
Executive Summary

ACP FOUNDATION PRESENTS



NATIONAL CONFERENCE

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THE AMERICAN COLLEGE OF PHYSICIANS
FOUNDATION



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Health Care Communication:
A Key To Quality
National Conference.*



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Introduction and Overview

The ACP Foundation is committed to improving health care quality by supporting programs that enhance communication throughout the nation's complex health care landscape. To this end, in 2002 the Foundation embarked upon its nationwide Health Communication Initiative, a campaign to improve health outcomes for Americans by improving health communication.

Clearly, the task of improving health communication is vast. Health communication includes everything from quiet conversations between two people, to electronic databases of patient medical records, to computer programs for measuring health outcomes, to internet-based information-sharing networks intended to help patients become more involved in their own health care. Communication challenges exist across the full health care continuum: between patients and clinicians, between family caregivers and clinicians, among primary care team members, between generalists and sub-specialists, between providers and payers, and in communication with the public at large about health. Like the elephant in the parable of the blind men and the elephant, how one defines "health communication" depends on exactly where in the health care landscape one is standing.

As its Health Communication Initiative takes form, the Foundation must determine how to best leverage its resources to improve health communication. The first step is to assess the spectrum of health communication challenges; the next step is to develop a strategic plan, pinpointing the facets of the problem that require the most urgent attention. To assist in this task, the Foundation, in partnership with the Institute of Medicine, organized "Health Care Communication: A Key to Quality," a conference held at the National Academy of Sciences in Washington, DC, on October 22, 2002. The purpose of the conference was to examine, in a broad sense, what people mean when they talk about health communication by allowing players from across the health care landscape to define communication challenges from their unique perspectives. In organizing the conference, the Foundation aimed to accomplish the following five goals:

- To spotlight the importance of communication for the health of the public, emphasizing communication among all participants in the health care system, especially health care providers and their patients;



- To reassess the nature of personal interactive communication given cultural and linguistic diversity among patients, physicians, and other health professionals;
- To evaluate the role of new and innovative technologies in improving the quality, speed, security, and accuracy of communication among all participants in health care and its subsequent impact on health care outcomes;
- To provide an emphasis on the management of chronic disease;
- To assess priority areas of evaluation and research in the field of health care communication.

Indeed, conference speakers and participants addressed each topic outlined in the goals, elucidating nuances and raising new ideas. Conference speakers represented the public and private sectors; academic medicine and community medicine; patient, provider, and payer points of view. As the day unfolded, several strong themes emerged, including the following:

- Information technology is playing an increasingly important and exciting role in many facets of health care communication. However, the cost of implementing high tech systems is prohibitive.
- A health care literacy crisis in the U.S. threatens all levels of communication between patients and their health care providers and payers, and providers are often unaware that a problem exists.
- Communication strategies that are “culturally competent,” or take into account race, ethnicity, and language have a direct relation to improved health outcomes.
- Training programs aimed at improving communication among members of the health care team - and also between physicians and other health professionals - will improve health outcomes for patients living with chronic illness.
- The health care system lacks metrics to measure the effectiveness of communication in health care encounters.



This Executive Summary of the ACP Foundation-Institute of Medicine conference, “Health Care Communication: A Key to Quality” offers a snapshot of the conference. It provides a synopsis of each speaker’s presentation and, in a few cases, abridged versions of their talks. This Executive Summary serves as a digest of some of the diverse meanings of “health care communication,” as defined by conference speakers and participants. Like the conference itself, this document is divided into the following sections:

- Opening remarks
- Interpersonal and Systems Communication in Health Care
- Visions of Future Health Care Communication
- Putting a Face on the Problem
- Three Model Systems
- Critical Issues in Health Communication
- Future Agenda for the Nation

The ACP Foundation will use this document for reference as it develops a strategy for its Health Communication Initiative. By analyzing the ideas generated by the conference, the Foundation will determine how its resources can best be leveraged to improve health care communication, and thereby to improve the personal health status of Americans and the overall quality of health care in the nation.



Speakers

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*Past President, Institute of Medicine
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*Professor and Chair, Department of Medical Informatics,
College of Physicians and Surgeons,
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William W. Stead, MD

*Associate Vice Chancellor Health Affairs,
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Opening Remarks

Voices from the ACP Foundation and the Institute of Medicine

“ It is said that the core of medicine is information, and communication is the transfer of information. Ergo, communication is the very center of our health care system. ”

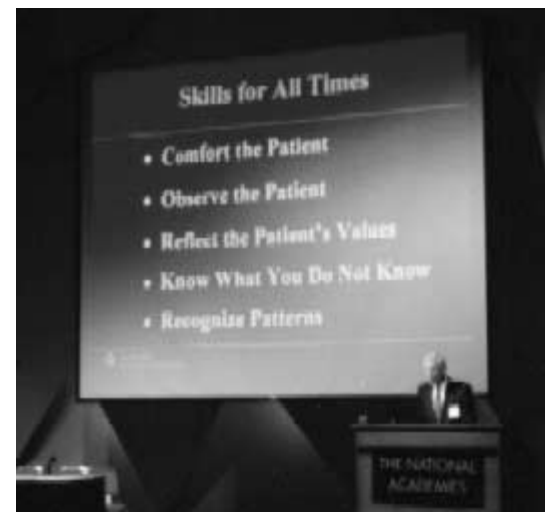
Harold Fallon, MD, MACP
Chair, ACP Foundation Health Communication Conference Planning Committee
Home Secretary, Institute of Medicine

“ ...communication extends all the way from the intimate interaction between a clinician and a patient, to the most public dissemination of information. ”

Harvey Fineberg, MD, PhD
President, Institute of Medicine

“ The Foundation’s primary focus is our Health Communication Initiative. Communicating humanistic qualities of compassion, empathy, and understanding in the clinical encounter is one aspect. Improving communication between primary care and subspecialty care and the referral process is the second. And developing communication strategies to reduce racial and ethnic disparities is the third. ”

Whitney Addington, MD, MACP
Chair, ACP Foundation Board of Trustees



Harold Fallon, MD, MACP





Interpersonal and Systems Communication in Health Care

Daniel D. Federman, MD, MACP

Today I am going to put forward a topology that uses the forms of speech - specifically what's called "voice" by grammarians - within the health care context, and draw some illustrations from that about health care communication. I will examine the Imperative Voice, which is used to influence behavior; the Declarative Voice, which is used to share information (and, in this context, it is also used to share feeling); and the Interrogative Voice, which is used to gather information. From there, I will briefly discuss some key communication systems within the hospital setting.

