Patient-Centered Communication in Pharmacy Practice

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Overview

- In order to meet their professional responsibilities, pharmacists have become more patient-centered in their provision of pharmaceutical care.

- Pharmacists have the potential to contribute even more to improved patient care through efforts **to reduce medication errors** and **improve the use of medications by patients**.

- Using effective communication skill is **essential** in the provision of patient care.

Introduction - *Why is patient-centered communication so crucial to a professional practice?*

Consider the following:

- ***Case 1***

A 36-year-old man was prescribed a fentanyl patch to treat pain resulting from a back injury. He was not informed that heat could make the patch unsafe to use.

He fell asleep with a heating pad and died. The level of fentanyl in his bloodstream was found to be 100 times the level it should have been (Fallik, 2006).

Introduction - *(Continued)*

- ***Case 2***

A patient prescribed Normodyne for hypertension was dispensed Norpramin.

She experienced numerous side effects including blurred vision and hand tremors.

Since she knew that she was supposed to be taking the medication to treat hypertension, even minimal communication between the pharmacist and patient about the therapy would have prevented this medication error (ISMP, 2004).

Introduction - *(Continued)*

A study by Weingart and associates (2005) found that, while 27% of patients experienced symptoms they attributed to a new prescription, many of these symptoms (31%) were not reported to the prescribing physician.

The first author reported in a news release that "For every symptom that patients experienced but failed to report, **one in five resulted in an adverse drug event** that could have been prevented or made less severe."

The authors' speculation on why patients failed to report symptoms focused on <u>health care providers</u> who **do not inquire** about problems with drug therapy and <u>patients</u> who **dismiss** the seriousness of side effects or who do **not want to be seen as complaining** to physicians about their prescribed treatments (Weingart et al, 2005).

Introduction - *(Continued)*

- Pharmacists are accepting increased responsibility in ensuring that patients avoid adverse effects of medications and also reach desired outcomes from their therapies.
- The changing role of the pharmacist requires practitioners to **switch** from a “medication-centered” or “task-centered” practice to patient-centered care.
- As revealed in the three situations described above, it is **not enough** for pharmacists to simply provide medication in the most efficient and safest manner (i.e., focus on systems of drug order fulfillment).

Introduction - *(Continued)*

- **Pharmacists MUST participate** in activities that enhance *patient adherence* and the *wise use of medication* (i.e., focus on patient-centered elements including patient understanding and actual medication taking behaviors).

- Patient-centered care depends on your ability to develop *trusting* relationships with patients, to engage in an open exchange of information, to involve patients in the decision-making process regarding treatment, and to help patients reach therapeutic goals that are understood and endorsed by patients as well as by health care providers.

- Effective communication is central to meeting these patient care responsibilities in the practice of pharmacy.

PHARMACISTS' RESPONSIBILITY IN PATIENT CARE

- **The incidence of preventable adverse drug events and the cost to society associated with medication-related morbidity and mortality is of growing concern** (Easton et al, 2004; Ernst and Grizzle, 2001; Gurwitz et al, 2003; Johnson and Bootman, 1995; Manasse, 1989; Rodriguez-Monguio et al, 2003).

- The Institute of Medicine (IOM) report on patient safety concluded that **medication-related errors are among the most prevalent errors in medical care** (Committee on Quality of Health Care in America, 1999).

- The potential of pharmacists playing a pivotal **role** in reducing the incidence of both medication-related errors and drug-related illness is also receiving increased attention (Bunting and Cranor, 2006; Cranor et al, 2003; Garrett and Bluml, 2005; Hepler, 2001; Hepler and Strand, 1990; Leape et al, 1999; Schnipper et al, 2006).

- Hepler and Strand (1990) have made a **compelling case for the societal need for pharmaceutical care**, which they define as "*the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life*."

- Mission statements of <u>Professional Pharmacy Associations</u> have been *changed* in recent years to reflect the **increased responsibility pharmacists** are being asked to assume for the appropriate use of drugs in society.

- The “patient-centered” role envisioned by pharmacy mission statements would afford pharmacists a value to society far beyond that provided by their current “drug-centered” role.

