medical home be similarly twisted to other goals for health care.

Commonwealth Fund (2007). Closing the divide. How medical homes promote equity in healthcare. Accessed from http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224

The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

Commonwealth Fund. (2009). Can Patient-Centered Medical Homes Transform Health Care Delivery?. Accessed from http://www.commonwealthfund.org/Content/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx

In 2007, four primary care specialty societies—representing more than 300,000 internists, family physicians, pediatricians, and osteopaths—agreed on the Joint Principles of the Patient-Centered Medical Home:

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and

- payment that recognized the added value provided to patients who have a patient-centered medical home.

Today, few Americans say they have a source of care with these features. In fact, the Fund's 2008 National Scorecard on U.S. Health System Performance found that only 65 percent of adults under age 65 reported that they have an accessible primary care provider; there were wide variations by race, income, and insurance status. Only half of the overall group said they had received all recommended screening and preventive care.

Among adults who were uninsured all year, just 30 percent had received the appropriate preventive care. A 2008 Fund survey showed almost half of U.S. adults report a lack of care coordination, such as a specialist not receiving basic information from their primary care provider and vice versa, or never being called about test results. The Fund's 2008 Scorecard shows that only a little more than half of all Americans report open and clear communication with their primary care clinician. When there is good communication, and care is delivered in a timely and coordinated manner, patients are more likely to adhere to treatment plans, fully participate in decisions, and receive better care overall.

Creating medical homes throughout the country will clearly require a significant restructuring of our existing health care delivery "system." Whereas most doctors' offices and hospitals are currently isolated from each other—electronically and otherwise—providing patients with around-the-clock access to coordinated care will require that providers are linked and working together. Medical homes are associated with better preventive care and improved chronic disease management (chronic diseases are a major source of high health care costs). Forty-two percent of people with a medical home have regular blood pressure checks, for example, compared with 20 percent without a regular source of care or medical home, according to the Fund's 2006 Health Care Quality Survey. Furthermore, patients with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care provider, and fewer medical errors. The quality survey also showed that medical homes do not just improve, but actually eliminate, disparities in getting needed medical care. Medical homes also produce efficiencies. U.S. adults with medical homes were less likely to have medical reports unavailable during a visit or to have to undergo duplicative tests, according to the Fund's latest international survey.

Cooley, W.C., et.al. Improved Outcomes Associated with Medical Home Implementation in Pediatric *Primary Care. Pediatrics* 2009;124;358-364.

OBJECTIVE: The medical home model with its emphasis on planned care, care coordination, family-centered approaches, and quality provides an attractive concept construct for primary care redesign. Studies of medical home components have shown increased quality and reduced costs, but the medical home model as a whole has not been studied systematically. This study tested the hypothesis that increased medical homeness in primary care practice is associated with decreased utilization of health services and increased patient satisfaction.

METHODS: Forty-three primary care practices were identified through 7 health plans in 5 states. Using the Medical Home Index (MHI), each practice's implementation of medical home concepts "medical homeness" was measured. Health plans provided the previous year's utilization data for children with 6 chronic conditions. The plans identified 42 children in each practice with these chronic conditions and surveyed their families regarding satisfaction with care and burden of illness.

RESULTS: Higher MHI scores and higher subdomain scores for organizational capacity, care coordination, and chronic-condition management were associated with significantly fewer hospitalizations. Higher chronic-condition management scores were associated with lower emergency department use. Family survey data yielded no recognizable trends with respect to the medical home measurement.

CONCLUSIONS: Developing an evidence base for the value of the primary care medical home has importance for providers, payers, policy makers, and consumers. Reducing hospitalizations through enhanced primary care provides a potential case for new reimbursement strategies supporting medical

home services such as care coordination. Larger-scale studies are needed to further develop/examine these relationships.

Harvey R. (2010, Spring). Training for preventive care: An ambitious plan. *Health POWER*: 8-9. Available at http://www.prevention.va.gov/healthpower/HealthPower2010SpringFinal.pdf

Provides an overview of a behavior change training initiative to VA healthcare staff that is grounded in "whole person" orientation of the PCMH and motivational communication and health coaching. A training curriculum is currently being developed through a collaboration with several VHA offices including the Employee Education System (EES), Office of Mental Health Services, Public Health and Environmental Hazards, Office of Nursing Services, Spinal Cord Injury Services and others.

Kellerman, R. (2009). The patient centred medical home. A new model of practice in the USA. *Australian* Family Physician, 38, 5, 279.

A new model of medical practice, the patient centred medical home (PCMH), has gained traction in the United States as an advancement in primary care delivery that will bring better value to patients and to those who pay for health care.

Kuzel, AJ. (Nov/Dec 2009). 10 Steps to a Patient-Centered Medical Home. *Family Practice Management*. 18-24.

Growing recognition of the current crisis in access to primary care in the United States, with all that implies for quality, cost and patient experience of care, makes the PCMH attractive. Many payers, employers, patient advocacy groups and providers are working to develop pilot projects to demonstrate the feasibility and impact of the PCMH. These pilots typically depend upon new payment models and means of evaluation, however. Given that, they strike some physicians as overly complex and onerous in the context of the already stressed, poorly organized and poorly staffed environment that is too typical of primary care in the United States. While these projects have obvious merit, I want to suggest what may be a simpler approach – one that does not depend on new models of financing and that follows a logical series of steps, each building on the one before to develop the capacity and infrastructure for a high-volume practice capable of sophisticated population care and management.

Step 1: Improve documentation and coding.
Step 2: Hire more nurses or medical assistants.
Step 3: Implement advanced-access scheduling.
Step 4: Increase the number of patients you see per day.
Step 5: (Optional) Expand hours.
Step 6: Buy and implement an EHR.
Step 7: Start doing systematic, population-based care.
Step 8: Buy and implement a patient portal.
Step 9: Work with local health systems to create electronic linkages.
Step 10: Improve management of high-cost patients.

National Partnership for Woman and Families. Principles for Patient- and Family-Centered Care: The Medical Home from the Consumer Perspective. Washington, DC. Accessed May 31, 2010 from: http://www.nationalpartnership.org/site/DocServer/Advocate_Toolkit-Consumer_Principles_3-30-09.pdf?docID=4821

Nutting, P., et.al. Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. *Ann Fam Med* 2009;7:254-260.

A preliminary evaluation of a two-year national demonstration conducted by the American Academy of Family Physicians suggests that it is possible to transform a primary care practice into a patient-centered medical home. The results also suggest that those leading other medical home

demonstrations around the country vastly underestimate the magnitude, timeframe, technology, and capital required to implement this transformation.

Reid, R.J., et.al. Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *Am J Manag Care*. 2009;15(9):e71-e87.

BACKGROUND: A patient-centered medical home (PCMH) demonstration was undertaken at 1 healthcare system, with the goals of improving patient experience, lessening staff burnout, improving quality, and reducing downstream costs. Five design principles guided development of the PCMH changes to staffing, scheduling, point-of care, outreach, and management.

OBJECTIVE: To report differences in patient experience, staff burnout, quality, utilization, and costs in the first year of the PCMH demonstration.

Study Design: Prospective before and after evaluation.

METHODS: Baseline (2006) and 12-month (2007) measures were compared. Patient and staff experiences were measured using surveys from a random sample of patients and all staff at the PCMH and 2 control clinics. Automated data were used to measure and compare change components, quality, utilization, and costs for PCMH enrollees versus enrollees at 19 other clinics. Analyses included multivariate regressions for the different outcomes to account for baseline case mix.

RESULTS: After adjusting for baseline, PCMH patients reported higher ratings than controls on 6 of 7 patient experience scales. For staff burnout, 10% of PCMH staff reported high emotional exhaustion at 12 months compared with 30% of controls, despite similar rates at baseline. PCMH patients also had gains in composite quality between 1.2% and 1.6% greater than those of other patients. PCMH patients used more e-mail, phone, and specialist visits, but fewer emergency services. At 12 months, there were no significant differences in overall costs.

CONCLUSIONS: A PCMH redesign can be associated with improvements in patient experience, clinician burnout, and quality without increasing overall cost.

Patient-Centered Primary Care Collaborative. (2009). The patient-centered medical home. The purchasers guide. Understanding the model and taking action. Accessed from http://www.pcpcc.net/files/PurchasersGuide/PCPCC_Purchaser_Guide.pdf

This guide provides an overview of what is the Patient-Centered Medical Home, answers the question of why purchasers should consider supporting it, and then defines a list of potential strategies that purchasers should consider, including some recommended immediate steps that could be taken. The Guide also provides supplemental resources, including detailed case study descriptions, and in the appendices, additional information regarding current and forthcoming pilots, and draft RFI and contract language for purchasers.

Pittman KS. (2010, Spring). Integration of the VHA preventive care program into the patient-centered medical home model. *Health POWER*: 7. Available at http://www.prevention.va.gov/healthpower/HealthPower2010SpringFinal.pdf

Provides a brief presentation of the process of integrating VHA's Preventive Care Program into the PCMH Initiative including training curricula to help improve health coaching skills and patient self-management.

Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, & Larson EB. (2009). Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *American Journal of Managed Care, 15*(9):e71-e87.

Background: A patient-centered medical home (PCMH) demonstration was undertaken at 1 healthcare system, with the goals of improving patient experience, lessening staff burnout, improving

quality, and reducing downstream costs. Five design principles guided development of the PCMH changes to staffing, scheduling, point-ofcare, outreach, and management.

OBJECTIVE: To report differences in patient experience, staff burnout, quality, utilization, and costs in the first year of the PCMH demonstration.

STUDY DESIGN: Prospective before and after evaluation.

Methods: Baseline (2006) and 12-month (2007) measures were compared. Patient and staff experiences were measured using surveys from a random sample of patients and all staff at the PCMH and 2 control clinics. Automated data were used to measure and compare change components, quality, utilization, and costs for PCMH enrollees versus enrollees at 19 other clinics. Analyses included multivariate regressions for the different outcomes to account for baseline case mix.

RESULTS: After adjusting for baseline, PCMH patients reported higher ratings than controls on 6 of 7 patient experience scales. For staff burnout, 10% of PCMH staff reported high emotional exhaustion at 12 months compared with 30% of controls, despite similar rates at baseline. PCMH patients also had gains in composite quality between 1.2% and 1.6% greater than those of other patients. PCMH patients used more e-mail, phone, and specialist visits, but fewer emergency services. At 12 months, there were no significant differences in overall costs.

CONCLUSIONS: A PCMH redesign can be associated with improvements in patient experience, clinician burnout, and quality without increasing overall cost.

Rosser WW, *Colwill* JM, *Kasperski* J, *Wilson* L. (2010). *Patient-Centered Medical Homes* in Ontario, *New England Journal of Medicine*, 362(3):e7

In the early 1990s, the chairs of Ontario's five university departments of family medicine became increasingly concerned that the payment system rewarded high-volume practices rather than broad, patient-centered care.23 In response, a government-appointed committee identified a "basket" of services that family practices should provide. Specifically included are episodic and acute care; mental health care; chronic disease care; evidence-based prevention; education for self-care; care in the hospital, at home, and in the community; support for the terminally ill; and arrangements for around-the-clock response for urgent problems.

Schoen C, Osborn R, Huynh PT, Doty M, Davis K, Zapert K, Peugh J. Primary care and health system performance: adults' experiences in five countries. Health Aff (Millwood). 2004 Jul-Dec; Suppl. Web Exclusives:W4-487-503

This paper reports on a 2004 survey of primary care experiences among adults in Australia, Canada, New Zealand, the United Kingdom, and the United States. The survey finds shortfalls in delivery of safe, effective, timely, or patient-centered care, with variations among countries. Delays in lab test results and test errors raise safety concerns. Failures to communicate, to engage patients, or to promote health are widespread. Aside from clinical preventive care, the United States performs poorly on most care dimensions in the study, with notable cost-related access concerns and short-term physician relationships. Contrasts across countries point to the potential to improve performance and to learn from international initiatives.

Stark RC. (2010, Spring). The patient-centered medical home model. *Health POWER*: 3-4. Available at http://www.prevention.va.gov/healthpower/HealthPower2010SpringFinal.pdf

This article provides a brief overview of the evolution of the PCMH model in the VA which began more than 15 years ago when the VA transformed from an inpatient-based system to one rooted in primary care. The PCMH model builds upon the success of the last 15 years, using a patient-driven, team based approach that delivers efficient, comprehensive and continuous care through active communication and coordination of healthcare services.

