

CHF QUERI TIPS FROM AN IMPLEMENTATION STUDY OF VA TELEHEALTH:

MORE EFFECTIVE CHF COMMUNICATION FOR SHARED DECISION MAKING AND SELF-MANAGEMENT

Recommendations from national¹, disciplinary², and health systems³ advocate shared decision making with patients, based on evidence of improved patient participation, satisfaction, and outcomes in a variety of conditions^{4, 5, 6, 7}. Clinical guidelines for heart failure recommendations have begun to address shared decision making⁸. However, the specific communication practices that characterize the process are not well-described, especially in association with management of CHF and in telehealth services. At the system level, a study based on physician self-report proposes more infrastructure support to empower patients and increase their participation in shared decision making⁹. Yet the communication practices that might support more effective communication in heart failure decision making were not identified.

At the level of social interaction between providers and patients, this QUERI-funded study provided an opportunity to examine communication practices that can be expanded and improved when working with Veterans who have heart failure (HF). The information was collected from 50 recordings in a purposive qualitative sample taken between four nurse care coordinators and the Veterans with HF enrolled in their VA Care Coordination Home Telehealth (CCHT) program at a VAMC in the Southeast.

Two primary approaches are advocated for patient-centered chronic disease care: **shared decision making** and **self-management**¹⁰. Studies of physician-patient interaction have found relatively low rates of shared decision making¹¹, though shared decision making is associated with increased patient satisfaction, adherence, and improvement in knowledge of treatment¹². Our CHF QUERI funded study also found relatively low rates of shared decision making and patient participation with the CCHT nurses and even less self-management-focused communication.

Communication practices found in the evaluation tool of shared decision making (RPAD¹³) were used to code interactions and classify *Tips for More Effective CHF Communication*. RPAD is similar to the OPTION scale¹⁴ and sensitive to the quality of communication in health encounters assessed in other patient-centered instruments (FHCS¹⁵, SEGUE¹⁶). Members of the CCHT team participating in coding and reviewing the study results found the insights from the coding sheets new and very useful for continuing to improve their service. From the qualitative analysis, we offer examples of tips for best practices and areas for improvement.

Reflecting on the approach used by Pellerin and colleagues to evaluate shared decision making with patients and residents using the OPTION tool¹⁷, we organize the tips under the essential components of the Rochester Participatory Decision-making (RPAD) tool that was used for this analysis. This list summarizes the provider components we use to organizer observations and examples:

- Explored and explained the status of the clinical issue

- Discussed the uncertainties involved in the decision
- Clarified the patient's agreement with the problem and plan
- Examined barriers to problem solving
- Gave the patient an opportunity to ask questions and checked their understanding
- Spoke in a language that matched the patient's understanding
- Asked what other questions the patient had
- Used open-ended questions in exploring the problem
- Checked their understanding of the patient's perspective

Tips for More Effective CHF Communication

- Explore and explain the status of the clinical issue
 - 1) *Explore what the patient calls their condition and what they know about heart failure.* Almost half of the patients observed in a hospital sample could not name their disease as heart failure. When the CCHT nurses did follow-up interviews, they found that often the patients did not know or understand their heart condition. Listen for whether the patient refers indirectly to their heart failure rather than taking ownership of their condition. Example: *"They say I have heart trouble..."*
 - 2) *Avoid letting the technology structure your interaction with the patient.* By its multimedia nature, a telehealth service provides prompts to the nurse to call the patient about messages from the equipment, whether the Health Buddy, the Turtle or the electronic medical record. This externally set agenda can override patient-centered care, causing neglect in exploring the patient's immediate needs or perspective on their problem.
- Discuss the uncertainties involved in the decision
 - 1) *Consider ways to prompt patient participation in discussing the consequences of particular decisions.* Most nurse-patient discussions in our study avoided areas of uncertainties about HF decisions, just as studies have shown that physicians avoid discussion of uncertainties¹⁸. In follow-up discussions, CCHT nurses expressed that discussions of uncertainty associated with the HF decisions they were exploring had not seemed to be part of disease management or care coordination and had not been part of their training. They then expressed a desire for training in this area.
 - 2) *Use summaries at the end of a HF issue under discussion to offer choices, voices uncertainties, and potential consequences.* Example: One Veteran who was having panic attacks responded with detailed narratives and exploration of the complex problem, after the CCHT nurse offered an open ended question about choices, used active listening with secondary prompts:
 Patient: *But, I don't know what's causing it. I don't know, but I'm telling you right now, they are, they are something....* [Goes on to explain the problem and difficulty getting staff to schedule an appointment between services, while coping with HF]
 Nurse: *Gosh, that's, so this May, June, July, gosh, that's an eternity. So you are..*
 [Listens and prompts, until patient confirms plan]

- Clarify the patient's agreement with the problem and plan

- 1) *Certain communication practices demonstrate attention in interactions and prompt patient participation.* The nurse in the following segment, uses active listening, does not rush or interrupt the patient, and waits for responses. These practices produced one of the highest shared decision making scores in the group.