- However, while the mission statements of professional organizations can help guide practice, they **must be translated into patient care activities** that pharmacists provide to each of their patients.

- ***The quality of the interpersonal relationships pharmacists develop with patients depends upon effective communication.***

Importance of Communication in Meeting Your Patient Care Responsibilities

The communication process between you and your patients serves two primary functions:

1- It establishes the ongoing **relationship** between you and your patients;

And

2- It provides the **exchange of information** necessary to assess your patients’ health conditions, reach decisions on treatment plans, implement the plans, and evaluate the effects of treatment on your patients’ quality of life.

- Establishing trusting relationships with your patients is not simply something that is “nice to do” but that is **essentially peripheral** to the “real” purpose of pharmacy practice.

- ***The quality of the patient–provider relationship is crucial.***

- All professional <u>activities</u> between you and your patients take place in the context of the <u>relationship</u> that you establish.

- An effective relationship forms the **BASE** that allows you to meet professional responsibilities in patient care.

- The ultimate purpose of the professional–patient relationship must constantly be kept in mind. ***The purpose of the relationship is to achieve mutually understood and agreed upon goals for therapy that improve your patients' quality of life.***

→ Your activities must, therefore, be thought of in terms of the **patient outcomes** that you help to reach. You must begin to **redefine** what you do with the focus being on patient needs.

→ Your goal, for example, is changed from providing patients with drug information to a goal of ensuring that patients understand their treatment in order to take medications safely and appropriately.

→ Your goal is not to get patients to do as they are told (i.e., comply) but **to help them reach intended treatment outcomes**.

- Providing information or trying to improve adherence must be seen as a means **to reach a desired outcome**, rather than being an end in itself.

- Even communication with your patients is not an end in itself. Conversation between you and your patient has a **different purpose** than conversation between friends.

- ***Patient–professional communication*** is a ***<u>MEANS</u>*** to an end—that of establishing a **therapeutic relationship** in order to effectively provide health care services that the patient needs.

- **<u>Patient well-being is paramount</u>**. Because of your unique knowledge and special societal responsibilities, you must bear the greater burden of ensuring effective communication in your patient encounters.

What is Patient-Centered Care?

Mead and Bower (2000) describe five dimensions of patient-centered medical care:

1. Practitioners must understand the **social and psychological** as well as the **biomedical** factors that relate to the illness experience of a patient.

2. Providers must **perceive the "patient as person."** This requires understanding your patients' unique experience of illness and the "personal meaning" it entails.

3. Providers must **share power and responsibility**. The ideal relationship is more egalitarian than is traditionally seen, with patients more actively involved in dialogue and in the decision-making surrounding treatment.

Mead and Bower (2000) describe five dimensions of patient-centered medical care: (continued)

4. Providers must promote a **“therapeutic alliance.”**

This involves incorporating patient perceptions of the acceptability of interventions in treatment plans, defining mutually agreed upon goals for treatment, and establishing a trusting, caring relationship between you and your patients.

Patient perceptions that you “care” for them (as well as providing care) are essential to the establishment of trust.

Examination of reasons for <u>filing</u> malpractice claims against providers suggest that patient anger over a perceived lack of “caring” from providers and dissatisfaction with provider communication were important elements in decisions to file (Hickson et al, 1992).

Mead and Bower (2000) describe five dimensions of patient-centered medical care: (continued)

5. Providers must be **aware** of their own ***responses*** to patients and the sometimes unintended effects their ***behaviors*** may have on patients.

Providing Patient-Centered Care

The pharmacist must be able to:

- ✓ *Understand* the illness experience of the patient
- ✓ Perceive each patient’s experience as *unique*
- ✓ Foster a more *egalitarian* relationship with patients
- ✓ Build a “*therapeutic alliance*” with patients to meet mutually understood goals of therapy
- ✓ Develop self-awareness of *personal effects* on patients

Understanding Medication Use from the Patient Perspective

- Models of the prescribing process that are “practitioner-centered” have primarily focused on decisions made and actions taken by physicians and other health care providers.

- The patient is “acted upon” rather than being viewed as an **active participant** who makes ongoing decisions affecting the outcomes of treatment.