Team strategies and tools to enhance performance and patient safety (TeamSTEPPS) (2008), Department of Defense and Agency for Healthcare Research and Quality http://www.ahrq.gov/qual/teamstepps

TeamSTEPPS is a teamwork system based on 20 years experience and lessons learned from High-Reliability Organizations (HROs) (for example, military operations, aviation, community emergency response services, and nuclear power industries). These types of organizations have been conducting extensive research on how teams work, what makes them effective and how to enhance their performance. This research is directly relevant to health care because delivering effective care requires teamwork. TeamSTEPPS has incorporated the best practices from this research into a program to improve the quality, safety, and efficiency of health care by improving communication and other teamwork skills. These skills lead to important team outcomes like enabling the teams to:

- Adapt to changing situations.
- Have a shared understanding of the care plan.
- Develop positive attitudes toward and appreciate the benefits of teamwork.
- Provide more safe, reliable, and efficient care.

Designed with input from the medical community, it is an initiative that will work within the daily functioning of healthcare organizations (it is practical) and can be customized (adapted) to meet healthcare organization's needs. For example, TeamSTEPPS trainers can identify an appropriate teamwork tool/process to help address a known problem (from a variety of options) that will best work within the practice/hospital/specific department and focus time on training the team to use that tool.

Weiss LJ, Blustein J. (1996). Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans. Am J Public Health. 86(12):1742-7

OBJECTIVES: This study examined the impact of duration of physician-patient ties on the processes and costs of medical care.

METHODS: The analyses used a nationally representative sample of Americans 65 years-old or older who participated in the Medicare Current Beneficiary Survey in 1991 and had a usual source of care.

RESULTS: Older Americans have long-standing ties with their physicians; among those with a usual source of care, 35.8% had ties enduring 10 years or more. Longer ties were associated with a decreased likelihood of hospitalization and lower costs. Compared with patients with a tie of 1 year or less, patients with ties of 10 years or more incurred $316.78 less in Part B Medicare costs, after adjustment for key demographic and health characteristics. However, substantial impacts on the use of selected preventive care services and the adoption of certain healthy behaviors were not observed.

CONCLUSIONS: This preliminary study suggests that long-standing physician-patient ties foster less expensive, less intensive medical care. Further studies are needed to confirm these findings and to understand how duration of tie influences the processes and outcomes of care.

VHA Patient Centered Primary Care Implementation Work Group. (2010). Patient-Centered Medical Home Model: Concept Paper. Available at http://www1.va.gov/PrimaryCare/pcmh/

The Patient Centered Medical Home (PCMH) Model is a patient-driven, team-based approach that delivers efficient, comprehensive and continuous care through active communication and coordination of healthcare services. PCMH is based on a set of seven principles (1) and depends on a core and expanded team of healthcare personnel who work with the Veteran patient to plan for their overall health.

While most VHA Primary Care practices have already adopted many of the features of patient-centered care and the medical home, complete achievement will involve strategic assessment and redeployment of resources, realignment of priorities, and a major cultural change—an effort that will be truly transformative. It will help align VA with national health care reform initiatives and enable

VHA to continue to provide leadership in health care delivery while assuring that our Veterans' health is managed with the utmost quality, safety and effectiveness. With the Patient Centered Medical Home Model, our Veteran patient population will have superb access to high quality primary care that affords them a healthier lifestyle.

Related annotations: Patient and healthcare team communication

Agnew T. (2009). Acting with confidence. *Cancer Nursing Practice, 8*(1):18-20.

Video-taped role-play sessions and feedback are key aspects of a communications programme that is being introduced across England and presented by the National Cancer Action Team.

Apker J., Propp K.M., Zabava-Ford W.S., & Hofmeister N. (2006). Collaboration, credibility, compassion, and coordination: Professional nurse communication skill sets in health care team interaction. *Journal Professional Nursing, 22*:180–9.

This study explored how nurses communicate professionalism in interactions with members of their health care teams. Extant research show that effective team communication is a vital aspect of a positive nursing practice environment, a setting that has been linked to enhanced patient outcomes. Although communication principles are emphasized in nursing education as an important component of professional nursing practice, actual nurse interaction skills in teambased health care delivery remain understudied. Qualitative analysis of interview transcripts with 50 participants at a large tertiary hospital revealed four communicative skill sets exemplified by nursing professionals: collaboration, credibility, compassion, and coordination. Study findings highlight specific communicative behaviors associated with each skill set that exemplify nurse professionalism to members of health care teams. Theoretical and pragmatic conclusions are drawn regarding the communicative responsibilities of professional nurses in health care teams. Specific interaction techniques that nurses could use in nurse–team communication are then offered for use in baccalaureate curriculum and organizational in-service education.

Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Archives of Internal Medicine*, 154(12) 1365-1370.

OBJECTIVE: To explore plaintiff depositions to gain insight into issues that prompt malpractice claims.

DESIGN: Retrospective content analysis of depositions.

SETTING: Large metropolitan medical center.

SUBJECTS: Convenience sample of 45 patient depositions randomly selected from a sample of 67 made available from settled claims between 1985 and 1987.

INTERVENTIONS: None.

MEASURES: Information extracted included responses to the following questions: "Why are you suing?" and "Did a health professional suggest maloccurrence?"

RESULTS: Relationship problems were identified in 71% of depositions. Four themes emerged: 32% deserting the patient; 29% devaluing patient and/or family views; 26% delivering information poorly; and 13% failing to understand the patient and/or family perspective. Fifty-four percent of plaintiffs responded affirmatively when asked if health professionals suggested maloccurrence. Of these cases, 71% named the post outcome consulting specialist as the one who suggested maloccurrence.

CONCLUSIONS/RECOMMENDATIONS: The decision to litigate is most often associated with perceived lack of caring and/or collaboration in health care delivery. Particular attention needs to be paid to post adverse event consultant-patient interactions.

Beckman, H. B., & Frankel, R. M. (1984). The effect of physician behavior on the collection of data. *Annals of Internal Medicine*, 101(5) 692-696.

OBJECTIVE: To determine the effect of the physician's response at the opening of the medical interview on the completeness of data collection.

DESIGN: Audiotapes of visits to a primary care facility were reviewed to determine the effect of physician input in the initial stages of the medical interview.

SETTING: Primary care internal medicine practice at Wayne State University. 2 experienced physicians and 13 residents in internal medicine conducted interviews.

SUBJECTS: 74 interviews were taped. The patient population consisted primarily of the elderly and the chronically ill. Most were of low socioeconomic level. 64% female; 74% return visits.

INTERVENTIONS: None.

MEASURES: Audio tapes were coded using a method sensitive to production and timing of dialogue.

RESULTS: Patients were permitted to complete their opening statement of concerns in only 23% of the visits. Only 1 of 52 interrupted opening statements were subsequently completed. On average, interruption occurred 18 seconds after the patient began speaking. Completed statements of concerns took no more than 150 seconds.

CONCLUSIONS: Physician-directed interviewing at the beginning of a visit may eliminate the expression of patient concerns and questions.

Bonvicini, K.A., Perlin, M.P., Bylund, C.L., Carroll, J.G., Rouse, R., & Goldstein, M.G. (2009). Impact of communication training on physician expression of empathy in patient encounters. *Patient Education and Counseling*, 75:3-10.

OBJECTIVE: To examine whether an educational intervention that focused on physician communication training influenced physician empathic expression during patient interactions.

METHODS: This study used a quantitative research method to investigate the influence of communication training on physician-expressed empathy using two measures (global and hierarchical) of physician empathic behavior.

RESULTS: The differences in global empathy scores in the physician training group from baseline to follow-up improved by 37%, and hierarchical scores of physician empathic expression improved by up to 51% from baseline scores for the same group.

CONCLUSIONS: The results strongly supported the hypotheses that training made a significant difference in physician empathic expression during patient interactions demonstrated by both outside observer measures of global ratings and hierarchical ratings of physician empathic behavior.

PRACTICE IMPLICATIONS: These findings have significant implications for program design and development in medical education and professional training with the potential to improve patient outcomes.

Boyle, D., Kochinda, C. (2004). Enhancing Collaborative Communication of Nurse and Physician Leadership in Two Intensive Care Units. *Journal of Nursing Administration, 34*(2):60-70.

OBJECTIVE: To test an intervention to enhance collaborative communication among nurse and physician leaders (eg, nurse manager, medical director, clinical nurse specialist) in two diverse intensive care units (ICUs).

BACKGROUND: Collaborative communication is associated with positive patient, nurse, and physician outcomes. However, to date, intervention-focused research that seeks to improve collaborative communication is lacking.

METHODS: A pretest-posttest repeated measures design incorporated baseline data collection, implementation of the intervention over 8 months, and immediate and 6-months-post data collection.

FINDINGS: Communication skills of ICU nurse and physician leaders improved significantly. Leaders also reported increased satisfaction with their own communication and leadership skills. In addition, staff nurse and physician perceptions of nursing leadership and problem solving between groups increased. Staff nurses reported lower personal stress (eg, more respect from co-workers, physicians, and managers), even though they perceived significantly more situational stress (eg, less staffing and time).

CONCLUSION: Study findings provide evidence that nurse-physician collaborative communication can be improved.

Bylund, C. L., & Makoul, G. (2002). Empathic communication and gender in the physician-patient encounter. *Patient Education and Counseling*, 48(3) 207-216.

Although empathy in the physician-patient relationship is often advocated, a theoretically based and empirically derived measure of a physician's empathic communication to a patient has been missing. This paper describes the development and initial validation of such a measure, the Empathic Communication Coding System (ECCS), which includes a method for identifying patient-created empathic opportunities. To determine the extent to which empathic communication varies with physician and patient gender, we used the ECCS to code 100 videotaped office visits between patients and general internists. While male and female patients created a comparable number of empathic opportunities, those created by females tended to exhibit more emotional intensity than those created by males. However, female patients were no more likely than male patients to name an emotion in their empathic opportunities. Physician communication behavior was consistent with the literature on gender differences: female physicians tended to communicate higher degrees of empathy in response to the empathic opportunities created by patients. The ECCS appears to be a viable and sensitive tool for better understanding empathy in medical encounters, and for detecting modest gender differences in patients' creation of empathic opportunities and in physicians' empathic communication.

Commonwealth Fund 2001 Health Care Quality Survey, Retrieved from
http://www.cmwf.org/surveys/surveys_show.htm?doc_id=228171

This survey reveals that on a wide range of health care quality measures—including effective patient–physician communication and access to health care and insurance coverage—minority Americans do not fare as well as whites. African Americans, Asian Americans, and Hispanics are more likely than whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving care, to experience barriers to care such as lack of insurance or not having a regular doctor, and to feel they would receive better care if they were of a different race or ethnicity. MODE OF ADMINISTRATION: The Commonwealth Fund 2001 Health Care Quality Survey was a telephone survey conducted in English, Spanish, Mandarin or Cantonese, Vietnamese and Korean. SURVEY SAMPLE DESIGN: A stratified minority sample design was used. The survey employed standard list-assisted random-digit dialing methods, and telephone numbers from area code-exchange

combinations with higher-than-average densities of minority households were drawn disproportionately.

<u>PRIMARY SURVEY CONTENT</u>: The survey collected current information on the health care experiences of respondents, including information on health status, use of preventive services, access-to-care issues, experiences with the doctor-patient encounter, communication, health literacy, and compliance.

<u>POPULATION TARGETED</u>: The survey is a nationally representative survey of the U.S. adult population age 18 and older. In addition, the survey allows separate analyses of responses by African-American, Hispanic and Asian households.

Demographic Data:

Age, gender, race, ethnicity, country of birth, region, primary language spoken, insurance coverage, employment status, marital status, and household composition.

<u>YEARS COLLECTED</u>: 2001

<u>GEOGRAPHIC ESTIMATES</u>: National

CONTACT INFORMATION: Commonwealth Fund Web site: **http://www.cmwf.org**

Davis, K., Schoenbaum, S. C., Collins, K. S., Tenney, K., Hughes, D. L., & Audet, A. M. (2002). *Room for improvement: Patients report on the quality of their health care*. New York: Commonwealth Fund. Retrieved from **www.cmwf.org**

The American health care system is unparalleled in its technological sophistication. Yet a Commonwealth Fund Health Care Quality Survey reveals that medical care falls far short of the ideal. It is not enough to have the best technology. Health care should be safe, effective, patient-centered, timely, efficient, and equitable. High-quality care involves meeting patients. personal needs and treating them equitably regardless of their race, ethnicity, gender, income, or health status. Furthermore, high-quality care depends on a shared understanding between physicians and patients of the nature of the medical problem and an agreed-upon approach to addressing it. Communication between physicians and patients is often poor, however. Many patients say that physicians do not listen and that they do not have an opportunity to raise questions and to share in making decisions about their care. A disturbing one of four patients confessed that they did not always follow physicians. advice. Twenty-four percent reported a time in the past two years when they did not follow a doctor's advice for treatment plan, get a recommended test or see a referred doctor, in large part because they did not agree with the doctor, or the advice or plan ran counter to their beliefs or was impractical given their economic or other life circumstances.