Nurse: *I saw that you're on the MOVE program.* [Waits for a response]

Patient: *I've been in that, what, almost six months now.*

N: *I know. And how's it working?* [Affirmation of positive choice. Checking expectations]

P: *Well, I've lost about 30 some pounds.*

N: *I saw you down two more pounds.* [Affirmation]

P: *Oh, yeah, but I, let's see, we meet again next Monday....*[Continues on to explain his concerns, what he understands about the program and how it affects his HF and decision making about future use of the program]

- 2) [Also seen in the above example] *This Nurse emphasizes the patient's concerns while moving through potential problems and the actions the patient is taking, rather than start with signs of trouble.*

- Examine barriers to problem solving

- 1) *Avoid telling people what to do or offering to solve the problem for them.* There were tendencies in most HF care coordination talk for the CCHT nurse to transmit information to the patient, starting with the signs of failed self-management and what they should be doing, rather than exploring possible barriers. Systematic reviews of nurse communication point out that this provider-sided, information sender-receiver transmission approach is common¹⁹. The tip our team offers is to solicit the patient's insight.... "so what do you think is happening?" and attend carefully to the cues offered in patient responses. Often not noted in real-time, the luxury of transcriptions often shows when a patient's cue about a HF self-management barrier was missed in service of a more biomedical agenda.

- 2) *Consider the patient's social context.* One CCHT nurse explained that coding the transcriptions with the rating tool had quickly made her adopt new behaviors. As an example, she described a recent call where she wondered with the patient what types of things may have prompted a weight gain and paused. The Veteran confessed his weight had changed because he was eating all the time. His wife had had a heart attack. Alone with his fear and sorrow, he sought solace in the kitchen.

- Give the patient an opportunity to ask questions and check their understanding

- 1) *Avoid power-oriented interruptions that change the subject or shift away from what the patient is trying to explain.* Not all interruptions are negative; some build rapport, as seen in an affirmation, or some encourage more information exchange²⁰. Most speakers were unaware that they had interrupted and unaware of the consequence: the practice decreases patient opportunity to ask questions.

- 2) *Employ Teach-Back to check understanding.* As obvious at this approach sounds in 2011, the technique had not been taught to these four very experienced nurses a few decades before in their training or in the original VA training on telehealth. The opportunity to code actual interactions and discuss ways to confirm understanding brought Teach-Back²¹ into immediate enthusiastic practice after the study ended.
- Speak in a language that matched the patient's understanding
 - 1) *As a signal of trust and relationship, this dimension of communication overcomes jargon and transcends health literacy challenges.* Of all the ratings, this dimension was the one on which the CCHT nurses consistently scored highest. In discussions of heart failure, they adopted the patient's language.
 - 2) *Take the time to build trust and relationships.* The time the nurses and Veterans had invested previous to the recordings came across in references to family members, events in their lives, and assertions of how much it meant that someone was out there concerned about them. The ability to speak with the patient in shared language and frames of reference built decision making.
 - Asked what other questions the patient had
 - 1) *End the end the encounter asking "What other questions do you have?"* CCHT nurses were surprised at how rarely interactions ended purposefully. This aspect of shared decision making allows the provider to identify what the Veteran did not know about their HF or other co-morbidities, areas of confusion, or struggles with competing demands.
 - 2) *Consider making this encounter-ending question routine and not a yes/no close-ended choice.* In many ways, this question is the clean-up question of HF self-management. If providers have done an effective communication job, then there should be few if any questions. As a feedback loop, a chain of patient –initiated questions at this point is a measure that the interaction may not have been as patient-centered as they had thought.
 - Use open-ended questions in exploring the problem
 - 1) *Find a way to monitor the habit of yes/no and close-ended questions.* CCHT nurses were surprised at how much HF communication dealt with symptoms, instead of promoting self management. This biomedical focus seemed to rely on chains of yes/no questions that diminished patient participation and decreased the Veteran's participation in the interaction. Yet the yes/no practice is deeply embedded in patient- provider interactions that are not patient-centered and results in encounters that end without determining the patient's perspective or understanding²², especially a concern in trying to promote HF self-management.