- **The patient is seen as the object** of professional ministrations and as the cooperative (or recalcitrant) follower of professional dictates.

- One of our professional conceits seems to be that prescribing and dispensing a drug are the key decisions in the medication use process. However, in most cases, **it is the patient who must return home and carry out the prescribed treatment.**

- Drug therapy is the most ubiquitous of medical interventions and, in ambulatory care, is largely managed by the patient.

- The degree of autonomy that is possible with medication therapy makes it likely that patients will make decisions and assert control over treatment in various ways.

- Many PATIENTS make **<u>autonomous decisions to alter treatment regimens</u>**—decisions that may be made WITHOUT consultation or communication with you or other health care providers (Conrad, 1985; Donovan and Blake, 1992; George et al, 2005; Heath et al, 2002; Lowry et al, 2005; Trostle, 1988; Wroe, 2002).

- IGNORANCE of patient-initiated decisions on medication use, in turn, makes it difficult for health care professionals to accurately evaluate the effects of drug treatment.

- While you may view such patient behavior as ill advised, it would be more helpful for you to **acknowledge** the fact that **patients do exercise ultimate control over drug treatment.** Rather than trying to stifle patient autonomy, it would be more productive to strengthen the **therapeutic alliance** with your patients by increasing the level of patient participation and control in decisions that are made about treatment.

Encouraging a More Active Patient Role in Therapeutic Monitoring

- Providers, including pharmacists, could do more to help enable patients and their families or caregivers to *take a more active role in monitoring response to treatment*.

- The information a patient provides you as part of therapeutic monitoring is essential to **ensuring** that treatment goals are being met.

- While International Normalized Ratio (INR) or Hemoglobin A1c (HbA1c) values may **provide the comfort** of a “scientific” basis for therapeutic monitoring, for many ***chronic conditions*** you **must rely** on patient report of response to treatment.

- Treatment of **depression and pain**, for example, have **only** patient self-report as the **basis of evaluation** of response to therapy.

- Many other conditions such **as asthma, angina, gastroesophageal reflux disease (GERD), epilepsy, and arthritis rely heavily on patient report of symptoms**.

- In addition to conditions where patient report of symptomatic experience is critical to monitoring, research has documented the beneficial effects on patient outcomes **of increased patient involvement** in self-monitoring of physiological indicators of treatment effectiveness.

- Certainly, **patient self-monitoring of blood glucose** has become standard practice in managing diabetes.

- In addition, blood glucose awareness training programs (BGAT) teach patients to recognize signs of both hyperglycemia and hypoglycemia.

- The BGAT training programs have been found to improve a patient's ability to accurately estimate blood glucose fluctuations and prevent severe hypoglycemic episodes (Cox et al, 1994; Cox et al, 2001; Schachinger et al, 2005).

- Programs to increase patient participation in monitoring of **coagulation therapy** along with protocol-based patient management of warfarin dosing have led to reduced incidence of major bleeding in patient monitoring intervention groups (Beyth et al, 2000).

- These studies point to the sophistication with which patients can monitor response to therapy and make informed decisions when they are taught how to interpret both symptomatic experience and results of physiological tests.

- **Other programs** have designed interventions to TEACH patients how to be **more assertive in obtaining information from providers**.

- Intervention group subjects were found to be more likely than control subjects **to question providers** (Greenfield et al, 1985, 1988; Kaplan et al, 1989; Kimberlin et al, 2001; Roter, 1984) following the training intervention.

- In addition, patient **follow-up** found that intervention group patients had **improved health outcomes**, including improved glycemic control in diabetic patients, up to a year following the interventions (Greenfield et al, 1985; Kaplan et al, 1989).

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Agency for Healthcare Research and Quality (AHRQ) have published tips for patients to empower them to be more active in their own treatment and in decisions made on their care (Joint Commission, 2003; AHRQ, 2000; NCPIE, 2006).

- As an example, one tip for surgery patients from the Joint Commission states: "*Don't be afraid to ask about safety*.

- If you're having surgery, for example, *ask the physician to mark the area that is to be operated upon*, so that there's no confusion in the operating room."