The Commonwealth Fund 2001 Health Care Quality Survey, a national survey of Americans experiences with the health care system, highlights the importance of addressing the care issues of concern to patients, improving communication between patients and physicians, ensuring that care is responsive to patients. preferences, increasing choice, promoting trust and continuity in patient-clinician relationships, and instituting systems to ensure regular preventive care and better management of chronic conditions.

Delva D., Jamieson M, & Lemieux M. (2008). Team effectiveness in academic primary health care teams. *Journal of Interprofessional Care, 22*(6):598-611.

Primary health care is undergoing significant organizational change, including the development of interdisciplinary health care teams. Understanding how teams function effectively in primary care will assist training programs in teaching effective interprofessional practices. This study aimed to explore the views of members of primary health care teams regarding what constitutes a team, team effectiveness and the factors that affect team effectiveness in primary care. Focus group consultations from six teams in the Department of Family Medicine at Queen's University were recorded and transcribed and qualitative analysis was used to identify themes. Twelve themes were identified that related to the impact of dual goals/obligations of education and clinical/patient practice on team relationships and learners; the challenges of determining team membership including nonattendance of allied health professionals except nurses; and facilitators and barriers to effective team function. This study provides insight into some of the challenges of developing effective primary care teams in

an academic department of family medicine. Clear goals and attention to teamwork at all levels of collaboration is needed if effective interprofessional education is to be achieved. Future research should clarify how best to support the changes required for increasingly effective teamwork.

DiMeglio K, Lucas, S. Lucas, & Padula, C. (2005). Group Cohesion and Nurse Satisfaction. *Journal of Nursing Administration*. 35:3 , 110-120.

OBJECTIVES: The purpose of this study was to determine the impact of a team-building intervention on group cohesion, nurse satisfaction, and turnover rates.

BACKGROUND: Creating an environment that supports and retains nurses represents a formidable challenge for nursing leaders. Research related to strategies that positively impact the culture in which nurses practice, thus potentially improving nurse satisfaction and reducing turnover, is critically needed.

METHODS: Registered nurses (RNs) employed on inpatient units in a 247-bed, private acute care Magnet teaching hospital participated in this quasi experimental preintervention and postintervention design. The RN-RN interaction subscale from the National Database of Nursing Quality Indicators Adapted Index of Work Satisfaction, the National Database of Nursing Quality Indicators Adapted Index of Job Enjoyment, the Group Cohesion Scale, and a facilitator-developed measure were completed preimplementation and postimplementation of unit-tailored intervention strategies, which took place over a 12-month period. Turnover rates were collected 6 month preintervention and postintervention.

RESULTS: Improvement in group cohesion, RN-RN interaction, job enjoyment, and turnover was demonstrated.

CONCLUSION: Targeted, unit-based strategies can be an effective means of reducing turnover rates and improving group cohesion and nurse satisfaction.

Dougherty, M., & Larson, E. (2005). A Review of Instruments Measuring Nurse-Physician Collaboration *Journal of Nursing Administration. 35*(5):244-25.

OBJECTIVE: To review instruments used to measure nurse-physician collaboration and compare the strengths and potential opportunities of each instrument.

BACKGROUND: Nurse-physician collaboration has been studied using a variety of instruments. The ability to generalize the outcomes of studies and build on the findings is predicated on acceptable validity and reliability metrics of these instruments.

METHODS: A literature search using PubMed(R) and Health and Psychological Instruments databases was conducted for articles published between 1990 and May 2004 to identify instruments measuring staff nurse-physician collaboration. After the instruments were identified, a second search was conducted to identify at least one peer-reviewed article describing the psychometrics of the instrument. Articles identified were then entered into the ISI Web of Science(R) Citation Index to identify the instruments that had been used in at least 2 other studies. These selected instruments were then reviewed for the following information: background for the development of the tool, description of the tool, initial psychometric testing, and strengths and potential applications for each instrument.

RESULTS: Five instruments met study criteria: the Collaborative Practice Scale, Collaboration and Satisfaction About Care Decisions, ICU Nurse-Physician Questionnaire, Nurses Opinion Questionnaire, and the Jefferson Scale of Attitudes Toward Physician Nurse Collaboration.

CONCLUSIONS: The identified instruments have undergone initial reliability and validity testing and are recommended for future research on nurse-physician collaboration.

Dreachslin JL., Hunt PL., & Sprainer E.(1999). Communication patterns and group composition: Implications for patient-centered team effectiveness. *Journal of Healthcare Management, 44*(4):252-267.

To assess how diversity affects team communication and to identify strategies to improve communication and patient care, focus groups of care production team members were held in two care study hospitals that have implemented the patient-centered care model. Results indicate that care production team members generally support patient-centered care as a model that can work effectively in practice, even in an urban environment in which diversity concerns can affect team cohesiveness and communication. Successful implementation of the model, however, requires that hospitals consistently employ management strategies and reward structures that reinforce the value of teamwork and emphasize training and staff development.

Key steps that healthcare executives can undertake to improve the performance of care production teams are provided in this article in detail and center around the following themes:

- team involvement in process improvement;
- a heightened emphasis on training (e.g., team and diversity training for all team members, task-focused training for non-licensed care givers; and leadership training for RNs); and
- the implementation of team-based reward and incentive structures.

Easter, D. W., & Beach, W. (2004). Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions. *Current Surgery, 61*(3), 313-318.

OBJECTIVE: Core competencies in surgical education and clinical care rely on effective patient-physician communication. We aim to develop quantitative and empirical tools for understanding critical communication tasks during patient interviews.

METHODS: Residents in surgical training and attending physicians were separately video recorded during stressful, first visit oncology patient interview sessions. Taped sessions (n = 16) were analyzed in detail to identify and label patient-initiated actions (PIAs), or "empathic opportunities," that call for recognition or action from the caregiver. Doctor-responsive actions (DRAs) were labeled as matching to, or missing from, each empathic opportunity. Missed empathic opportunities occurred when a PIA did not have an associated DRA. Presession and postsession surveys queried the patient's perception of how well their health-care needs were met.

RESULTS: Resident trainees and attending physicians missed 70% of 160 clearly identified empathic opportunities. There was no clear association with the level of physician training. This pilot study did not have enough power to discern differences in patient satisfaction.

CONCLUSIONS: Physicians are often not very attentive to empathic opportunities offered by patients. Individual feedback and training regarding empathic opportunities in recorded patient communication encounters may improve resident and physician core competencies. These improvements may affect patient satisfaction related to these encounters.

Elliott VS (2010 June 14). Generation gaps: Managing a multigenerational staff. *American Medical News*, Available from http://www.ama-assn.org/amednews/2010/06/14/bisa0614.htm

A staff made up from a range of age groups with different priorities and styles can lead to conflict. Understanding generational tendencies can ease that. There are four distinct generations in the workplace, all of whom have wildly different expectations of how they will work and how they will be managed. Experts say a more rapidly changing society means that generational zeitgeist may be formed by vastly different experiences. The issue goes beyond the long-standing tradition of older generations thinking those who are younger are not working as hard as they once did.

Evanoff B, Potter P, Wolf L, Grayson D, Dunagan C, & Boxerman S. (2005). Can We Talk? Priorities for Patient Care Differed Among Health Care Providers. *Advances in Patient Safety, 1*:5-14.

OBJECTIVE: Poor communication and collaboration between members of a patient's health care team can result in medical errors and poor quality of care. The purpose of this study was to assess communication and consensus regarding patient care goals between members of the health care team (physicians, registered nurses [RNs], and patient care technicians [PCTs]) caring for the same patient on a given day.

METHODS**:** Frequency of communication and agreement on priorities for patient care were measured among team members. Four hundred thirty-seven inpatients were randomly selected from six nursing divisions in an acute care tertiary hospital, and the responsible physician, RN, and PCT were identified. Each health care provider was interviewed midmorning and midafternoon. Each provider was asked to identify other team members and to describe the top three priorities for the care of the individual patient.

RESULTS**:** Midmorning, 23 percent of physicians could name the RN caring for their patient and 42 percent of RNs could name the physician responsible for the same patient. Midafternoon, approximately 50 percent of physicians and RNs reported discussing the patient with each other, while over 90 percent of RNs and PCTs had discussed patient care with each other. There was full agreement on patient priorities between the physician and RN in 17 percent of cases, partial agreement in 53 percent of cases, and no agreement in 30 percent of cases. Agreement between physicians and RNs was higher than the agreement between RNs and PCTs.

CONCLUSION**:** Our findings show that the priorities of patient care differed between members of the health care team, and that verbal communication between team members was inconsistent.

Groopman, J. (2007). *How doctors think*. Houghton Mifflin Company: NY.

On average, a physician will interrupt a patient describing her symptoms within eighteen seconds. In that short time, many doctors decide on the likely diagnosis and best treatment. Often, decisions made this way are correct, but at crucial moments they can also be wrong -- with catastrophic consequences. Dr. Groopman pinpoints the forces and thought processes behind the decisions doctors make and explores why doctors err and shows when and how they can -- avoid snap judgments, embrace uncertainty, communicate effectively, and deploy other skills that can profoundly impact our health. The author draws on a wealth of research, extensive interviews with some of the country's best doctors, and his own experiences as a doctor and as a patient. He has learned many of the lessons in this book the hard way, from his own mistakes and from errors his doctors made in treating his own debilitating medical problems.

Hasan, S. (2008) A tool to teach communication skills to pharmacy students. *American Journal of Pharmaceutical Education, 72*(3), 1-6.

OBJECTIVE: To develop a tool to teach pharmacy students assertive communication skills to use when talking with physicians over the telephone.

DESIGN: As an assignment for their Communication Skills and Counseling course, students were asked to write a script involving a patient care issue or problem covering 3 different communication styles that could be used when contacting a prescriber by telephone: passive, aggressive, and assertive. Students worked in groups to write and act out the scripts for the class.

ASSESSMENT: Eight scripts were developed by students and rated by peers and faculty members. The script that received the highest ratings was used in the development of a multimedia educational CD.

CONCLUSION: The development of hypothetical scripts describing a drug therapy problem and illustrating the types of interactions between physicians and pharmacists while discussing the problem

allowed pharmacy students to explore different communication techniques and improve their communication skills.

Katzenbach JR., & Smith DK. (1993). The discipline of teams. *Harvard Business Review, 71*(2):111-120.

The essence of a team is shared commitment. Without it, groups perform as individuals; with it, they become a unit of collective performance. The best teams invest a tremendous amount of time shaping a purpose and they translate their purpose into specific performance goals. Team members also pitch in and become accountable with and to their teammates. The fundamental distinction between teams and other forms of working groups turns on performance. A working group relies on the individual contributions of its members for group performance. But a team strives for something greater than its members could achieve individually. The authors identify three basic types of teams: teams that recommend things, teams that make or do things, and teams that run things. The key is knowing where in the organization real teams should be encouraged. Team potential exists anywhere hierarchy or organizational boundaries inhibit good performance.

Keller, V. F., & Carroll, J. G. (1994). A new model for physician-patient communication. *Patient Education and Counseling, 23*, 131-140.

The authors present a model of communication that conceptualizes four communication or relationship tasks necessary for all medical encounters that are complementary to the biomedical tasks including engagement, empathy, education, and enlistment. The model purports that clinician patient communication comprises a set of competencies and skills that are mapped out in a model of communication. This model provided a behavioral approach of core relational strategies which form the basis for teaching the communication tasks in healthcare. The model's map of four communication or relationship tasks necessary for all medical encounters are seen as complementary to the biomedical tasks. The communication tasks include specific techniques and skills that clinicians use throughout the medical encounter to engage, empathize, educate, and enlist the patient in decision-making. This model has been embedded into continuing medical education programs, and has served as one of the five models central to the Kalamazoo Consensus Conference which brought health communication experts together to identify and delineate an essential set of communication tasks.