THE IMPERATIVE VOICE: Influencing Behavior

First, let's look at the Imperative Voice, which is used to influence the behavior of others. My first example of Imperative Voice is in the case of a cardiopulmonary arrest. There is no question here why the group is suddenly and newly convened. There is no question about the target of the function, the restoration of pulse and blood pressure. There is no question that someone has to be in charge. It is usually a resident or senior resident, or someone from the on-call team. They arrive after some preliminary steps have been taken, to take over. In our hospital, this is called "running the code."

"The conference was a heart-felt, passionate look at the issue of health literacy, clearly defining a serious problem and awakening a sense of the importance of this problem in our ability to deliver quality care."

William Varani, MD, JD
VP of Quality Improvement
Bon Secours Health System



In this context, the medicines to be drawn on are relatively successful and well known, and those administering them are trained for it. This situation brings about the most direct, immediate, goal-oriented communication from people who may or may not have known each other 30 seconds before.

Running the rounds is another example of a situation in which we use the Imperative Voice, although this situation is murkier. The goal of the care of the patient



may not be specific, and the diagnosis may not be known. This team sort of knows each other. The resident, a couple of interns, a medical student, a nurse, they sort of have a connection with each other, and they know some of the same language. But now teaching both the patient and the people around the table is incorporated into the communication, and is from our point of view, a part of medical education.

A third place where the Imperative Voice is used - and this time it is in writing - is in the order book. Someone has to decide that a drug is useful at this moment. Someone has to take the initiative of writing it down, and then it has to be implemented. Now, the same person who just wrote an order in the order book is also going to prescribe it for the patient going home. How different the Imperative Voice is when it is used this way, because the patient has to understand why the prescription is being given.

The education that is involved around the medicine is even a little different from why it is being given. And the motivation that needs to be created, just think of it. A single medication taken three times a day for a year is a thousand moments where that patient decided whether to carry out the instructions. One of our patients was recently discharged on 21 medicines. Think of the number of times per day and per year that patient had to be enlisted in the process.

In the case of secondary prevention, the patient's motivation is clear: he has already had his heart attack; he is highly motivated to prevent another one. But the patient's motivation is different if we are talking about primary prevention. A healthy 20-year-old without a care in the world learns from a genetic analysis that he has a blank gene. And on the basis of that, if he starts taking some medicine now, a likely eventuality for that case later will be averted. Think of what is going to be needed to get the imperative made into a shared decision in that setting.

THE DECLARATIVE AND COMPLEX VOICES: Sharing Information and More

Let's switch now to the second voice, the Declarative Voice, which is used to share information. Harvey Fineberg, in his introduction, said that all communication is about sharing information. I disagree. It's not polite to disagree with the host, but I want to explore affective communication, a transfer of *feeling* rather than information, because it means everything to the patient.

The affective aspect of communication is a huge part of what we do. I am thinking specifically of connectedness, which is also conveyed by a handshake or by a touch. Empathy is conveyed when we are sitting on the hospital grounds and looking a person in the eye. Much has been written about the power of nonverbal gestures, yet they are particularly difficult. As our reliance on technology in communication increases, this transfer of feeling remains a uniquely human task.

Here is a word that is not used in grammar, but that I have created for this talk - the Complex Voice. By this I mean the Affective (communicating emotion and compassion) plus the Declarative (communicating information). The affective part here is to convince a total stranger - a nervous, frightened, worried stranger - that you understand, that you empathize, and that you are there to help. Now, what are some of the barriers to that moment of complex communication?



First, the interesting age of the population. For a 26-year-old student to relate to a 76-, 86-, 96-year old patient is a long gap in experience (most of which the senior person has and the younger person does not). When you add a little trouble speaking, a small or limited ataraxia, or some other limitation, it becomes even worse.

Second, language is a significant barrier. These last 20 years have seen the largest influx of immigrants to our country since the early 1900s. It has brought people from all over the world, many of whom do not speak English. At Massachusetts General Hospital, we have been doing a project to increase the effectiveness of translation services. The techniques are not important for us right now, but what is important is what we learned from one particular translator. She said, “The words are easy. Any experienced translator can tell you what word you want for the word you are trying to say. What is hard is the meaning.” Then she drew herself up rather proudly, and she said, “We are the meaning makers.”

Third, cultural barriers to communication go along with linguistic ones. The image of what is a doctor, what is a patient, what is a disease, what is the course of treatment? How do we foresee to achieve an outcome? These are anthropological ethnic issues of enormous importance for us now.

THE INTERROGATIVE VOICE: Getting to the Heart of the Matter

So far, I have talked about the Imperative Voice, the role of which is to influence someone else’s behavior; the Declarative Voice, the role of which is to share information; and the Complex Voice, the role of which is to communicate feeling along with information. Now I want to switch to the center of what we do, the Interrogative Voice.

Asking questions is an essential part of taking a history. We are trying to get something essential from someone else’s memory, clouded by pain, by anxiety, by grave concern about where this is going, and by the sudden nature of being thrust into the sick role. What are the facts of these events? We need to get the facts straight from seven or eight months ago, and from earlier today. These facts are important diagnostic tools.