Other pieces of advice include:

✓ **“Make sure you can read the handwriting on any prescriptions written by your doctor. If you can’t read it, the pharmacist may not be able to either,”**

and

✓ **“If you are given an IV, ask the nurse how long it should take for the liquid to ‘run out.’** Tell the nurse if it doesn’t seem to be dripping properly (that it is too fast or too slow).”

- While this advice is important in promoting more patient-centered care, **patients must be TAUGHT** how to be more **involved** in decision making, and their **assertiveness** must be encouraged and reinforced by all health care providers involved in their care in order for such a dramatic change from the traditional role of the patient to be embraced.

- **If** some providers, in fact, punish the patient for asking more questions and being more assertive, *your attempts to establish more patient-centered care could be undone.*

A Patient-Centered View of the Medication Use Process

- A patient-centered view of the medication-use process **focuses** on the **patient role** in the process.

- The medication-use process for **noninstitutionalized** patients **begins** when the patient perceives a health care need or health-related problem.

- This is experienced as a deviation from what is “normal” for the individual.

- It may be the experience of “symptoms” or other sort of life-style interruption that challenges or threatens the patient’s sense of well being.

- The patient then **interprets** the perceived problem.

- This interpretation is **influenced** by a host of ***psychological and social* factors** UNIQUE to the individual.

→ These include the individual's previous experience with the formal health care system; family influences; cultural differences in the conceptualization of "health" and "illness"; knowledge of the problem (individuals vary greatly on the level of medical and biological knowledge); health beliefs which may or may not coincide with accepted medical "truths"; psychological characteristics; personal values, motives, and goals; and so on.

- In addition, the patient's interpretation may be **influenced** by ***outside forces***, such as family members who offer their own interpretations and advice.

- The patient at this point may take **no action** to treat the condition either **because** the problem is seen as minor or transitory **or** because the patient lacks the means to initiate treatment.

- **If the patient takes action**, the action can include **initiation of self-treatment**, initiation of contact with a nonmedical provider (such as a faith healer), and/or contact with a health care provider.

- **If the patient takes action** that involves **contact with a health care professional**, whether it is a physician, pharmacist, or other health care practitioner, he MUST describe his "symptom" experience and to some extent his interpretation of that experience.
- In many ways, it is at this point that **CONTROL IS TRANSFERRED** from the patient to the professional, for it is the professional who can legitimize the experience by giving it a name (*diagnosis*).

- Such an act, however, **transforms** the experience *from that with patient meaning into that with practitioner meaning* (which may or may not be shared by the patient).

- The quality of the **professional assessment depends**, in part, on the **thoroughness of the patient report**, the **practitioner's skill** in eliciting relevant information, and **the receptivity of the professional** to "hear" information from the patient that is potentially important.

- The practitioner's skill in **communicating information** about the diagnosis may **ALTER OR REFINE** the patient's conceptualization of her illness experience, making **patient understanding** more congruent with that of the health care provider.

- Once the health care provider reaches a professional assessment or diagnosis of the patient's problem based on patient report, patient examination, and other data, she or he makes a recommendation to the patient.

- If the recommendation is to **initiate** drug treatment, the patient may or may not carry out the recommendation.

- Data indicate that large numbers of prescriptions are written that are **never filled** (Olson et al, 2005; Safran, 2005) or that are filled but **remain unclaimed** in the pharmacy (Kinnaird et al, 2003).

- **Failure to initiate prescribed therapy** may be caused by *economic* **constraints**, a *lack of understanding* of the **purpose** of the recommendation, or *failure* to “**buy into**” the treatment plan.

- Some of these patient decisions may, in fact, reflect a *failure* in the **communication** process between the patient and the health care provider.

- ***When patients do accept the recommendations to initiate drug treatment***, obtain the medication, and attempt to follow the regimen as prescribed, they can do so only to the best of their ability as they understand the drugs are intended to be taken.

- For many patients, medication taking includes **misuse** caused by **misunderstanding** of what is recommended or by unintended **deviations** from the prescribed treatment regimen (e.g., doses are forgotten).

- Alternatively, patients may administer the drug but **with intentional modifications** of the regimen.