Kemp EC, Floyd MR, McCord-Duncan E, Lang F. (2008). Patients prefer the method of "tell back-collaborative inquiry" to assess understanding of medical information. J Am Board Family Med. 21(1):24-30.

PURPOSE: The goal of this study was to determine which approach to assessing understanding of medical information patients most prefer and perceive to be most effective. METHODS: Two videos were shown to participants: (1) a physician explaining a medical condition and its treatment and (2) a physician inquiring about patient understanding of the medical information the patient had been given using 3 different types of inquiry: Yes-No, Tell Back-Collaborative, and Tell Back-Directive. RESULTS: The Tell Back-Collaborative inquiry was significantly preferred over the other 2 approaches. CONCLUSIONS: Patients strongly prefer the Tell Back-Collaborative inquiry when assessing their understanding. We recommend that physicians ask patients to restate what they understand using their own words and that they use a patient-centered approach.

Larson, E. B., & Yao, X. (2005). Clinical empathy as emotional labor in the patient-physician relationship. *Journal of American Medical Association, 293*(9), 100-1106.

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (ie, management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's The Managed Heart in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors.

In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (ie, generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (ie, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers--and enjoy more professional satisfaction--when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

Lein C., & Wills CE. (2007). Using patient-centered interviewing skills to manage complex patient encounters in primary care. *American Academy of Nurse Practitioners, 19*:215-220.

PURPOSE: To describe effective and efficient patient-centered interviewing strategies to enhance the management of complex primary care patient encounters.

DATA SOURCES: Research literature and applied case study analysis.

CONCLUSIONS: Patient-centered interviewing can enhance effectiveness of care in complex patient encounters. A relatively small investment of time and energy has positive yields in regard to improvements in longer term physiological status, treatment adherence, quality of life, patient–provider working relationship, and patient and nurse practitioner satisfaction.

IMPLICATIONS FOR PRACTICE: Use of patient-centered interviewing strategies can enhance effectiveness of patient care processes and outcomes while retaining efficiency of patient management.

Levinson W, Lesser CS, & Epstein RM. (2010). Developing physician communication skills for patient-centered care. *Health Affairs, 29*(7): 1310–1318.

Growing enthusiasm about patient-centered medical homes, fueled by the Patient Protection and Affordable Care Act's emphasis on improved primary care, has intensified interest in how to deliver patient centered care. Essential to the delivery of such care are patient-centered communication skills. These skills have a positive impact on patient satisfaction, treatment adherence, and self-management. They can be effectively taught at all levels of medical education and to practicing physicians. Yet most physicians receive limited training in communication skills. Policy makers and stakeholders can leverage training grants, payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centered communication.

Levinson, W., Gorawara-Bhat, R., & Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *Journal of the American Medical Association, 284*(8), 1021-1027.

CONTEXT: Patients often present clues (direct or indirect comments about personal aspects of their lives or their emotions) during conversations with their physicians. These clues represent opportunities for physicians to demonstrate understanding and empathy and thus, to deepen the therapeutic alliance that is at the heart of clinical care. A paucity of information exists regarding how physicians address the psychological and social concerns of patients. OBJECTIVES: To assess how patients present clues and how physicians respond to these clues in routine primary care and surgical settings. DESIGN, SETTING, AND PARTICIPANTS: Descriptive, qualitative study of 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons in community-based practices in Oregon and Colorado, audiotaped and transcribed in 1994. MAIN OUTCOME MEASURES: Frequency of presentation of clues by patients during office visits, nature (emotional vs social) and content of clues, and nature of physician responses to clues, coded as positive or missed

opportunity. RESULTS: Fifty-two percent and 53% of the visits in primary care and surgery, respectively, included 1 or more clues. During visits with clues, the mean number of clues per visit was 2.6 in primary care and 1.9 in surgery. Patients initiated approximately 70% of clues, and physicians initiated 30%. Seventy-six percent of patient-initiated clues in primary care settings and 60% in surgical settings were emotional in nature. In surgery, 70% of emotional clues related to patients' feelings about their biomedical condition, while in primary care, emotional clues more often related to psychological or social concerns (80%) in patients' lives. Physicians responded positively to patient emotions in 38% of cases in surgery and 21% in primary care, but more frequently they missed opportunities to adequately acknowledge patients' feelings. Visits with missed opportunities tended to be longer than visits with a positive response. CONCLUSION: This study suggests that physicians in both primary care and surgery can improve their ability to respond to patient clues even in the context of their busy clinical practices.

Lindeke LL, & Sieckert AM. (2005). Nurse physician workplace collaboration. *Online Journal of Issues in Nursing*, Vol #10, #1, Available: www.nursingworld.org/ojin/topic26/tpc26_4.htm

Maximizing nurse-physician collaboration holds promise for improving patient care and creating satisfying work roles. The purpose of this article is to describe strategies that will facilitate effective nurse-physician collaboration. First the nature and the benefits of collaborative communication will be reviewed. This review will be followed by a discussion of self-development, team development, and communication-development strategies that can enhance nurse-physician collaboration.

Manojlovich, M., & Antonakos, C. (2008). Satisfaction of Intensive Care Unit Nurses With Nurse-Physician Communication. *Journal of Nursing Administration. 38*(5):237-243.

OBJECTIVE: The objective of this study was to determine if specific communication elements contribute to nurses' satisfaction with communication.

BACKGROUND: Little research has focused on communication satisfaction, which may be linked to overall communication effectiveness, job satisfaction, and turnover intentions.

Methods: Using a non-experimental, descriptive design, all nurses (N = 866) who worked in 25 intensive care units located in 8 hospitals in Southeast Michigan were anonymously surveyed on their perceptions of registered nurse/doctor of medicine communication and satisfaction with communication.

RESULTS: There were 407 usable surveys. Nurses were more satisfied with open, accurate, and understanding communication ($R2 = 0.66$). Years of experience in intensive care unit and satisfaction with communication were inversely related ($r = -0.10$, $P = .04$). Nurses preferred communicating with attending-level physicians ($r = 0.12$, $P = .02$) than with first year residents ($r = -0.21$, $P < .001$).

CONCLUSION: Although touted as a patient safety tool, the timeliness of communication was not associated with communication satisfaction. Nurses are more satisfied with understanding, open, and accurate communication, especially with attending-level physicians.

Marvel, M. K., Epstein, R. M., Flowers, K., & Beckman, H. B. (1999). Soliciting the patient's agenda: Have we improved? *JAMA : The Journal of the American Medical Association*, 281(3) 283-287.

OBJECTIVE: To examine the extent to which experienced family physicians in various practice settings, elicit the agenda of concerns patients bring to the office.

DESIGN: Cross-section survey using linguistic analysis of a convenience sample of 264 patient-physician interviews.

SETTING: Primary care offices of 29 Board-certified family physicians practicing in rural Washington (n=13%), semi-rural Colorado (n=20; 69%), and urban settings in the United States and Canada (n=8; 27%).

SUBJECTS: 29 Board-certified family physicians (9 had fellowship training in communication skills and family counseling).

INTERVENTION: None.

MEASURES: Physician-patient verbal interactions including physician solicitation of patient concerns, rate of completion of patient responses, length of time for patient responses, and frequency of late-arising patient concerns. Interview transcripts were analyzed using a method described by Beckman and Frankel.

RESULTS: Physicians solicited patients concerns in 199 interviews (75.4%). Patients' initial statements of concerns were completed in 74 interviews (28%). Physicians redirected the patient's opening statement after a mean of 23.1 seconds. Patients allowed to complete their statements of concerns used only 6 seconds more, on average, than those that were redirected before completion of concerns. Late-arising concerns were more common when physicians did not solicit patient concerns during the interview (34.9% vs. 14.9%). Fellowship-trained physicians were more likely to solicit patient concerns and allow patients to complete their initial statements of concerns (44% vs. 22%).

CONCLUSIONS/RECOMMENDATIONS: Physicians often redirect patients' initial descriptions of their concerns. Once redirected, descriptions are rarely completed. Consequences of incomplete initial descriptions include late-arising concerns and missed opportunities to gather potentially important patient data. Soliciting the patients' agenda takes little time and can improve interview efficiency and yield increased data.

Martin, K.L. & Hodgson, D. (2006). The role of counseling and communication skills: how can they enhance a patient's 'first day' experience? *Journal of Radiotherapy in Practice, 5,* 157-164.

A patient arriving for their first Radiotherapy appointment can exhibit an array of behaviours, such as anxiety or aggression, which are generated by intense emotions. Each patient will have their own individual concerns and their needs should be addressed, to make their first experience in the Radiotherapy Department as smooth and stress free as possible.

The radiographer's role at this point is undoubtedly to provide patients with information, whilst demonstrating a compassionate and genuine nature. This can make all the difference to the way a patient reacts and copes with the entire course of radiotherapy.

The skills that will allow a radiographer to handle these situations are, in the first instance; good communication skills, but in addition to this the development of some basic counselling skills could further enhance patient care.

The aim of this article is to discuss the benefits of utilising basic counselling skills to create the best environment possible for the patient, and possibly answer some questions about their legitimate nature.

McCaffrey R.G., Hayes R., Stuart W., Cassell A., Farrell C., Miller-Reyes C., & Donaldson A. (2010). A program to improve communication and collaboration between nurses and medical residents. *Journal of Continuing Education Nursing, 41*(4), 172-178.

A program was implemented for nurses and medical residents to improve communication and collaboration. It has been noted that communication and collaboration between members of the health care team improve patient outcomes and job satisfaction among nurses. Nurses on the unit where medical residents trained attended a 2-hour educational program that reviewed effective communication styles and positive aspects of collaboration, including role-playing examples. Medical residents received a self-learning packet with a posttest that was returned to researchers when completed. Focus groups, including both nurses and medical residents, were held twice a month for 6 months after the educational program. Overall improvements in communication, collaboration, patient outcomes, and job satisfaction were noted from the focus group data. The educational program

proved to be successful in improving collaboration and communication between nurses and medical residents, which in turn improved patient care.

Peterson, M. C., Holbrook, J., Von Hales, D., Smith, N. L., & Staker, L. V. (1992). Contributions of the history, physical examination and laboratory investigation in making medical diagnoses. *Western Journal of Medicine, 156*, 163-165.

The researchers report an attempt to quantify the relative contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. In this prospective study of 80 medical outpatients with new or previously undiagnosed conditions, internists were asked to list their differential diagnoses and to estimate their confidence in each diagnostic possibility after the history, after the physical examination, and after the laboratory investigation. In 61 patients (76%), the history led to the final diagnosis. The physical examination led to the diagnosis in 10 patients (122%),and the laboratory investigation led to the diagnosis in 9 patients (1 10%). The internists' confidence in the correct diagnosis increased from 7.1 on a scale of 1 to 10 after the history to 8.2 after the physical examination and 9.3 after the laboratory investigation. These data support the concept that most diagnoses are made from the medical history. The results of physical examination and the laboratory investigation led to fewer diagnoses, but they were instrumental in excluding certain diagnostic possibilities and in increasing the physicians' confidence in their diagnoses.

Rabinowitz, I., Tamir, R., & Reis, A. (2004). Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter. *British Medical Journal, 328*, 501-502.

OVERVIEW: The patient's opening statement in a consultation (the patient's monologue) is an important part of history taking, and doctors are encouraged not to interrupt the patient--but they often do, probably because they think that the patient's monologue is time consuming. When uninterrupted, patients conclude their monologue in less than 30 seconds in primary care and about 90 seconds in consultant settings. The researchers assessed encounters in primary care that included a new clinical problem, recording the length and rate of completion of patients' monologues before and after instructing doctors not to interrupt.

Rao JK, Anderson LA, Inui TS, & Frankel RM. (2007). Communication interventions make a difference in conversations between physicians and patients: a systematic review of the evidence. *Medical Care, 45*(4):340-9.