An aggressive intellectual process underlies the interview. Clinicians constantly revise their next questions on the basis of the answer they first heard. A single answer changes the prior probabilities. During the interview, you might notice the patient has a little bit of a cough, or maybe you can already see the thyroid is enlarged. Or you can see there is a little bit of drooping in an eyelid. And then again, your questions change as a result. So the communication here is very active, constantly revised, subject to the feedback process.

On the other hand, open-endedness is terrific. One of my favorite stories is about a patient with very aggressive, rapidly progressing angio who was referred to the cardiology service at the hospital. The cardiologist went into the room. All he said was, “tell me what happened.” And the patient said, “I was standing by the window talking on the telephone when the tiger leapt through the window and tore my chest apart.” Unstable angio began. She had a dissecting aneurism. It was perfectly obvious from less than a minute of conversation. She had surgery a few hours later.



So, in our Interrogative role, we are torn between an open-ended, “tell me a story” approach and a very aggressive, fast-moving, constantly revised interview. The history is not at all a simple rote thing.

Now I want to look at another voice we use - the combination of the Interrogative and the Subjunctive. This voice surrounds care particularly at the end of life.

“If your heart were to stop beating...” That sentence construction slides us into the Subjunctive voice. “What would you want us to do? Would you want to be intubated? Would you want to have cardiopulmonary resuscitation?” We sometimes transfer this voice to a designated proxy: “What would your mother want us to do?” It’s an extraordinary melding of the Interrogative and the Subjunctive.

Communication in the Hospital System

For the time remaining, I am going to focus on a few important communication issues on the system side of what we do.

First, communication regarding hospital admission. Think of the number of people affected by the simple fact that Mrs. Smith is being admitted tomorrow: the admissions office, dietary, all the other people, and, of course, the building system as well. This is compounded when it comes from the emergency service and same day surgery. In our hospital at the moment, 90 percent of the patients operated on were not in the hospital the night before. We know that fewer than 20 percent of the interns and medical students met the patient before she was draped. Where is our educational obligation in teaching students how decisions are made? How is the patient first informed of a pending operation? I’m not trying to focus only on the student now, but on the student later as a practitioner considering surgery. What training has that person had?

Second, let’s look at the communication issues around billing. I understand this is an essential function of the hospital today, and from our point of view, we would like it to be accurate and transparent, and to reflect our shared responsibility to payers. But have you looked at the hospital bill of a relative recently? Most of you come to that moment with a modicum of preparation to understand it. How transparent was the bill? Could you really understand the darn thing? The present system has a lot of weaknesses from that point of view.

Third, I want to mention communication regarding referral and continuity of care. It used to be that after an acute phase and early improvement, the patient was moved to convalescence when he or she went home. Now, patients go home still sick, on active drugs being given for acute indications, often superimposed over drugs for chronic conditions. Now, the family takes over what used to be the doctor’s role during convalescence. For this period, faxes and emails have been fabulous communication tools. We are all doing much better using technology for this.

Technology has improved our access to patient records, and to lab and data images. However, it also endangers our connection to our patients. As you watch the interaction of the medical team, you will



notice that there is always someone whose primary emotional connection is to the computer rather than to the patient.

I feel that the safe and sensitive care of patients is a sacred trust to which communication is absolutely central. I have tried to suggest a topology for voices in the grammatical sense, or forms of speech that I see our students have to deal with. With that, I fulfill my duty as the first stage rocket of this conference, and I will sit down and watch what I have launched. Thank you.





Visions of Future Health Care Communication

William W. Stead, MD

[Dr. Stead was unable to attend the conference, so Dr. Harold Fallon, the Conference Chair, heroically stepped in to present Dr. Stead's data and explain his vision of health care communication in the future.]

In the future, physicians will blend elements of traditional physician-patient communication - empathy, observation, and knowledge - with advanced communication technology. The result, Dr. Stead believes, will be a system in which patients are active and educated partners in their health care, with access to the same information sources as their health care providers. In this future, the patient and physician will both be capable of tracking the patient's care against a standard of care, and the standard of care will evolve - even change instantaneously - as physicians and patients receive new data about medication risks and new therapies.

To illustrate his vision, Dr. Fallon presented a series of three videotapes prepared by Dr. Stead. In the first, a physician presents a patient with a diagnosis of congestive heart failure, and together they view a web site with information about the patient's condition. The situation presents what Dr. Stead calls a "teachable moment." When this physician prescribes medication for his patient, he also prescribes a user

name and password to the web site, where the patient can learn about treatment options and standards of care, as well as upload her own medical data - weight and blood pressure - for the physician's use. Technology, in this scenario, enhances an ongoing physician-patient relationship. The physician uses the computer to augment his communication with the patient, and they work together to improve her understanding of her medical condition.

When the patient and physician are revisited in

" Health Care Communication: A Key to Quality was an excellent conference and it alerted us to issues many are not aware of in the field of health care quality."



Jerry M. Earll, MD
Professor of Medicine,
Georgetown University
Vice President of Medical Affairs,
The Washington Home



the second video, they are following up on the phone and both are logged onto the web site. The patient suggests treatment changes, and the physician reviews her medical data to determine whether her suggestions are appropriate. In this scene, Dr. Fallon notes, communication is immediate and direct. The physician and patient have access to identical data, and the educated patient is clearly a partner in her own care.

In the third video, the physician is notified electronically about a recommended medication change, based on very new data. Through an automated, voice-activated system, the physician calls up information about patients affected by the proposed change. The automated system creates a “teachable moment” for the physician, and the recommendation instantly becomes the new standard of care.

Advanced technology has the potential to dramatically improve communication between patients and their health care providers, but it does not replace human intelligence and insight. To maximize the benefit of the technology, providers will use it in conjunction with old-fashioned medical skills - providing empathy and comfort, using their own eyes and ears to recognize symptoms and patterns, and developing ongoing therapeutic relationships with their patients.