- In both **unintentional and intentional modifications** of the prescribed treatment, the patient’s actions may be **influenced** by

→*how well you and other health care providers succeed in establishing mutually understood and agreed upon treatment plans.*

Regardless of the medication-taking practices that patients establish, they evaluate the consequences of the treatment in terms of perceived **benefits** and perceived **costs or barriers**.

- This evaluation **results in** patients *continuing* to take the medications, patients *altering* their drug treatment regimens, or patients *discontinuing* drug therapy.

- In any case, patients are continuously **estimating** what they perceive the effects of their actions to be and adjusting their behavior accordingly.

It is inevitable that, as patients **begin** drug treatment,

→they will “monitor” their own response

→ they will decide whether or not they feel differently;

→ they will look for signs that the treatment is effective

→ or, alternately, indications that there may be a problem with the drug.

- The problem is not that patients monitor their response to medications—it is inevitable and desirable that they do so.

- The PROBLEM THAT EXISTS is that patients **often lack information**

✓on what to expect from treatment

✓on what to look for that will give them valid feedback on their response to the medication.

LACKING THIS INFORMATION, THEY APPLY THEIR OWN “COMMON SENSE” CRITERIA.

- Patients may **interrupt** the treatment process by **failing to contact** you and other providers when follow-up is expected, which may involve discontinuing participation in the formal health care system for a period of time or **contacting a new provider** and beginning the whole process again.

→ Of the patients who do contact their providers, some will communicate their perceptions, problems, and decisions regarding treatment.

→ Other patients may contact providers and *not* convey this information (or not convey all pertinent aspects).

- This follow-up contact occurs during <u>revisits</u> with a physician or refills of prescriptions from pharmacists.

- The **nature of the their relationships** with you and other providers, the degree to which patients feel “safe” in confiding difficulties or concerns, the skill of providers in eliciting patient perceptions, and the extent to which a sense of “partnership” has been established regarding treatment decisions—all influence the patient decision to recontact providers.

- These factors also influence the degree to which medication-taking practices are reported and perceptions shared.

- *Regardless of how completely patients report their experience with therapy* when they recontact providers, the provider will make a **professional** assessment of patient response to treatment <u>based on </u>what the patient does report and/or laboratory values and other physiological measures.

- This assessment will lead:

→ to recommendations to continue drug treatment as previously recommended,

→ to alter drug treatment (i.e., to change dose, change drug, add drug),

→ or to discontinue drug treatment.

Reasons to Encourage Patients to Share Their Experience with Therapy

- They have unanswered questions
- They have misunderstandings
- They experience problems related to therapy
- They “monitor” their own response to treatment
- They make their own decisions regarding therapy

AND

- *They may not reveal this information to you unless you initiate a dialogue.*

Analysis of the medication-use process highlights several things..

→First, the decision by you and other providers to recommend or prescribe drug treatment is a small part of the process.

→ Second, patients and professionals may be carrying out **parallel** decision making with only **sporadic** communication about these processes.

→ Furthermore, the communication that does occur may be **incomplete and ineffective.**

- Yet both you and your patients may continue making decisions and evaluating outcomes regardless of the quality of understanding of each other’s goals, actions, and decisions.

- One of the **aims** of the communication process should be to make the understanding of the patient and you regarding the disease, illness experience, and treatment goals as congruent as possible

- It is obvious that there are numerous points in the process where the quality of the patient–professional relationship and the **thoroughness of the information exchange** affect the decisions of both patients and health professionals.

- It is at these points that your communication skills are **critical** and can have the most effect on the outcomes of treatment.

- You must seize the **opportunities** in this process when they become available.

- These opportunities will occur in structured and unstructured environments, in a variety of practice settings, and using varying amounts of time.

- **The key is to maximize patient outcomes by using patient-centered communication skills.**

Summary

- In establishing effective relationships with patients, your responsibility to help patients achieve **desired health outcomes must be kept in mind.**
- The patient is the focus of the **medication-use process**.
- Your communication skills can facilitate formation of **trusting relationships with patients.**
- Such a relationship fosters an **open exchange** of information and a sense of "**partnership**" between you and your patients.
- An effective communication process can optimize the chance that patients will make **informed decisions, use medications appropriately, and ultimately, meet therapeutic goals**.


Thank You!