OBJECTIVE: We sought to synthesize the findings of studies examining interventions to enhance the communication behaviors of physicians and patients during outpatient encounters.
METHODS: We conducted searches of 6 databases between 1966 and 2005 to identify studies for a systematic review and synthesis of the literature. Eligible studies tested a communication intervention; were randomized controlled trials (RCTs); objectively assessed verbal communication behaviors as the primary outcome; and were published in English. Interventions were characterized by type (eg, information, modeling, feedback, practice), delivery strategy, and overall intensity. We abstracted information on the effects of the interventions on communication outcomes (eg, interpersonal and information exchanging behaviors). We examined the effectiveness of the interventions in improving the communication behaviors of physicians and patients.
RESULTS: Thirty-six studies were reviewed: 18 involved physicians; 15 patients; and 3 both. Of the physician interventions, 76% included 3 or 4 types, often in the form of practice and feedback sessions. Among the patient interventions, 33% involved 1 type, and nearly all were delivered in the waiting room. Intervention physicians were more likely than controls to receive higher ratings of their overall communication style and to exhibit specific patient-centered communication behaviors. Intervention patients obtained more information from physicians and exhibited greater involvement during the visit than controls.
CONCLUSIONS: The interventions were associated with improved physician and patient communication behaviors. The challenge for future research is to design effective patient and physician interventions that can be integrated into practice.

Rhoades, D. R., McFarland, K. F., Finch, W. H., & Johnson, A. O. (2001). Speaking and interruptions during primary care office visits. *Family Medicine, 33*(7), 528-532.

BACKGROUND: Patients and physicians value effective communication and consider it an essential part of the medical encounter. This study examined physician-patient communication patterns, and interruptions in communication, during patient visits with family practice and internal medicine residents.

METHODS: Observational data obtained from 60 routine primary care office visits included the time that resident physicians and patients spoke and the number and types of interruptions. A total of 22 family practice and internal medicine residents participated, 9 from family practice and 13 from internal medicine.

RESULTS: Patients spoke, uninterrupted, an average of 12 seconds after the resident entered the room. One fourth of the time, residents interrupted patients before they finished speaking. Residents averaged interrupting patients twice during a visit. The time with patients averaged 11 minutes, with the patient speaking for about 4 minutes. Computer use during the office visit accounted for more interruptions than beepers. Verbal interruptions, a knock on the door, beeper interruptions, and computer use all interfered with communication, and increased frequency of interruptions are associated with less favorable patient perceptions of the office visit. Female residents interrupted their patients less often than did male physicians. All residents interrupted female patients more often than male patients. Early and increased interruptions were associated with patients' perception that they should have talked more. Third-year residents interrupted patients less frequently than did first-year residents.

CONCLUSIONS: Numerous interruptions occurred during office visits. Gender was associated with the pattern of interruptions. Physicians frequently interrupted patients before the patients were finished speaking. Computer use also interrupted physician-patient communication.

Rider EA, & Brashers V. (2006). Team-based learning: A strategy for interprofessional collaboration. *Medical Education, 40*:486-487.

Team-based learning is content grounded and allows for problem solving and mastery of concepts for large groups within a small-group setting. The authors developed an innovative method of expert-presented content followed by collaborative team-based learning, to teach health-care leaders in the National Academies of Practice (NAP) skills for effective interprofessional patient care. The NAP, an honorific, national group comprised of elected members in 10 academies representing medicine and 9 other health care professions, serves as a distinguished policy forum that advises governmental bodies on interprofessional approaches to problems in health care.

Rider EA, & Keefer CH. (2006). Communication skills competencies: Definitions and a teaching toolbox. *Medical Education, 40*:624-629.

BACKGROUND: Doctors' interpersonal and communication skills correlate with improved health care outcomes. International medical organisations require competency in communication skills. The Accreditation Council for Graduate Medical Education (ACGME) developed a toolbox for assessing this competency and 5 others, yet none initially for teaching these skills.

PURPOSE AND METHODS: The original focus in the development of the ACGME competencies was evaluation. This paper represents a significant step toward defining methods for teaching communication skills competencies. A total of 16 medical education leaders from medical schools worldwide, participating in the 2003 Harvard Macy Institute Program for Physician Educators, worked together to: (1) further define the ACGME competency in interpersonal and communication skills; (2) delineate teaching strategies for each level of medical education; and (3) create a teaching toolbox to integrate communication skills competencies into medical curricula. Four subgroups

defined sub-competencies, identified teaching strategies for undergraduate, graduate and postgraduate medical training and brought their work to the larger group. The expanded communication competencies and teaching strategies were determined by a consensus of the larger group, presented to 80 Harvard Macy Scholars and Faculty for further discussion, then finalised by consensus.

CONCLUSION: The teaching toolbox expands the ACGME core communication competencies, adds 20 subcompetencies and connects these competencies to teaching strategies at each level of medical training. It represents the collaboration and consensus of a diverse international group of medical education leaders in a variety of medical specialities and institutions, all involved in teaching communication skills. The toolbox is applicable globally across different settings and specialities, and is sensitive to different definitions of health care.

Salas Eduardo, DiazGranados E, Klein C, Burke CS, StagI KC, Goodwin GF, & Halpin SM. (2008). Does Team Training Improve Team Performance? A Meta-Analysis. Human Factors, 50(6):903-933.

OBJECTIVE: This research effort leveraged the science of training to guide a taxonomic integration and a series of meta-analyses to gauge the effectiveness and boundary conditions of team training interventions for enhancing team outcomes.

BACKGROUND: Disparate effect sizes across primary studies have made it difficult to determine the true strength of the relationships between team training techniques and team outcomes.

METHOD: Several meta-analytic integrations were conducted to examine the relationships between team training interventions and team functioning. Specifically, we assessed the relative effectiveness of these interventions on team cognitive, affective, process, and perfonnance outcomes. Training content, team membership stability, and team size were investigated as potential moderators of the relationship between team training and outcomes. In total, the database consisted of 93 effect sizes representing 2,650 teams.

RESULTS: The results suggested that moderate, positive relationships exist between team training interventions and each of the outcome types. The findings of moderator analyses indicated that training content, team membership stability, and team size moderate the effectiveness of these interventions.

CONCLUSION: Our findings suggest that team training interventions are a viable approach organizations can take in order to enhance team outcomes. They are useful for improving cognitive outcomes, affective outcomes, teamwork processes, and performance outcomes. Moreover, results suggest that training content, team membership stability, and team size moderate the effectiveness of team training interventions.

APPLICATION: Applications of the results from this research are numerous. Those who design and administer training can benefit from these findings in order to improve the effectiveness of their team training interventions.

Salas, E, DiazGranados D, Weaver SJ, & King H. (2008). Does Team Training Work? Principles for Health Care. Academic Emergency Medicine, 15:1002–1009.

Teamwork is integral to a working environment conducive to patient safety and care. Team training is one methodology designed to equip team members with the competencies necessary for optimizing teamwork. There is evidence of team training's effectiveness in highly complex and dynamic work environments, such as aviation and health care. However, most quantitative evaluations of training do not offer any insight into the actual reasons why, how, and when team training is effective. To address this gap in understanding, and to provide guidance for members of the health care community interested in implementing team training programs, this article presents both quantitative results and a specific qualitative review and content analysis of team training implemented in health care. Based on this review, we offer eight evidence-based principles for effective planning, implementation, and evaluation of team training programs specific to health care.

Saunders, J. (2004). Handling unexpected distress on the telephone: the development of interdisciplinary training. International Journal of Palliative Nursing, 10(9):454-459.

St Nicholas' Hospice recognized that its non-clinical staff needed support and guidance regarding the management of particularly difficult telephone conversations. It is understandable that patients and family members who are experiencing extreme uncertainty, fear and worry might express anger and despair, however, nonclinical staff were troubled by having to handle such raw emotions on the telephone. Despite palliative care excelling at counseling skills and training in breaking bad news, no material or courses exist to help these staff handle unanticipated distress on the telephone. A training session was established and, unexpectedly, many clinical staff enrolled. Although a formal in-depth evaluation did not take place, participant feedback suggested it was equally beneficial to non-clinical and clinical staff. A key element of the apparent success was the interprofessional, interagency, interpersonal sharing and exchange of ideas.

Sharp, M. (2006). Enhancing interdisciplinary collaboration in primary healthcare. *Canadian Journal of Dietetic Practice and Research, 67*: Suppl:S4-S8.

BACKGROUND: Dieticians of Canada has endorsed the Principles and Framework for Enhancing Interdisciplinary Collaboration in Primary Healthcare (EICP) created by the EICP Initiative. The Initiative focused on the conditions required for health professionals to work together in the most effective and efficient way, so that they can produce the best health outcomes for individuals and families – the patients, clients and consumers of our national health system. The Initiative was spearheaded by a Steering Committee of 11 national health professional organizations, and brought together leaders, health professionals, and key stakeholders in Canada's primary health care system in a change process designed to facilitate more interdisciplinary collaboration.

PRINCIPLES AND FRAMEWORK: In the context of the EICP Initiative, the Principles are values shared by stakeholders. They are critical to the establishment of collaboration and teamwork to achieve the best health outcomes. The elements of the Principles are patient/client engagement, a population health approach, the best possible care and services, access, trust and respect, and effective communication. The Framework builds upon these Principles and is composed of the structural and process elements required to support collaborative primary health care. The elements of the Framework are health human resources, funding liability, regulation, information, and communications technology, management and leadership, and planning and evaluation.

CONCLUSIONS: The Boards of Directors of the ten health professions leading the EICP Initiative agreed upon the values and key structural and process elements that need to be put in place to enhance interdisciplinary collaboration in Primary Health Care in Canada. Dieticians of Canada will continue to seek opportunities to further the change process started by EICP. Approximately 40 research papers and a toolkit to help primary health care providers work together have been produced.

Sinsky, CA., Sinsky, TA, Althaus, D, Tranel, J, & Thiltgen, M. (2010). 'Core Teams': Nurse-physician partnerships provide patient centered care at an Iowa practice. *Health Affairs, 29*, 5:966-968.

PRACTICE: Department of Internal Medicine, Medical Associates Clinic and Health Plans. Who and Where: General internists and nurses at a large, multispecialty group practice providing 540,000 clinic visits in Dubuque, Iowa, a town of 60,000 people.

CORE INNOVATION: The "core team," in which nurses are paired with a physician as integral partners in patient care.

KEY RESULTS: Core teams enhance communication and continuity of care. Nurses' attention to preventive care and disease management tasks enables physicians to focus on active problems and patients' concerns.

CHALLENGES: Staffing for core teams requires a ratio of 1.5–2 nurses per physician. A nurse's skills and training are desirable for the optimal functioning of a core team. However, not all practices

can afford or recruit nurses. Other pilot projects have used a similar model with medical assistants instead of nurses.

Team strategies and tools to enhance performance and patient safety (TeamSTEPPS), Department of Defense and Agency for Healthcare Research and Quality http://www.ahrq.gov/qual/teamstepps/

TeamSTEPPS is a teamwork system designed for health care professionals that is a powerful solution to improve patient safety within organizations. It also is an evidence-based teamwork system to improve communication an teamwork skills among health care professionals. AHRQ and the Defense Department have teamed to build a national training and support network called the National Implementation of TeamSTEPPS project.

Thiedke CC. (January 2007). What do we really know about patient satisfaction? *Family Practice Management,* 33-36.

    This article reviews the literature on patient satisfaction most relevant to family physicians. Physicians can promote higher rates of satisfaction by improving the way they interact with their patients. . Patients who reported being treated with dignity and who were involved in decisions were more satisfied and more adherent to their doctor's recommendations.

Ustun B. (2006). Communication skills training as part of a problem-based learning curriculum. *Educational Innovation, 45*(10):421-424.

    Communication skills are an essential element of professionalism. The goal of the problem-based learning (PBL) model is to provide nursing students with the communication skills needed in the helping process. This article addresses the structure of communication skills training at the Dokuz Eylül University School of Nursing. There, students work within a module, first determining the part of the scenario related to communication, adapting this as a learning topic, and then learning the communication skills related to that topic on a cognitive level. A communication laboratory has been set up to permit implementation of the communication skills related to the topic within each learning module. This is necessary because communication requires both knowledge and skill development. Another important facet of communication skills training in this PBL model is that this training occurs during a 4-year learning period. In keeping with the structure of the PBL curriculum, the aim of this study was to provide students first with the skills for self communication, then for communication with other healthy individuals and groups, and finally, for communication with individuals and groups with specific problems.

Vazirani S, Hays RD, Shapiro MF, & Cowan M. (2005). Effect of multidisciplinary intervention on communication and collaboration among physician and nurses. *American Journal of Critical Care, 14*(1):71-76.

    BACKGROUND: Improving communication and collaboration among doctors and nurses can improve satisfaction among participants and improve patients' satisfaction and quality of care.

    OBJECTIVE: To determine the impact of a multidisciplinary intervention on communication and collaboration among doctors and nurses on an acute inpatient medical unit.