Putting A Face on the Problem The Patient's View

Ruth M. Parker, MD, FACP

“Houston, we’ve got a problem. We’ve got some mismatches in communication going on.”

Synopsis:

Health care providers impart a great deal of crucial information during their encounters with patients, but that information has value only if the patients can understand, remember, and act on it. In her work defining and measuring “health literacy,” Dr. Parker has discovered that for

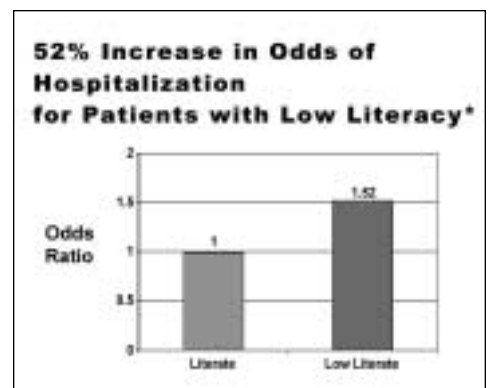
an alarming number of patients, the language of health care is largely impenetrable.

Spurred by reports of low literacy among the U.S. population, Dr. Parker and her colleagues developed a method to measure how well people understand everyday tasks related to health care. Using a sample of over 30,000 patients in managed care plans around the country, the researchers learned that the deficits in understanding are significant:

- 22% were unable to understand a real pill bottle with directions to take medication every six hours;
- 27% could not understand labels warning not to take medication on an empty stomach;
- 21% had difficulty understanding instructions for an upper GI series (which were written by health literacy experts at a 4th grade level); and
- 46% struggled with the “Rights and Responsibilities” section of a Medicaid application.

This disparity between what health care providers say and what patients understand constitutes a “silent epidemic,” with damaging implications for patient health and high financial costs. According to one estimate, the toll of poor health literacy may be as high as \$50 billion a year - low health literacy scores correlate to more hospitalizations, ineffective use of prescriptions, and misunderstood treatment plans.

Because patients are often reluctant to admit that they do not understand, mismatches in communication often go unnoticed by health care providers, who are giving out copious amounts of information in an effort to help inform patients about their medical needs. But, unfortunately, many patients are just not getting the message. By being vigilant and understanding this information about health literacy, health care providers can take the first step toward narrowing this gap in understanding.



*Adjusted for age, gender, socioeconomic status, health status, and regular source of care.



Putting A Face on the Problem

The Clinician's View

Goffrey Gordon, MD, FACP

“Communication skills are things like letting a patient finish an opening statement, checking a patient’s understanding after you have done some explanation, and expressing empathy in response, when a patient talks about what he/she is feeling.”

Synopsis:

As a physician faced with the sobering statistics about health literacy, Dr. Gordon admits to a range of reactions: defensiveness, denial, even despair. Since optimum health care depends on the ability of the provider and the patient to develop shared goals regarding the nature of the problem and the goals of treatment, clear communication is vital to ensuring health care quality. Add to the health literacy problem the barrier of time constraints, and the potential for adequate communication dims. In his presentation, Dr. Gordon explores how training can help health care providers begin to overcome these barriers.

As a clinician-educator, Dr. Gordon believes that to be effective communicators, health care providers need specific skills that can be taught and learned. These include basic communication skills (allowing patients to complete their opening statements and checking patient understanding, for instance), and interpersonal skills (such as being present, despite the time pressure and demonstrating respect). In order to attain competence and confidence in their communication skills, learners also need motivation and a supportive environment.

Teachers, for their part, should develop a curriculum that covers specific skills, allows the learners to apply their skills at levels of increasing complexity over time, and provides opportunities for learners to observe successful encounters between patients and health care providers. Finally, Dr. Gordon notes, teachers need metrics for assessing the learners’ competence.

Successful health care is a patient-centered process. Improving health care providers’ ability to create and sustain therapeutic relationships with patients is an important step toward improving the overall quality of health care.



Model Systems I: The Academic Model

Eric Larson, MD, MPH, FACP

“ MINDscape represents the most significant change in how we practice medicine that we have seen in the last decade. ”

Synopsis:

Every day, health care providers in the University of Washington system log onto MINDscape and enter the future of health care information technology. In his presentation, Dr. Larson demonstrates how MINDscape, an Internet-based electronic medical records system, enhances communication among members of the

University of Washington health care team and supports providers by instantly linking them to the information they need to make decisions about their patients' care. This improved communications capacity has a direct effect on quality: MINDscape puts patients' medical history, tests, and medical data at the fingertips of health care providers at the moment they need it most - when they are making decisions about treatment.

In his presentation, Dr. Larson focused on four key advantages that MINDscape offers health care providers within the system:

- MINDscape uses the Internet to provide data online. The University of Washington system serves patients in five states, covering a full 27% of the U.S. land mass. MINDscape makes patient records available wherever providers are seeing patients, and in a format that is easy to learn and to use.
- MINDscape helps clinicians organize the information they gather. For example, the system contains “smart templates” that automatically cull information from the system and transport it to the patient's discharge summary.
- MINDscape provides images and decision support at the point of service. Health care providers (no matter how distant) can view images together and consult interactively to reach the right diagnoses and treatment decisions. The system also integrates expert, peer-reviewed databases into the electronic medical record, making a wealth of decision support information available alongside data.



- MINDscape enhances clinicians' ability to share information with patients. The system supports clinical email and other channels for clinician-patient online communication.

MINDscape can provide other academic medical centers with a model of a system for improving quality of care by improving communication among providers, and between providers and patients. As a colleague of Dr. Larson put it, MINDscape represents “the most significant change in how we practice medicine that we have seen in the last decade.”



Model System II: Information Technology for Quality and Value in the Veterans Health Administration

Jonathan B. Perlin, MD, PhD, MSHA, FACP

“Spinal cord patients in Florida can actually upload their temperature and respiratory rate to detect an infection before they are even aware of subtle manifestations of a compromise.”