N: *You're feeling the same as you... you've said you're very short of breath:::*
 [Tone prompts the patient to continue, rather than functions as a yes/no request]
 P: *It's the same thing. Same day all the way round.*
 N: *So, what do you mean by off and on? Sometimes it's a little....* [Pause]
 [This statement and pause prompts an explanation and triggers participation.]

Example of the challenge of Yes/No Questions. Consider this alternative:

N: *I'm calling ahm.. sir because I noticed that your weight was up a little bit this weekend?* [open-ended question, but tone prompts a 'yes-no' reaction]

P: *Yep.*

N: *And I was calling to see what happened?* [Quick pace; yes/no tone]

P: *Don't know.*

N: *You don't know?* [yes/no question]

P: *No.*

N: *Okay, are you having any signs of any heart failure?*
[Assumes knowledge of HF]

P: *N..n..not that I know of.* [Notice the stumble, suggesting not knowing]

N: *Okay, how's your breathing?* [Invites evaluation, but tone sets up yes/no chain. Notice the use of "Okay". In conversation analysis, "okay" or "oh" at the beginning of a sentence can be a signal to the listener, a marker that your speaking turn and the topic is over, and the speaker is changing the subject²³.]

P: *Good.*

N: *And, are you holding on to any water?*

P: *Ahm..... No.* [Yes-No questions follow, with an inconclusive end]

2) *Open-ended questions in HF communication take practice.* The CCHT nurses were quick to identify the yes/no chains, but acknowledged that breaking the long-held habit in health care takes practice and feedback. However, the reward in confirming the patient's understanding and discovering assumptions they had not realized provided reinforcement.

- Check their understanding of the patient's perspective

As a team, we all acknowledge that many of the tips above concern checking for the understanding of the Veteran's perspective. Prior to recording, transcribing, and coding, this element was one that each individual nurse might have considered they did routinely. It was in the close examination and ratings of shared decision making that this tip resonated.

Among the lessons learned the team wanted to share:

a) *Do not assume a shared understanding of HF, its risk signs, or what the prognosis may be.* It was through close examination of communication and follow up interviews with Veterans that we discovered that often nurse and patient did not share the same understanding, even when they had a positive relationship over a long period of time.

b) *Symptom management is not HF self-management.* The focus on symptoms did not often involve shared decision making and, consequently, the focus was not on empowering the patient with problem-solving strategies.

Conclusion:

The dialogue fostered by the examination of communication as a process stimulated discussions about HF self-management that may not have happened otherwise. We thank the CHF QUERI group for its guidance and support. We believe that our findings provide the basis for an intervention to expand the effectiveness of HF communication in the telehealth service.

Acknowledgement:

- **VA Chronic Heart Failure (CHF) Quality Enhancement Research Initiative (QUERI)
Solicitation: Implementing Research into Practice to Improve Care Delivery (2009-2011)**
- This material is based upon work supported by the Office of Research and Development, Department of Veterans Affairs, and the Ralph H. Johnson VAMC, Charleston, SC REAP: Center for Disease Prevention and Health Interventions for Diverse Populations
- Funding support was provided through VA HSR&D QUERI Award (# RRP 09-151).
- Disclaimer: The views expressed in this presentation are those of the authors and do not necessarily represent the views of the U.S. Department of Veterans Affairs.

A Special *Thank You* to the investigators responsible for the RPAD tool at the University of Rochester School of Medicine:
Cleveland Shields, Peter Franks, Kevin Fiscella, Sean Meldrum, and Ronald Epstein.

In constructing a community based participatory research approach to this implementation evaluation of CCHT, the nurses regarded their use of this rating tool as one of the most instructive and essential components of the study project. The essential elements we have tried to illustrate above provided a structure for the tips that deepened how we could view the talk of HF telehealth encounters.