    METHODS: During a 2-year period, an intervention unit was created that differed from the control unit by the addition of a nurse practitioner to each inpatient medical team, the appointment of a hospitalist medical director, and the institution of daily multidisciplinary rounds. Surveys about communication and collaboration were administered to personnel in both units. Physicians were surveyed at the completion of each rotation on the unit; nurses, biannually.

    RESULTS: Response rates for house staff (n = 111), attending physicians (n = 45), and nurses (n = 123) were 58%, 69%, and 91%, respectively. Physicians in the intervention group reported greater collaboration with nurses than did physicians in the control group (P < .001); the largest effect was

among the residents. Physicians in the intervention group reported better collaboration with the nurse practitioners than with the staff nurses (P < .001). Physicians in the intervention group also reported better communication with fellow physicians than did physicians in the control group (P = .006). Nurses in both groups reported similar levels of communication (P = .59) and collaboration (P = .47) with physicians. Nurses in the intervention group reported better communication with nurse practitioners than with physicians (P < .001).

CONCLUSIONS: The multidisciplinary intervention resulted in better communication and collaboration among the participants.

Weaver SJ, Rosen MA, DiazGranados D, Lazzara EH, Lyons R, Salas E, Knych SA, McKeever M, Adler L, Barker M & King HB. (2010). Does teamwork improve performance in the operating room? A multilevel evaluation. *The Joint Commission Journal on Quality and Patient Safety, 36*(3):133-142.

BACKGROUND: Medical care is a team effort, especially as patient cases are more complex. Communication, cooperation, and coordination are vital to effective care, especially in complex service lines such as the operating room (OR). Team training, specifically the TeamSTEPPS™ training program, has been touted as one methodology for optimizing teamwork among providers and increasing patient safety. Although such team-training programs have transformed the culture and outcomes of other dynamic, high risk industries such as aviation and nuclear power, evidence of team training effectiveness in health care is still evolving. Although providers tend to react positively to many training programs, evidence that training contributes to important behavioral and patient safety outcomes is lacking.

METHOD: A multilevel evaluation of the TeamSTEPPS training program was conducted within the OR service line with a control location. The evaluation was a mixed-model design with one between-groups factor (TeamSTEPPS training versus no training) and two within-groups factors (time period, team). The groups were located at separate campuses to minimize treatment diffusion. Trainee reactions, learning, behaviors in the OR, and proxy outcome measures such as the Hospital Survey on Patient Safety Culture (HSOPS) and Operating Room Management Attitudes Questionnaire (ORMAQ) were collected.

RESULTS: All levels of evaluation demonstrated positive results. The trained group demonstrated significant increases in the quantity and quality of presurgical procedure briefings and the use of quality teamwork behaviors during cases. Increases were also found in perceptions of patient safety culture and teamwork attitudes.

DISCUSSION: The hospital system has integrated elements of TeamSTEPPS into orientation training provided to all incoming hospital employees, including nonclinical staff.

B. Wilson, C. Schoen, and P. Neuman et al. (2007). Physician–Patient Communication about Prescription Medication Nonadherence: A 50-State Study of America's Seniors. *Journal of General Internal Medicine, 22*(1):6-12.

CONTEXT: Understanding and improving the quality of medication management is particularly important in the context of the Medicare prescription drug benefit that took effect last January 2006.

OBJECTIVE: To determine the prevalence of physician-patient dialogue about medication cost and medication adherence among elderly adults nationwide.

DESIGN: Cross-sectional survey.

PARTICIPANTS: National stratified random sample of community-dwelling Medicare beneficiaries aged 65 and older.

MAIN OUTCOME MEASURES: Rates of physician-patient dialogue about nonadherence and cost-related medication switching.

RESULTS: Forty-one percent of seniors reported taking five or more prescription medications, and more than half has 2 or more prescribing physicians. Thirty-two percent overall and 24% of those with 3 or more chronic conditions reported not having talked with their doctor about all their different medicines in the last 12 months. Of seniors reporting skipping doses or stopping a medication because of side effects or perceived nonefficacy, 27% had not talked with a physician about it. Of those reporting cost-related nonadherence, 39% had not talked with a physician about it. Thirty-eight percent of those with cost-related nonadherence reported switching to a lower priced drug, and in a multivariable model, having had a discussion about drug cost was significantly associated with this switch (odds ratio [OR] 5.04, 95% confidence interval [CI] 4.28-5.93, P < .001).

CONCLUSIONS: We show that there is a communication gap between seniors and their physicians around prescription medications. This communication problem is an important quality and safety issue, and takes on added salience as physicians and patients confront new challenges associated with coverage under new Medicare prescription drug plans. Meeting these challenges will require that more attention be devoted to medication management during all clinical encounters.

Pain Management

Barkin RL (2010, April). Treatment challenges of acute and chronic pain: Current concepts. *Advanced Studies of Pharmacy, 7*(1): 11-17.

Recent approaches to pain management have increasingly emphasized the use of individualized treatment strategies that are based on the patient's specific and patient-centered physiologic and psychologic analgesic needs, the underlying pathophysiology of pain, the use of new analgesic polymodal medications and combinations, the application of pharmacokinetic and pharmacodynamic drug profiles, and the prevention of drug-seeking or other aberrant behaviors. A thorough pain assessment is the foundation of an individualized treatment plan. Clinicians must know the right questions to ask when reviewing the patient's medical, surgical, and psychiatric history, but they must also be able to listen carefully to the patient's responses and to those who accompany the patient. Assessment of pain should go far beyond the typical 10-point rating scale to include an evaluation of the pain quality and intensity. Thorough periodic assessment of patients who are being treated for pain is required to confirm treatment efficacy and effectiveness and to identify adverse events. Confirmatory drug testing using ultra-high pressure liquid chromatography and mass spectroscopy is preferred to ensure that patients are utilizing and metabolizing pharmacotherapies as prescribed. Nonsteroidal anti-inflammatory drugs and acetaminophen are widely used for the treatment of pain and are available in many prescription and nonprescription products. However, these agents are associated with clinically significant adverse events, and careful patient selection is required to ensure that they are utilized safely. Two new opioid agents have recently entered clinical practice. Tapentadol is a μ-opioid agonist and a monoamine reuptake inhibitor (primarily norepinephrine); oxymorphone is a specific μ-opioid agonist. Both agents are metabolized primarily by phase II metabolism and do not produce toxic metabolites that various older opioids, most of which are metabolized by phase I metabolism, produce. It is important to understand the distinction between addiction (a pattern of impaired compulsive drug use control with a careless disregard for harm to self and others, usually with the goal of achieving drug-induced euphoria) and pseudoaddiction (a pattern of escalating analgesic demands in response to inadequate pain relief). Finally, effective pain management necessitates effective ongoing bilateral communication between the pharmacist and the prescriber(s) to ensure adequate pain control while reducing the risk of adverse effects and medication misuse, abuse, or diversion.

Canaday BR (2009). A day in the life: Pain management strategies for frontline pharmacists. *Advanced Studies of Pharmacy, 6*(2): 37-44.

Analgesics are among the most widely prescribed of all medications, yet many patients continue to experience poorly managed pain. Studies of patients with chronic or acute pain have demonstrated

that many are unsatisfied with the pain relief that they are able to achieve, and that approximately 20% of all hospitalized patients report inadequate pain control. Misuse or diversion of pain relievers is a significant problem, especially among adolescents and young adults. Concerns about opioid dependence, addiction, or nonmedical use often create barriers to effective pain management. Opioid abusers have developed several techniques to compromise controlled-release mechanisms. Tablets may be crushed and swallowed or snorted, or the active ingredient may be extracted in a solvent and taken by mouth or injected. Newer abuse-resistant technologies are being developed to make it more difficult for substance abusers to misuse opioid medications. However, the risk of opioid misuse is low among patients with chronic pain who do not have preexisting substance use disorders. The US Food and Drug Administration is developing new strategies that will be required of manufacturers of opioid analgesics to help prevent drug misuse. Pharmacists have a dual role in management of pain as both caring clinicians and as professionals who are responsible for meeting legal and ethical standards for dispensing controlled substances. It is necessary to maintain some degree of vigilance regarding the potential for medication misuse, yet it is also important to avoid stigmatizing our patients with chronic pain. Communication between the patient, pharmacist, and prescribing physician is essential to avoid misunderstandings and prevent inappropriate medication use. Pharmacists must also be able to counsel patients about the expected benefits of treatment, possible adverse effects, what to do in the event of a serious adverse event, and strategies to mitigate some of the predictable adverse events of opioid therapy. The effective medical management of pain requires the consideration of many different patient-related and medication-related factors, including the intensity of pain, risk or history of substance abuse, medication dose and route of administration, and equianalgesic conversion for patients who are transitioning from one opioid to another. Pharmacists are ideally positioned to significantly improve the effectiveness and safety of pain management.

Clarke, K.A., Iphofen, R. (2008). The effects of failing to believe patients' experience of chronic pain. *Nursing Times*; *104*: 8, 30-31.

> **BACKGROUND:** Some patients with chronic pain complain that they feel they are not believed.
> **AIM:** To explore the effects of healthcare professionals not believing patients with pain.
> **METHOD:** This study (n=8) adopted a multi-method approach involving a low-structured interview coupled with patients' diaries and a follow-up interview. It is based on a hermeneutic analytical approach within a phenomenological framework.
> **RESULTS:** The themes identified were: 'I am in pain'; 'I don't believe you'; 'When you feel that you are not genuine'; 'Alienation'; and 'Being believed'.
> **CONCLUSION:** This study highlights that healthcare professionals can show they believe patients by simple means. These are: active listening; being non-judgmental; and accepting the pain experience as credible as recounted by patients, thus showing them that the relationship is based on caring and empathy.

Frantsve L, Kerns RD (2007). Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision-making. *Pain Medicine, 8,* 25-35.

> **OBJECTIVE:** This article reviews the literature on patient-provider interactions among patients with chronic pain conditions with an emphasis on shared medical decision making.
> **RESULTS:** Key findings suggest that: 1) patients with chronic pain and health care providers are likely to have opposing attitudes and goals, with patients seeking "to be understood as individuals" and struggling to have their pain concerns legitimized while their health care providers may place a greater focus on diagnosis and treatment than quality of life concerns; and 2) female patients may face additional challenges when communicating their pain concerns with providers. Increased emphasis on communication training and efforts to promote a shared decision making process are proposed as possible mechanisms to improve patient-provider interactions.
> **CONCLUSIONS:** Treatment of chronic pain is often complex and may be further complicated when patients and health care providers have differing goals and attitudes concerning treatment. Difficulties in engaging in collaborative treatment decision making may result. Efforts to enhance patient-provider communication as well as to systematically examine nonspecific treatment factors are likely to promote effective management of chronic pain.

Green CR, Anderson KO, Baker, TA, Campbell LC, Decker S, Fillingim RB, Kaloukalani DA, Lasch KE, Myers C, Tait RC, Todd KH, & Vallerand AH. (2003). The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain. *American Academy of Pain Medicine, 4*(3): 277-294.

Context. Pain has significant socioeconomic, health, and quality-of-life implications. Racial- and ethnic-based differences in the pain care experience have been described. Racial and ethnic minorities tend to be undertreated for pain when compared with nonminorities.

Objectives. To provide health care providers, researchers, health care policy analysts, government officials, patients, and the general public with pertinent evidence regarding differences in pain perception,

assessment, and treatment for racial and ethnic minorities. Evidence is provided for racialand ethnic-based differences in pain care across different types of pain (i.e., experimental pain, acute postoperative pain, cancer pain, chronic pain) and settings (i.e., emergency department). Pertinent literature on patient, health care provider, and health care system factors that contribute to racial and ethnic disparities in pain treatment are provided.

Evidence. A selective literature review was performed by experts in pain. The experts developed abstracts with relevant citations on racial and ethnic disparities within their specific areas of expertise. Scientific evidence was given precedence over anecdotal experience. The abstracts were compiled for this manuscript. The draft manuscript was made available to the experts for comment and review prior to submission for publication.

Conclusions. Consistent with the Institute of Medicine's report on health care disparities, racial and ethnic disparities in pain perception, assessment, and treatment were found in all settings (i.e., postoperative,

emergency room) and across all types of pain (i.e., acute, cancer, chronic nonmalignant, and experimental). The literature suggests that the sources of pain disparities among racial and ethnic minorities are complex, involving patient (e.g., patient/health care provider communication, attitudes), health care provider (e.g., decision making), and health care system (e.g., access to pain medication) factors. There is a need for improved training for health care providers and educational interventions for patients. A comprehensive pain research agenda is necessary to address pain disparities among racial and ethnic minorities.