Synopsis:

The Veterans Health Administration’s information technology system is designed to address a single, sweeping goal: To ensure that the maximum benefit of health care is achieved for every patient. In other words, the system is designed to eliminate the gap between the evidence-based best care, and the care that each patient actually receives.

Considering the size of the VHA - 4.3 million patients, 1,300 sites of care, and 200,000 employees - ensuring the maximum benefit of health care is a monumental undertaking.

To accomplish this goal, the VHA designed and implemented a gold standard information technology system structured around an interactive electronic medical record. The success of the VHA’s patient record system rests on three elements: a graphical user-interface, responsive clinical decision support tools, and built-in measurement tools. Since some 70 percent of physicians experience some component of their medical training within the VHA, the agency’s comprehensive information technology system is raising the expectations of physicians entering practice.

As Dr. Perlin demonstrated the VHA patient record system, he pointed out its benefits for health care providers, management, and patients.

For physicians and other providers, the VHA patient record system offers real-time decision support, and built-in safeguards to prevent medical errors. Providers take notes online during the clinical encounter, creating a natural language record and eliminating the need to transcribe notes later. Templates prompt providers for specific information, and the system automatically produces reminders for diagnostic and preventive procedures. The interface is highly graphical and easy to use.

From the management perspective, the VHA system contains important measurement tools to track overall improvements in patient outcome as well as individual provider performance.





As Dr. Perlin explained, the system provides “an accountability framework that allows us to look at performance over time.”

From the patient perspective, the VHA’s information system provides a new, important communication tool. Using a pilot web-based program called “My Health,” VHA patients have immediate access to reliable health information, as well as their own health records. Patients can choose to search for information, or they can request that information about their conditions be “pushed” to them via email as it becomes available. The system also allows patients to upload their own health information - for

instance, spinal cord injury patients in Florida can upload their temperatures and respiratory rates, and the system can help them detect subtle manifestations of problems before they become acute. Patients can also use the system to schedule appointments, refill prescriptions, and update their health information.

The VHA information technology system, Dr. Perlin concluded, “links information and communication, quality and value.” It gives providers the best possible information about patient health, information “that is crucial to effective, efficient decision-making.”



Model System III: Private Health Sector Model

Włodrow A. Myers, Jr., MD, MACP

“The consumer wants reliable information and wants to know that his/her physician will be rewarded for quality care.”

Synopsis:

The current health care environment holds a different set of challenges for payers than for providers. Hospitals and physicians sometimes operate in an atmosphere of distrust and animosity toward payers, and, a backlash against managed care has raised questions about the quality of care patients receive. A primary challenge for Wellpoint, the country's fourth largest health care company, is to use technology-based communication to change

the focus of discussion from cost to quality, and to work to align the interests of payers, physicians, and patients.

In his presentation, Dr. Myers demonstrated two pilot web-based communication initiatives - one for physicians and one for health care consumers - designed to shift the spotlight from economic considerations (which tend to reward physicians for doing less than is medically necessary) to quality considerations (which reward physicians for doing exactly what is medically necessary).

The Physician Quality and Incentive Program (PQIP) is a pilot for Blue Cross of California physicians (Wellpoint is the parent company of Blue Cross of California). PQIP allows physicians to log onto a web site to see where they stack up against their colleagues, according to a series of quality indicators. The physicians can compare themselves to others in their specialty, or in their geographic region. Physicians with high scores are eligible for financial bonuses; those who score lower receive as a “consolation prize” Skolar MD, a computer software program to use for medical literature search and decision support.

The second communication initiative Dr. Myers demonstrated is a tool targeted to patients. Members of Blue Cross of California can log in to see their claims history, learn more about their contract provisions, or locate providers. This site also links members to Subimo (which provides instant comparative data about hospital quality and cost) and MedCall (which provides reliable medical and treatment information). These resources empower patients to make informed choices about their own health care and balancing for themselves the issues of cost and quality.

Dr. Myers concluded that “quality care is critical to the treatment of your patients, our members, and it is predicated on a reliable data information system.” Wellpoint, he added, is pushing toward a future in which the payment system is cost efficient and cost effective, and physician compensation is based on quality.





Critical Issues in Health Communication

Opportunities and Obstacles: Issues for Payers

Lawrence S. Lewin

“Most payers have all but given up trying to influence physicians. The reason for that is... that [physicians] see little benefit to themselves from the things that payers suggest, and even less benefit to their patients.”

Synopsis:

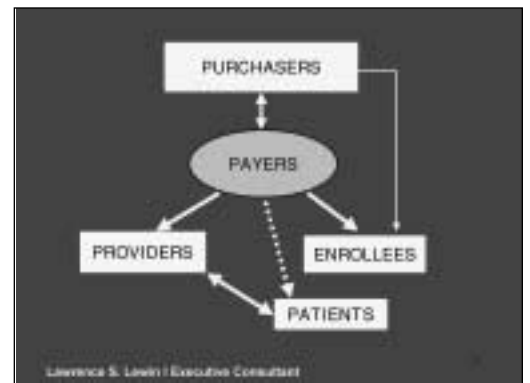
While payers are sometimes blamed for all that is wrong with the health care system, they are really the middlemen in the complex health care landscape, Mr. Lewin says. Payers have relationships with purchasers, providers, enrollees, and patients; each of these groups poses communication challenges.

For purchasers, the primary consideration when choosing an insurance plan for their employees is cost. In the last year or two, especially, with health care costs spiking dramatically, health plan purchasers are less concerned with quality and innovation. Therefore, Mr. Lewin points out, “payers are expected to bear the cost of innovation themselves, because employers are not going to bear it.”

In their relationship with providers, purchasers have all but abandoned their attempts to influence providers’ behavior (there are a few exceptions here, the most noteworthy being in “integrated health care networks,” in which the payer and provider are working for the same entity). Providers, having seen little benefit to themselves - and even less benefit to their patients - from payers’ suggestions have come to see payers as a nuisance, even as the adversary.