References

- ¹ AHRQ. (2011). Shared Decision Making. From *The CAHPS Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Taken from the Internet (8/24/11) AHRQ: <https://www.cahps.ahrq.gov/qiguide/content/interventions/shareddecisionmaking.aspx>
- ² Brindis, R. and Spertus, J. (2010). President's Page: Employing shared decision-making models to improve care and patient value: A cardiovascular professional initiative. *Journal of the American College of Cardiology*, 56, 2046-48.
- ³ Doyle, L., Joyce, J., Caplan, W. and Larson, P. (2002). Strengthening self-care, self-management, and shared decision-making practices at Kaiser Permanente. *The Permanente Journal*, 6, 53-56.
- ⁴ Mandelblatt, J., Kreling, B., Figueiredo, M., and Feng, S. (2006.) What is the impact of shared decision making on treatment and outcomes for older women with breast cancer? *Journal of Clinical Oncology*, 24, 4908-13.
- ⁵ Loh, A., Simon, D., Wills, C., Kriston, L., Niebling, W., and Harter, M. (2007). The effects of a shared decision-making intervention in primary care of depression: A cluster-randomized trial. *Patient Education and Counseling*, 67, 324-332.
- ⁶ Lee, M., Noh, D., Nam, S., Ahn, S., Park, B., and Lee, E. (2010). Association of shared decision-making with type of breast cancer surgery: A cross-sectional study. *BMC Health Services Research*, 10: 48-. Available from: <http://www.biomedcentral.com/1472-6963/10/48>
- ⁷ Arterburn, D., Westbrook, E., Bogart, T., Sepucha, K., Bock, S. and Weppner, W. (2011). Randomized trial of a video-based patient decision aid for bariatric surgery. *Obesity*, 19, 1669-75.
- ⁸ Allen, L., Gheorghide, M., Reid, K., Dunlay, S., Chan, P. et al. (2011). Identifying patients hospitalized with heart failure at risk for unfavorable future quality of life. *Circulation: Cardiovascular Quality and Outcomes*, 4, 389-98.
- ⁹ Lovell, B., Lee, B, and Brotheridge, C. (2010). Physician communication: Barriers to achieving shared understanding and shared decision making with patients. *Journal of Participatory Medicine*, 2,e12-.
- ¹⁰ Schmitt diel, J., Mosen, D., Glasgow, R., Hibbard, J., Remmens, C. and Bellows, J. (2007). Patient assessment of chronic illness care (PACIC) and improved patient-centered outcomes for chronic conditions. *Journal of General Internal Medicine*, 23, 77-80.
- ¹¹ Pellerin, M-A., Elwyn, G., Rousseau, M., Stacey, D., Robtaille, H. and Legare, F. (2011). Toward shared decision making: Using the OPTION scale to analyze resident-patient consultations in family medicine. *Academic Medicine*, 86, 1010-18.
- ¹² Wilson, S., Strub, P., Buist, A., Knowles, S., Lavori, P., Lapidus, J., et al. (2010). Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. *American Journal of Respiratory and Critical Care Medicine*, 181, 566-77.
- ¹³ Shields, C., Franks, P., Fiscella, K., Meldrum, S., and Epstein, R. (2005). Rochester Participatory Decision-Making Scale (RPAD): Reliability and validity. *Annals of Family Medicine*, 3, 436-42.
- ¹⁴ Elwyn, G., Hutchings, H. Edwards, A., Rapport, F., Wensing, M., et al. (2005). The OPTION Scale: Measuring the extent that clinicians involve patients in decision-making tasks. *Health Expectations*: 8, 34-42.
- ¹⁵ Fossil, J., Gulbrandsen, P., Benth, J., Dahl, F., Krupat, E., Finset, A. (2010). Interrater reliability for the Four Habits Coding Scheme as part of a randomized controlled trial. *Patient Education and Counseling*, 80, 405-9.
- ¹⁶ Makoul, G. (2001). The SEGUE Framework for teaching and assessing communication skills. *Patient Education and Counseling*, 45, 23-34.
- ¹⁷ Pellerin, M-A., Elwyn, G., Rousseau, M., Stacey, D., Robtaille, H. and Legare, F. (2011). Toward shared decision making: Using the OPTION scale to analyze resident-patient consultations in family medicine. *Academic Medicine*, 86, 1010-18.
- ¹⁸ Politi, M. and Legare, F. (2010). Physicians' reactions to uncertainty in the context of shared decision making. *Patient Education and Counseling*, 80, 155-57.

-
- ¹⁹ Fleisher, S., Berg, A., Zimmermann, M. Wuste, K., Behrens, J. (2009). Nurse-patient interaction and communication: A systematic literature review. *Journal of Public Health, 17*, 339-53.
- ²⁰ Goldberg, J. (1990). Interrupting the discourse on interruptions. *Journal of Pragmatics, 14*, 883-903.
- ²¹ Kripalani, S. and Weiss, B. (2006). Teaching about health literacy and clear communication. *Journal of General Internal Medicine, 21*, 888-890.
- ²² Kripalani, S., Jackson, A., Schipper, J. and Coleman, E. (2007). Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. *Journal of Hospital Medicine, 2*, 314-23.
- ²³ Heritage, John (1984) A change of state token and aspects of its sequential placement. In J.M. Atkinson, and J. Heritage, (Eds.), *Structures of Social Action: Studies in Conversational Analysis* (pp. 299-345). Cambridge, UK: Cambridge University Press.