Gunningberg L, & Idvall E. (2007). The quality of postoperative pain management from the perspectives of patients, nurses and patient records. *Journal of Nursing Management, 15*, 756–766.

Aim To study the quality of postoperative pain management in a university hospital. Method Paired patient and nurse assessments of the patient's pain management were conducted in two departments, complemented with audit of patient records. The Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire was answered by 121 patients and 47 Registered Nurses.

Results Of 14 items in the Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire, four items in general surgery and five items in thoracic surgery reached the threshold for high quality of care. No significant differences were found between the assessments in the two departments, but the patients in general surgery experienced more pain than the patients in thoracic surgery. In general surgery, the patients assessed their worst pain significantly higher than the nurse did. The patients who experienced more pain than expected were less satisfied with the quality of their care and experienced higher pain intensity levels. For 25 (41.0%) patients in general surgery and four (6.7%) patients in thoracic surgery, pain intensity was documented according to hospital quality goals.

Conclusion In both departments, areas for improvements could be found in all subscales of the Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire, i.e. communication, action, trust and environment. It is important to discuss what information the patient needs, as well as how and when it should be given. Furthermore, considering earlier pain experience and the goal of pain relief for the individual patient may facilitate an adequate assessment of the patient's pain. In future, electronic health records have the potential to support the use of clinical guidelines.

Haskell SG, Brandt CA, Krebs EE, Skanderson M, Kerns RD, & Goulet JL.(2009). Pain among Veterans of Operations Enduring Freedom and Iraqi Freedom: do women and men differ? *Pain Med. 10*(7):1167-73.

OBJECTIVE: To evaluate sex differences in the prevalence of overall pain, moderate-severe pain, and persistent pain among Veterans of Operations Enduring Freedom and Iraqi Freedom seen at VA outpatient clinics, and to evaluate sex differences in pain assessment.
DESIGN: The observational cohort consisted of Veterans discharged from the U.S. military from October 1, 2001 to November 30, 2007 that enrolled for Veterans Administration (VA) services or received VA care before January 1, 2008. We limited the sample to the 153,212 Veterans (18,481 female, 134,731 male) who had 1 year of observation after their last deployment.
RESULTS: Pain was assessed in 59.7% (n = 91,414) of Veterans in this sample. Among those assessed, 43.3% (n = 39,591) reported any pain, 63.2% (n = 25,028) of whom reported moderate-severe pain. Over 20% (n = 3,427) of Veterans with repeated pain measures reported persistent pain. We found no significant difference in the probability of pain assessment by sex (RR = 0.98, 95% CI 0.96, 1.00). Female Veterans were less likely to report any pain (RR 0.89, 95% CI 0.86, 0.92). Among those with any pain, female Veterans were more likely to report moderate-severe pain (RR 1.05, 95% CI 1.01, 1.09) and less likely to report persistent pain (RR 0.90, 95% CI 0.81, 0.99).
CONCLUSIONS: As the VA plans care for the increasing numbers of female Veterans returning from Iraq and Afghanistan, a better understanding of the prevalence of pain, as well as sex-specific variations in the experience and treatment of pain, is important for policy makers and providers who seek to improve identification and management of diverse pain disorders.

Jacobsen R, Møldrup C, Christrup L, & Sjøgren P. (2009). Patient-related barriers to cancer pain management: a systematic exploratory review. *Scandinavian Journal of Caring, 23*:190-203.

The aim of this review was to systemically explore the current evidence regarding patient-related barriers to cancer pain management to find new areas that might be important for better understanding of patient barriers' phenomenon. The method used in this study was a   computerized literature search, carried out in Cochrane Library, Medline (through PubMed), Web of Science and EMBASE databases for the period 1994–2005. Thirty-seven studies, dealing with cognitive, sensory and affective patient-related barriers, as well as studies, describing patients' pain communication and their adherence to analgesic regimen were included and analysed. The dominant part of articles studied cognitive patient-related barriers to cancer pain management, while affective, sensory barriers, as well as pain communication and pain medication adherence were studied in much less extend. However, the findings from different studies regarding relationships between between cognitive barriers and pain intensity were not consistent. On the contrary, the quality of pain communication was consistently found to be not satisfactory in some key areas. The associations between more expressed attitudinal as well as sensory barriers and less optimal adherence were also consistent. In conclusions suggestion for the new research areas on patient-related barriers to cancer pain management are made. Firstly, further research is needed to differentiate the role of cognitive, affective and sensory factors with respect to their impact on pain relief, pain communication and medication adherence. Besides that, validated instruments to assess patients' pain communication and adherence to analgesic regimen are lacking.

Kerns RD & Dobscha SK. (2009). Pain among Veterans Returning from Deployment in Iraq and Afghanistan: Update on the Veterans Health Administration Pain Research Program. *Pain Medicine, 10*(7): 1161-1164.
In November 1998, the former Undersecretary for Health for the Department of Veterans Affairs (VA), Dr. Kenneth Kizer, launched the Veterans Health Administration (VHA) National Pain Management Strategy establishing pain management as a national priority. The overall objective of the national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness. Among the key elements of the strategy, a need to "expand basic and applied

research on management of acute and chronic pain, emphasizing conditions that are most prevalent among Veterans," was articulated.

Kerns, R.D., Booss, J., Bryan, M., Clark, M.E., Drake, A., Gallagher, R.M., Green-Rashad, B., Markham, R., Rosenberg, J., & Turner, A. (2006). Veterans Health Administration National Pain Management Strategy: Update and future directions. *American Pain Society Bulletin, 16,* 1-15.

The focus of the Bulletin's innovations column is often some form of new assessment, diagnostic technique, or treatment strategy. Another important type of practice innovation involves fundamental changes in the healthcare system and day-to-day behaviors of healthcare providers, that is, how clinicians and teams coordinate and deliver high-quality pain management to all patients across all settings. In July, APS published updated recommendations for improving the quality of acute and cancer pain (Gordon et al., 2005). A critical message in these recommendations is that all care settings should formulate a structured, multilevel system approach (sensitive to the type of pain and setting of care) that ensures safe, high-quality pain management to all patients. A shining example of dedication and innovation to making this type of systematic change is the ongoing effort of the Department of Veterans Affairs (VA). This article provides an update on the VA's impressive quality initiative.

Lew HL, Otis JD, Tun C, Kerns RD, Clark ME, & Cifu DX. (2009). Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: polytrauma clinical triad. *J Rehabilitation Res Dev. 46*(6):697-702.

This study examines the prevalence and coprevalence with which returning Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans were reporting symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS). The medical records of 340 OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network Site were comprehensively reviewed. Analyses indicated a high prevalence of all three conditions in this population, with chronic pain, PTSD, and PPCS present in 81.5%, 68.2%, and 66.8%, respectively. Only 12 of the veterans (3.5%) had no chronic pain, PTSD, or PPCS. The frequency at which these three conditions were present in isolation (10.3%, 2.9%, and 5.3%, respectively) was significantly lower than the frequency at which they were present in combination with one another, with 42.1% of the sample being diagnosed with all three conditions simultaneously. The most common chronic pain locations were the back (58%) and head (55%). These results underscore the complexity of the presenting complaints in OIF/OEF veterans and support the importance of a multidisciplinary team approach to assessment and treatment.

Mangione MP, & Crowley-Matoka M. (2008). Improving Pain Management Communication: How Patients Understand the Terms "Opioid" and "Narcotic". *Journal of General Internal Medicine, 23*(9): 1336–1338

Background/Objectives
Pain specialists often advocate discontinuing use of the term "narcotic," with the negative connotations it bears for many patients, in favor of the term "opioid." To contribute empirical data to this argument, we elicited and compared patient understandings of the terms "narcotic" and "opioid."
Design/Participants
Brief, anonymous surveys were administered to 100 outpatients. Respondents were asked to describe what a narcotic/opioid is, give example(s), explain why someone would take a narcotic/opioid and describe long term consequences of use.
Results
Of the 100 outpatients, 86% responded "don't know" to all four opioid questions. Only 12% did not know what a narcotic was (< 001). While 50% of patients related "narcotics" to pain management, more than a third cited addiction or abuse. Of the 100 outpatients, 78% feared an adverse outcome from long-term narcotic use, with 66% of those answers citing "addiction."
Conclusion

Most patients were unfamiliar with the term opioid, while a substantial percentage identified a narcotic as an illegal drug and most reported adverse consequences as the outcome of long term use. Our findings, while preliminary, suggest that "opioid" is a more unfamiliar term, but raise questions about whether simply using different terminology would affect patient fears about this class of medications.

McHugh G (2001). Living with chronic pain: the patient's perspective. *Nurs Stand.18*;15(52):33-7.

AIM: The aim of this study is to investigate patients' perceptions and experiences of chronic pain management before and after attending pain services.
METHOD: A sample of 245 patients with chronic pain, who attended specialist pain services in 11 UK hospitals, were interviewed using a structured questionnaire. Patients' ages ranged between 23 and 86 years (median 51 years), and the duration of pain ranged between six months and 57 years (median five years).
RESULTS: Patients reported that pain had had a profound effect on their lives, restricting daily living and leisure activities. 33 per cent (81) were classified as medically disabled. Patients' perceptions and attitudes to the management of chronic pain varied. Their main concern was that, although they wanted a specific diagnosis, they were often not given a reason for their chronic pain.
CONCLUSION: Pain management requires a significant amount of input by health professionals. Patients wanted advice on the best techniques to help them cope with chronic pain. Most patients had previously tried many different pain treatments to obtain short-term pain relief. One third of patients had waited up to four months for their initial pain assessment at the pain service. Once referred to specialist pain services, patients were satisfied with their care. Almost half (47 per cent, 115) of the interviewees reported that their pain had improved. As chronic pain has a profound effect on patients' lives, it is important that early diagnosis, treatment and referral to appropriate specialists is given high priority. This study has raised the awareness and understanding of an important, but often misunderstood area.

Mitchinson AR, Kerr EA, & Krein SL (2008). Management of Chronic Noncancer Pain by VA Primary Care Providers: When Is Pain Control a Priority? *American Journal of Managed Care, 14*:77-84

Objective: -To examine how primary care providers (PCPs) prioritize management of chronic pain in patients with multiple chronic conditions and to determine PCP perspectives on chronic pain management and pain treatment resources.
Study Design: Survey mailed to a random sample of 500 Department of Veterans Affairs (VA) PCPs at VA medical centers and community-based outpatient clinics.
Methods: After reading a vignette describing a patient with multiple chronic conditions and chronic pain, PCPs were asked to identify the 3 most important issues to address during the visit. The survey also asked about the availability of services, and level of confidence and satisfaction with chronic pain management.
Results: A total of 279 eligible PCPs (57%) responded to the survey, 77% of whom identified pain control among the top 3 treatment priorities. PCPs who did not choose pain control were more likely to indicate that chronic pain patients should see a specialist (54% vs 35%, $P = .006$) and were less confident about using opioid analgesics (52% vs 72%, $P = .002$). Of the respondents, 86% reported psychology or mental health clinics were available at their clinic site; 71%, physical therapy; and 20%, multidisciplinary pain clinics. Most PCPs (74%) were satisfied with the quality of care they provide for patients with chronic pain but only 30% were satisfied with access to pain specialty services.
Conclusion: Additional training opportunities for PCPs and more effective use of ancillary services may be needed for further improvements in care for chronic pain patients.

Paulson M, & Dekker AH. (2005). Healthcare Disparities in Pain Management. Journal of the American Osteopathic Association, Supplement 3, 15(6): S14-S17.

Despite efforts targeted at physicians for improving the way in which they manage pain, discrepancies still abound in how they treat certain patients for this condition. Special populations of patients such as racial minorities, women, and substance abusers are victims of deficiencies in pain

management and suffer needlessly. Healthcare providers need to be aware of disparities that may not be readily apparent. To provide appropriate care, physicians need to follow pain management guidelines; however, they receive contradictory information on how to treat patients in pain, and they may be apprehensive about prescribing opioids. Recognizing that pain is one of the most frequent reasons a patient may see a physician, it is important to recognize the healthcare disparities in managing pain as well as the barriers to providing appropriate treatment for pain. Only when physicians acknowledge disparities and barriers can they begin to evaluate and improve on their own practices of pain management.