In their relationship with patients, payers are finding that keeping a competitive advantage requires implementing new communication strategies. Some, as Dr. Myers described in his presentation earlier in the day, are providing links to sources of reliable medical information. Some payers are also beginning to experiment with telephonic and online care management services in an effort to engage patients in their own care, particularly patients with chronic conditions. Mr. Lewin believes that these fledgling efforts hold great promise as a means of facilitating communication between patients, physicians, and payers.

Mr. Lewin’s vision of a future system is one in which payers overcome their “bad guy” image among patients and providers. To do this, he says, “we have to find new paradigms so that health insurance payments can recognize and centers can be aligned with quality and health outcomes, as well as efficiency.” When the concept of “managed health” overtakes “managed care,” he adds, “we will be headed in the right direction.”





Critical Issues in Health Communication

Opportunities and Obstacles: A Clinician's Perspective

Isabel V. Hoverman, MD, FACP

“ [Physicians] use of the Internet for medical information is limited, and it's limited for the same reasons that patients have difficulty accessing the data — and that is that they don't know where to go. ”

Synopsis:

Dr. Hoverman believes that electronic communication systems - what she calls the “Field of Dreams philosophy of technology development” - offer potentially great opportunities, but for physicians in private practice the obstacles to such systems are much more immediate than the ultimate payoff. In her presentation, she reviewed data about physicians' use of computers, and then took a close look at how a variety of clinical practices in her own community integrate technology. Finally, she offered insight into how private clinicians might best benefit from

the information technology revolution, and proposed a strategy for moving ahead.

In 2002, the AMA published two studies about physicians' use of computers, specifically their use of the Internet. The studies showed that between 1997 and 2001 there was what Dr. Hoverman calls “an utterly remarkable change in physicians' acceptance, use, and comfort with the Internet.” In addition, most physicians in private practice are linked to hospital computer systems; and many have implemented their own practice management systems. The doctors surveyed by the AMA use personal computers to access the Internet, use word processing programs, manage their finances, shop, and arrange travel services. Some physicians use the Internet to find medical information but, just like the general population, they do not always know how to find reliable information.

To get a reality-based perspective on how physicians use technology in their practices, Dr. Hoverman surveyed a variety of private medical practices in her own community of Austin, Texas, and learned that most use technology to some degree, but all face daunting obstacles, including the ones outlined below.

- * Cost. Medical practice programs are expensive to purchase and implement. While computers offer some efficiencies that save staff time and money, the efficiencies seldom outweigh the enormous costs.
- * Time Constraints. Without high-speed Internet access, performing practice-management tasks, sharing images online, and searching for medical information on the Web can be frustrating and time consuming.



- * Lack of Standardization. Computer programs are sometimes unable to integrate different types of information. For instance, in one practice Dr. Hoverman surveyed, an electronic medical record could not contain both radiological images and medical data within the same patient record.

Dr. Hoverman concludes that physicians in private practice need to work together to overcome the significant obstacles they face in implementing information technology systems to improve communication within their practices. By asking early adopters of technology to lead the way, and by sharing information across types of practices, she suggested that, “perhaps we can develop a medical informatics roadmap so that government capital investment” can be targeted “to help create a homogeneous system.”



Critical Issues in Health Communication

Cultural Considerations

N_{icole} Lurie, MD, MSPH, FACP

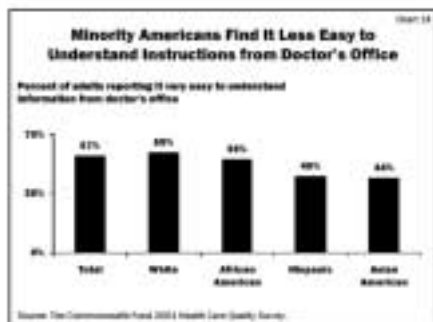
Synopsis:

Health care providers are frequently unaware of the countless cultural factors that buzz invisibly around the room during their encounters with patients. Study after study has shown that culture, ethnicity, and socioeconomic status are related to disparities in patient health and health care. In her presentation, Dr. Lurie explored how cultural differences can affect the quality of care patients receive, she identified “points of leverage” within the delivery system for which communication is crucial to adequate patient care, and she presented a model of a “culturally competent” clinical practice.

Disparities in health delivery begin with disparities in access. Ethnicity and socioeconomic factors account for differences in insurance status. Even when patients have insurance, cultural factors may make them reluctant to initiate care. Cultural and language barriers can make it difficult for patients to make appointments. Once that obstacle is overcome, and a patient is in a provider’s office, communication may be undermined by different culturally based assumptions that lie unspoken between the patient and the provider. A patient’s likelihood of following through with referrals is also sometimes linked to culture and ethnicity. In short, cultural factors create cracks on the path to health care delivery into which patients can easily fall.

Closing the cracks in the system requires effort. Some successful intervention strategies team patients with culturally matched “buddies” to navigate with them through the system and provide moral support. To really address cultural disparities in health care, however, providers need to take a hard look at how they communicate - not only with patients, but with each other. Research shows that a high proportion of physicians are unaware that cultural disparities in health care even exist, and that those who are aware are often apathetic toward the issue. Providers should consider ethnicity and culture as factors in patient care, just as physical symptoms are factors.

In closing, Dr. Lurie defined “cultural competence” in a clinical environment, and outlined several factors that mitigate the barriers posed by culture and ethnicity (*See box on following page*).





A culturally competent clinical environment contains the following elements:

- Diversity within the work force, including physicians and other staff,
- Easy access to good interpreters,
- Printed information in a variety of languages that is easy to read and written for a low level of literacy,
- Systematic data collection, particularly about quality of care,
- Ongoing research to detect areas for improvement, and
- Health care providers who understand clinical practice, know how to find information, and have culturally appropriate communication skills.



Critical Issues in Health Communication Decision Support in the Clinical Encounter

David Goldmann, MD, FACP

“ Good quality medical knowledge has to be packaged properly, and it has to be deployed in an appropriate way so that we can do a better job of bringing up-to-date medical knowledge to the point of care. ”

Synopsis:

The situation is a common one: a physician and patient are sitting in the physician's office, trying to evaluate information that the patient found online or elsewhere. “Doc, I think maybe I need this test - what do you think?” How does the physician determine whether the found information is valid? Where does she go for immediate, accurate, evidence-based decision support while in the midst of a clinical encounter?

One important new resource, Dr. Goldmann asserts, is PIER, the Physicians' Information and Education Resource, a tool that is being developed by the American College of Physicians. PIER is designed to help physicians make the best possible clinical decisions. PIER is a decision-support tool that rests on evidence-based medicine. With PIER, the evidence is packaged in a form that allows it to be deployed quickly, and in as much depth as the provider needs. Right now, PIER is a free-standing website, but it is put together in such a way that it will eventually be integrated into electronic medical records. Already, PIER content can be downloaded into a handheld computer and used anywhere.

When making clinical decisions, physicians balance three large categories of factors: evidence (patient data, basic research, clinical trials, and systematic reviews); patient-doctor factors (personal beliefs, experience, education, values); and constraints imposed by the system (policies and laws, community standards, time, reimbursement policies). PIER supports physicians as they evaluate evidence and provides a channel for communicating evidence - from doctor to patient and from the medical literature to doctors and patients. At the same time, it helps providers sort out evidence to help them make the best possible clinical decisions.

Interpreting evidence is a challenge - and a time-consuming one - that all clinicians face. As Dr. Goldmann put it, health care providers are constantly asking, “Does this guideline help me with this patient who is in the office now? Is there a guideline available to help me with this patient? Is this guideline believable?” PIER provides ACP-vetted guidelines, packaged with other evidence-based information, to allow physicians to answer YES to these questions. The information is structured so that the physician can “drill down” through levels of complexity, based upon the physician's needs and time constraints.



When deployed directly from an electronic medical record, PIER will be a uniquely valuable knowledge resource, fully integrated with an individual patient's data, and available to use while the patient is sitting in the physician's office.

In sum, Dr. Goldmann said, "good quality medical knowledge has to be packaged properly and deployed appropriately to bring up-to-date medical knowledge to the point of care." PIER and similar systems, he concluded, will improve the quality of medical decision-making, which in turn will improve the quality of health care patients receive.



Future Agenda for the Nation

Edward H. Shortliffe, MD, PhD, FACP

I was asked to try to summarize the take-home lessons of today. To that end, I will try to reiterate some of the problems we have discussed, focusing on the role of information technology in health care in general, and in particular how technology affects communication and relationships between health care providers and patients. As I walk through it I will try to build up to some of my own feelings about many of these concerns. I will extract some of the important lessons, talk about the implications for the future, and think out loud about the role the ACP Foundation might play in trying to address some of the problems we heard about today.

LESSON #1: Information Technology Has Great Potential To Improve Health Care

Some people worry that computers are somehow too mechanical to be useful tools for human communication. I would like to suggest that the absence of computers is more of a problem; with proper use of information technology, we may be able to recognize some of the barriers that get in the way of the right kind of communication. Today we heard about a variety of ways in which information technology can support practitioners. The emphasis in today's discussion on communication and information access highlights the

computer's ability to help us make better-informed decisions and to reduce the number of medical errors. We also talked about the computer's role in creating new approaches to learning, that are responsive to the "teachable moment" we have heard about, and opportunities to cement new knowledge at the moment that knowledge is pertinent.

I would also like to suggest that the proper use of technology may increase the chances that we will actually enjoy our jobs as clinicians more. It allows us to feel less like we are struggling uphill, and more like we really have the tools to allow us to do our best, and help our patients do their best as a result.

" The conference provided insight into issues that we had only vaguely appreciated beforehand and engendered enthusiasm for addressing the issue of health care communication within our organization."

William Varani, MD, JD
VP of Quality Improvement
Bon Secours Health System





There are so many ways in which we assist in the care of patients; let's explore where technology can play a role. Technology holds great potential to support the physician-patient relationship, even when the two parties are not together. The patient can store data about himself in the computer, and in an asynchronous mode, the physician can check trends, note where there are problems, and send information back. When it is done in the context of an existing relationship between the doctor and the patient, this kind of interaction fits naturally within our model of a quality health care delivery system.

LESSON #2: Technology Helps Make Partners Of Our Patients

It is a rare physician who has not been faced by a patient holding a large printout from the Internet. The Internet now facilitates patient access to information. Information that has always been available to patients at the library. The difference is, now the information is easier to get to, and those who have access to computers - in their homes or libraries or schools or workplaces - are using the Internet for facilitated searches to find medical information.

Physicians can certainly prescribe online materials for our patients, as we saw demonstrated in Dr. Stead's video, but of course most use of the Internet is actually self-guided by a patient who is seeking information to help him better understand his own disease, or that of a family member. Information is available online about virtually any health issue.

This type of increasing patient involvement complements our trend toward sharing decision-making with patients. Several of the speakers today have referred to patients being involved with their care, which is becoming quite common and very appreciated among patients themselves.

What we have been talking about today is not as radical as we might sometimes think. After all, "telephone medicine" has been a part of medical practice for decades. We have inserted a technology (the telephone) between patients and physicians, and we have used it as a mechanism for communication; we sometimes make treatment decisions over the phone. The telephone is part and parcel of the way in which everybody practices medicine these days. One of the reasons that telephones work so well for us is that people tend to have the equipment. In fact, 95 percent of U.S. households have telephones; they are essentially ubiquitous.