Rosenberger PH, Kerns R, Jokl P, & Ickovics JR (2009). Mood and Attitude Predict Pain Outcomes Following Arthroscopic Knee Surgery. *Annals of Behavioral Medicine, 37*:70-76.

Background Decreased pain represents a clinically important outcome following arthroscopic knee surgery. However, little is known about preoperative mood and attitudinal factors and their potential relationship with pain outcomes.
Purpose This prospective, longitudinal study investigated the influence of preoperative depression, stress, and optimism on pain severity and interference with functioning, controlling for relevant demographic and clinical factors 1 year postoperatively.
Methods Participants (N=180, mean age=48.2 years) completed scales assessing pain severity and interference both preoperatively and postoperatively. Demographics, depression, stress, optimism, and body mass index were assessed preoperatively. Physicians assessed extent of knee osteoarthritis during surgery.
Results Hierarchical regression analyses controlling for relevant demographic and clinical variables revealed that optimism and stress were significant predictors of pain severity at 1 year but not pain interference. Extent of osteoarthritis predicted pain interference.
Conclusions These findings support that optimism and stress are important predictors of patient-rated pain severity. They do not, however, predict the extent to which pain interferes with daily functioning.

Tait RC. (2008). Empathy: Necessary for effective pain management? *Current Pain and Headache Reports, 12*(2):108-112.

Empathy is a provider attribute that has been a topic of increased clinical interest, particularly as it relates to pain. This article examines various dimensions of the pain and empathy literature: definitions of empathy, research regarding the psychophysiology of empathy for pain, and research related to empathy in psychological and medical care. Research regarding topics broadly related to empathy is also reviewed, including communication skills and patient-centered care. Although this literature supports the clinical value of provider empathy and/or behaviors likely to reflect empathy, little research has explicitly examined empathy in the treatment of pain. Nonetheless, when considered in the broader context, the evidence is sufficient to draw some conclusions regarding approaches to pain care that are likely to reflect and/or elicit provider empathy and are central to effective pain management.

Walid MS, Donahue, SN, Darmohray, DM, Hyer, LA, & Robinson JS. (2008). The Fifth Vital Sign—What Does It Mean? *Pain Practice,8*(6): 4417–422

Acute pain is reported as a presenting symptom in over 80% of physician visits. Chronic pain affects an estimated 76.2 million Americans—more than diabetes, heart disease, and cancer combined. It has been estimated to be undertreated in up to 80% of patients in some settings. Pain costs the American public more than $100 billion each year in health care, compensation, and litigation. That's why pain was officially declared "The Fifth Vital Sign." Henceforth the evaluation of pain became a requirement of proper patient care as important and basic as the assessment and management of temperature, blood pressure, respiratory rate, and heart rate. The numeric pain scale certainly has a place in care and in pain management; however, it is important to assess the patient's communication and self-management style and to recognize that patients, like pain, are on a continuum with varied styles of communication and adaptation. It is easy to get lost in the process, even when the process is

initiated with the best of intentions. In the quest for individualized medicine, it might be best to keep pain assessment in the individualization arena.

Wasan, AD, Wootton J, & Jamison RN. (2005). Dealing with difficult patients in your pain practice. *Regional Anesthesia and Pain Medicine, 30*(2):184-192.

Pain patients can be difficult. They can provoke negative feelings of frustration and anger among clinicians and damage the doctor-patient relationship. This article helps practitioners to identify those pain patients who would be prone to difficult behavior and sheds light on some of the reasons behind the behavior, and chronic noncompliance are discussed. Specific recommendations are also given of the best ways to manage patients with difficult behavior.

Wiedemer NL, Harden PS, Arndt IO, & Gallagher RM (2007). The Opioid Renewal Clinic: A Primary Care, Managed Approach to Opioid Therapy in Chronic Pain Patients at Risk for Substance Abuse. *Pain Medicine, 8*(7): 573-584.

Objective. To measure the impact of a structured opioid renewal program for chronic pain run by a nurse practitioner (NP) and clinical pharmacist in a primary care setting.
Patients and Setting. Patients with chronic noncancer pain managed with opioid therapy in a primary care clinic staffed by 19 providers serving 50,000 patients at an urban academic Veterans hospital.
Design. Naturalistic prospective outcome study.
Intervention. Based on published opioid prescribing guidelines and focus groups with primary care providers (PCPs), a structured program, the Opioid Renewal Clinic (ORC), was designed to support PCPs managing patients with chronic noncancer pain requiring opioids. After training in the use of opioid treatment agreements (OTAs) and random urine drug testing (UDT), PCPs worked with a pharmacist-run prescription management clinic supported by an onsite pain NP who was backed by a multi-specialty Pain Team. After 2 years, the program was evaluated for its impact on PCP practice and satisfaction, patient adherence, and pharmacy cost.
Results. A total of 335 patients were referred to the ORC. Of the 171 (51%) with documented aberrant behaviors, 77 (45%) adhered to the OTA and resolved their aberrant behaviors, 65 (38%) self-discharged, 22 (13%) were referred for addiction treatment, and seven (4%) with consistently negative UDT were weaned from opioids. The 164 (49%) who were referred for complexity including history of substance abuse or need for opioid rotation or titration, with no documented aberrant drug-related behaviors, continued to adhere to the OTA. Use of UDT and OTAs by PCPs increased. Significant pharmacy cost savings were demonstrated.
Conclusion. An NP/clinical pharmacist-run clinic, supported by a multi-specialty team, can successfully support a primary care practice in managing opioids in complex chronic pain patients.

Wilson D, Williams M, & Butler D. (2009). Language and the pain experience. *Physiother. Res. Int*. 14: 56–65

Background and Purpose. People in persistent pain have been reported to pay increased attention to specific words or descriptors of pain. The amount of attention paid to pain or cues for pain (such as pain descriptors), has been shown to be a major factor in the modulation of persistent pain. This relationship suggests the possibility that language may have a role both in understanding and managing the persistent pain experience. The aim of this paper is to describe current models of neuromatrices for pain and language, consider the role of attention in persistent pain states and highlight discrepancies, in previous studies based on the McGill Pain Questionnaire (MPQ), of the role of attention on pain descriptors. The existence of a pain neuromatrix originally proposed by Melzack (1990) has been supported by emerging technologies. Similar technologies have recently allowed identification of multiple areas of involvement for the processing of auditory input and the construction of language. As with the construction of pain, this neuromatrix for speech and language may intersect with neural systems for broader cognitive functions such as attention, memory and emotion.
Method. A systematic search was undertaken to identify experimental or review studies, which specifically investigated the role of attention on pain descriptors (as cues for pain) in persistent pain

patients. A total of 99 articles were retrieved from six databases, with 66 articles meeting the inclusion criteria. After duplicated articles were eliminated, the remaining 41 articles were reviewed in order to support a link between persistent pain, pain descriptors and attention.

Results. This review revealed a diverse range of specifi c pain descriptors, the majority of which were derived from the MPQ. Increased attention to pain descriptors was consistently reported to be associated with emotional state as well as being a signifi cant factor in maintaining persistent pain. However, attempts to investigate the attentional bias of specifi c pain descriptors highlighted discrepancies between the studies. As well as the diversity of pain descriptors used in studies, they were inconsistently categorized into domains of pain. A lack of consistent bias towards certain pain descriptors was observed, and may be explained simply by the fact that the words provided are not those which subjects themselves would use.

Conclusion. These findings suggest that the multidimensional and individual nature of the persistent pain experience may not be adequately explained by pain questionnaires such as the MPQ. Personalized pain descriptors may communicate the pain experience

Useful Websites

http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care.

This Web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.

http://www.transformed.com/PPC/PCMH/TransforMED-patient-centered-model2.cfm

In much the same way that primary care treats the whole person, the TransforMED Patient-Centered Model recognizes that all the elements of a successful Patient-Centered Medical Home practice are interrelated, thus the TransforMED approach "treats the whole practice." The model unites the enduring relationship-centered values of primary practice with new technologies and approaches that enable medical practices to better meet the needs of both patients and the practice team.

http://www.ncqa.org/tabid/631/default.aspx

NCQA's initial Physician Practice Connections®- Patient-Centered Medical Home™ (PPC-PCMH) program reflects the input of the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association and others in the revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

To help you better understand NCQA's Physician Practice Connections®--Patient-Centered Medical Home™ program standards, NCQA has created a companion guide that incorporates summaries for the standards and real world examples from physician practices. The 32-page document- designed for practices looking for clarity on a specific standard or those evaluating the program basics for anticipated adoption, can be found through this link: http://www.ncqa.org/tabid/1034/Default.aspx

http://www.cancer.org/acs/groups/content/@nho/documents/document/painmanagementpockettoolpdf.pdf

American Cancer Society. Pain Management Pocket Tool.

www.cochrane.org

Website of the Cochrane Collaboration, an international project devoted to conducting and maintaining updated reviews of the evidence in many different areas of health care**.** Also contains reviews of self-management and behavior change evidence on topics such as physical activity, healthy eating, and smoking cessation.

http://www.doh.wa.gov/cfh/wsc/default.htm

Washington State Diabetes Collaborative website

http://www.healthdisparities.net

Bureau of Primary Health Care collaborative site contains tools for the chronic care model

www.improvingchroniccare.org

Website of the Robert Wood Johnson Foundation supported Improving Chronic Illness Care program. Contains information on the applications of the Chronic Care Model of Wagner and colleagues.

http://www.mainehealth.com/clinical_integration/resource.php?program_resource_id=9

Maine Health website that has links to diabetes education materials that providers can use including goals-setting contracts and diabetes self-management forms.

www.med.umich.edu/mdrtc

University of Michigan website has links to self-management assessments such as the Diabetes Empowerment Scale (DES and DES-SF) and other tools and publications related to self-management and patient empowerment.

- **The Purchasers Guide** (http://www.pcpcc.net/content/purchaser-guide): Aims to address – What is the PCMH? Why should employers/purchasers support it? What strategies and action steps should employers/purchasers consider now?
- **Meaningful Connections : IT Resource Guide** (http://www.pcpcc.net/content/meaningful-connections-it-resource-guide): Identifies the capabilities and functionalities of eHealth applications that experts consider crucial to support PCMH.
- **Engaging the Consumer** (http://www.pcpcc.net/content/engaging-consumer-family-patient-employee-community-etc): Multiple resources from various sources aimed at helping the consumer/patient/family better understand and become engaged in the PCMH model, including a video, brochures, checklists, guides, and white papers.*
- **PCMH Pilot Compilation** (http://www.pcpcc.net/content/pcpcc-pilot-projects): A list of PCMH pilots underway and under development, along with their key features and contact information.

http://www.hsph.harvard.edu/healthliteracy/

Health Literacy Studies, Harvard School of Public Health.

The Health Literacy Studies group is engaged in a variety of research efforts focused on communication and literacy skills. We are interested in exploring the pathways from education to health outcomes. We examine literacy-related barriers to a variety of health services and care. Our work is based in community, public health, health care, and adult education settings. Our goal is to help reduce health disparities and eliminate literacy barriers.

Institute for Healthcare Communication

Our Mission

The Institute for Healthcare Communication (IHC) advances the quality of healthcare by optimizing the experience and process of healthcare communication. We accomplish this by:

- Creating and disseminating innovative educational programs and services
- Advocating for the importance of communication as an essential aspect of healthcare
- Engaging in collaborative research on communication in healthcare
- Partnering with other leading organizations that share our vision

History

IHC is a publicly supported, tax-exempt 501 (c)(3) non-profit organization established in 1987. IHC's highly interactive educational programs assist clinicians and other health care team members to enhance their communication, counseling and self-management support skills. Communication skills programs are based on a patient-centered model of care that emphasizes the value and impact of collaborative partnerships between clinicians and patients and family members.

IHC programs are disseminated using a faculty development model that provides faculty with advanced communication skills training as well as teaching and coaching skills.

Background

Research evidence indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies show that the clinician's ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. Further, communication among healthcare team members influences the quality of working relationships, job satisfaction and has a profound impact on patient safety.

Clinicians and other members of the healthcare team conduct thousands of patient interactions during his or her career. Similar to other medical procedures, communication skills can be learned and improved upon. Improvement in communication skills requires commitment and practice. IHC's evidence-based communication training provides extensive practice opportunity for all members of the healthcare team through the use of reflective exercises, video case examples, skills demonstrations and skills practice and use of simulated patients (actors portraying patients).