Something that we have anticipated is clearly going to happen: traditional analog telephone service will be replaced with digital technology. In fact the underlying technology is changing so much that the phone line of today may well disappear, and we will get information primarily via the Internet in the near future.

This technology is already having an impact. In special settings and pilot programs this technology is working well within our own communities, and even in private homes. At my own university, a Medicare-funded project aimed at practicing telemedicine over the Internet is a case in point. Patients use videophones and computers to submit data into central medical records. The project raises some of the special issues discussed here today because many of the patients in the study are unable to read. In addition, many do not have any computer experience. They are all Medicare patients, most are older, and many do not speak English. Our solution has been new technology development. We have created buttons to push that easily turn the system on and make the Internet connection without requiring the patient to understand the technology, and a



patient interface that is much less dependent upon text and makes much more use of audio and graphical information. There is ample evidence that we can do the kind of research necessary to provide functional support for folks who may not be able to read, still by using the Internet.

We are suddenly seeing more situations in which both physicians and patients use computers. We ought to be taking advantage of this situation for disease management education; for instance, we can deliver custom-tailored videos to our patients via their home computers. Further, computers make possible direct, automated entry of data. As we heard today, asthma patients' respirometers and diabetic patients' glucometers can be linked directly to the computer, and data can be downloaded into a centralized database system for clinicians to monitor. Clearly, the day is not distant when the Internet replaces the telephone as the mechanism by which we communicate with our patients from a distance.

LESSON #3: The Doctor Will Not Be Replaced By A Computer

Whenever we discuss the issue of information found online, in terms of the role of the Internet in supporting patient access to information and empowering patients in decision-making, questions arise regarding the risks associated with this information: how can we ascertain whether the information our patients find online is any good?

No matter what we do in health care, there will always be some things that computers do not know, and we need to consider the difficulties that they might generate for us at the margin. Your patients have access to a full array of health-related web sites, and you have to worry about whether they are using them in lieu of the good care process that we have come to think of as especially valuable. So we return to the concern that computers are too mechanical. They do not do things the same way that human beings do, and therefore their role in decision-making is questionable. And there is the concern that somehow or another, we lose something of our humanity when we bring technology into our milieu, that is may be detrimental to us as human beings, and perhaps that is particularly so if we introduce them into health care.

LESSON #4: The Obstacles Are Formidable, But The Benefits Are Worth It

Another concern I have heard today is that physicians have been too slow to embrace technology and appreciate its inevitable benefits for practice. Well, no matter how motivated one may be to become adept at using information technology, unless you happen to work in a setting where this is facilitated, there is no easy way to pick it up. It is expensive, and it requires health care providers to make decisions that most individuals do not feel qualified to make. As a general rule, physicians in private practice do not have the technology and specialist support to build systems that facilitate everything from routine work to communication with patients to marketing strategy such as in the Kaiser or the VA systems.

Given these obstacles, if we *are* seeing a change now in how physicians use technology - and the AMA data shows that we are - what accounts





for it? The first factor is the emergence of the information society; computer use by the general population has increased dramatically, and physicians are part of that population. Second, as Dr. Myers discussed today, changes in health care financing have created new pressures for using technology. Third, concerns about patient safety have focused attention on entry order systems; institutions are becoming more aware of how technology may help them to improve patient safety.

There are barriers to implementing information technology across the board, but we are in the beginning of a process, and there will be a day when people will be incredulous that there was ever resistance to these changes, because of their naturalness and their obvious benefit with regard to health.

The Future Agenda and the Role of the ACP Foundation

So where do we go from here? For the ACP Foundation, the agenda is almost certainly education. Clinicians need new skills, skills that have been discussed today, and new awareness of some of the issues that have been hampering their ability to have optimum communication. Dr. Stead's concept of the "teachable moment" has to be implemented, and we should explore how people learn. These are areas in which the Foundation and other entities can play a large role.

Since many of the major issues to be addressed have to do with investment and research, there is a role for the Foundation in educating policy makers, those who invest, and those who define the research agenda.

Perhaps the Foundation can also play a role in trying to help us all address the issues of an infrastructure that is currently fragmented. This accounts for some of the problems that the small group practices have when they try to figure out how to get "on-board" technologically. The Foundation can help to coordinate and convene the right people, and provide education about why we need standards in place to cut down on the cost of implementing new systems. With this coordination, the electronic medical record system that you want to purchase will connect to your practice management and billing systems. Without a basic standard for interconnecting systems, there will always be problems.

I believe that the biomedical world needs to understand and embrace information technology as a fundamental issue in the future of health care, for its measurement, for its delivery, and for its support of health-related communication. We have to stop thinking about it as an operations issue, but rather as a strategic issue within organizations. Technology plays a strategic role in planning for the future of services, and that comes down to provider organizations and individual practices.

We need to work together to develop the kind of shared vision and strategy both within the government and the health care community with new models of support for providers, regardless of their practice settings. Computers need not be a threat to our goal of providing care. I think we made that point today. Rather, the goal is to use computers to improve the quality of relationships between patients and caregivers.





Conclusion and Next Steps

From its inception, planners of the ACP Foundation's inaugural conference, "Health Care Communication: A Key to Quality," intended to listen very closely to conference speakers and to monitor the reactions of conference attendees to pick up data about the aspects of health communication that most urgently require the resources and attention of the Foundation. In this aim, the conference was a resounding success. For the foreseeable future,

the Foundation's Health Communication Initiative will focus on two themes that emerged at the conference: health literacy and health technology. Specifically, the initiative will focus on developing practical tools to improve health literacy and expand access to high-tech strategies for improving communications in health care delivery. By structuring its future agenda around this dual focus, the ACP Foundation intends to help health professionals improve health outcomes for their patients.

" I was particularly interested in the issue of health literacy, which is an emerging issue that needs to be addressed."



Jerry M. Earll, MD
Professor of Medicine,
Georgetown University
Vice President of Medical Affairs,
The Washington Home





Executive Summary



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