Dr. Ruth Adewuya, MD:

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Welcome to Season 4 of Stanford Medcast. This episode is part of our Leadership mini-series. In this episode, I will be chatting with Dr. Jeffrey Schnipper on advancing patient safety through communication.

Dr. Jeffrey Schnipper is a Professor of Medicine at Harvard Medical School and the Research Director of the Division of General Internal Medicine and Primary Care at Brigham and Women's Hospital. He's also the Director of Clinical Research of the Brigham Health Hospital Medicine Unit. He completed both his undergrad and medical degrees at Harvard University, and also obtained a master's in public health. His research interest focused on improving the quality of healthcare delivery for general medical patients. Thanks so much for chatting with me, today.

Dr. Jeffrey L. Schnipper, MD, MPH:

Oh, thank you so much for having me.

Dr. Ruth Adewuya, MD:

This episode is part of our Leadership mini-series, and we're really focusing on communication, and specifically, this approach to improving patient safety through communication. So, we know that effective communication is crucial for patient safety. Could you share some of the most common communication challenges that you've observed in healthcare settings, and what have been their potential impact in patient safety?

Dr. Jeffrey L. Schnipper, MD, MPH:

Absolutely. I think about this all the time. If you think about it, healthcare settings, in general, and I would say hospitals, in particular, are almost hostile to communication. We have all these different people we have to communicate with, whether that is providers talking to each other, or providers talking to patients and their families. The goal is to have all of us instantly on the same page, with a shared understanding of what's going on at a time of very high stress, especially for these patients. People have varying levels of health literacy. They may literally, or figuratively, be speaking different languages. We're under incredible amounts of time pressure, and there's lots of noise and distractions everywhere. It's actually amazing that we are able to communicate, at all, as well as we do. That's a testament to how hard we work at it, but it is often ineffective and dangerous frankly, for the patients that we're trying to take care of.

There's a healthcare communication specialist named, Avigra Onawa, and she's the one who first introduced me to this concept. Healthcare settings and hospitals are really far from ideal settings for effective communication.

Dr. Ruth Adewuya, MD:

I really appreciated how you framed that, in the sense that the environment itself is inherently not conducive for effective communication. One of the areas that you can see, potentially, some miscommunication is during patient transitions, transitions between healthcare settings, whether internal or external to the organization. How can healthcare providers improve those handoffs and communication to ensure patient safety during these critical points?

Dr. Jeffrey L. Schnipper, MD, MPH:

That's a great question. Transitions of care, as you said, are very fraught times for patients, and especially, I would say, the one that I study a lot, discharges from the hospital.

By definition, patients are going to be moving to a less monitored setting. They're going to have to start taking care of themselves, or their families are going to have to start helping take care of them. There are a lot of new behaviors that they may have to take on, medication changes, other self-care activities, follow-up appointments to make. Yet, these patients are still sick, not feeling well. They're often sleep-deprived, over-medicated, sedated, de-conditioned, all these areas that Harlan Krumholz calls the post-discharge syndrome. So, it's a very dangerous time.

There's a few things that we can do to try to improve handoffs during that time. So one of them is to acknowledge that, again, it is not an ideal time for communication. At that point, on the day of discharge, all the patient wants to do is go home. All their family wants to do is take them home, so they're not really even listening to you. I liken it to the teacher in the Peanuts cartoon, where the teacher is talking and all the student hears is, "Wah, wah, wah." They're saying, "Yes, ma'am. No ma'am." It's the same thing, "Yes, doc. Whatever you say, as long as I can get out of here."

So one thing to do, is first of all, you have to involve the family, even if they're offended by that idea, just emphasize that "There has to be a second person with you, or on the speakerphone," when you're delivering these messages.

Second, keep the messaging pretty short on that day. For example, "What changes have we made to your medication regimen, compared to what you came in with? What other major healthcare behaviors do you have to do, now? What follow-up appointments do you have? What things should you be watching out for, and what should you do if those things happen? When should you go to the emergency department? When should you call your doctor?" That's about it. Those are the main sort of survival skills that a patient needs when they leave the hospital.

Then, the other reality is that we probably need to call these patients up a couple of days later. It may not have to be us. It could be a pharmacist, it could be a nurse, it could be on our side, it could be on the primary care provider's side. All of a sudden they get home and they're like, "Now, what did that doctor say to me?" Now, they're all of a sudden confronting all those healthcare behaviors and probably they weren't listening. Now is a great time to re-engage them and have a conversation about all those survival activities that they're going to need to do to take care of themselves after they get back home. So, those are probably some of the key ones, I would say.

Dr. Ruth Adewuya, MD:

That's incredibly important because once a patient gets home, everything changes. Their environment changes, the people are taking care of them changes. Then, they might have new symptoms. I can see how it can impact anxiety with the patients and with their potential caregivers.

You mentioned patient engagement. You see it a lot, now, in healthcare organizations. You have a patient engagement specialist, or an office. In your experience, what role does patient engagement play in improving communication and patient safety?

Dr. Jeffrey L. Schnipper, MD, MPH:

You could almost argue that patient safety and communication doesn't happen without it. Patients and their families have to be engaged in their own care for any of this to succeed. What I always tell my residents and other trainees is that when a patient's about to leave the hospital, their agenda isn't, "Oh, I need to take better care of my diabetes. I need to take better care of my heart failure." It's, "I want to

be able to babysit my grandchildren. I want to be able to walk my dog. I want to be able to attend town meetings." So, whatever their agenda is, find out what it is. Then, see if you can link their agenda to your agenda. "If your heart failure starts getting worse and you don't take your water pill, and you start putting on fluid, then you're not going to be able to babysit your grandchildren, or walk your dog, because you're going to be too short of breath."

Those kinds of ways of making inroads to engaging patients in their own care. Then, there's the whole field of motivational interviewing. Again, we don't always have a behavior change that we are trying to have patients engage with, but sometimes we are. Motivational interviewing is all about active listening, and meeting patients where they are and not being judgmental, and more active listening. In the end, the goal is engagement. So, if they're asking a question at a time and a place where they're ready to hear an answer, that's the first step towards behavior change.

Dr. Ruth Adewuya, MD:

One of the questions that I had was, "How can healthcare providers encourage patients to participate in their care?" You've answered that already, in the sense of motivational interviewing is the art of active listening. What I also heard you say, is that you need to get to know your patients beyond just their medical care. You won't know that they do want to walk their dog and they want to attend this really important town meeting, if you're just focusing on it.

Statistics, in the news, showcases how incredibly busy clinicians are and the number of patients and the responsibilities that they have. How do you balance that with what we just said about, "Hey, you need to listen to your patients and engage them in their care?"

Dr. Jeffrey L. Schnipper, MD, MPH:

You're absolutely right. We are as stressed and as understaffed as I've ever seen in the 20 plus years I've been in healthcare. I consider this kind of an upfront investment. If you spend 10 minutes the first day, getting to know a patient well, you will achieve so much better rapport with them and better outcomes and have fewer conflicts later in the hospitalization. They will be listening to you more. They'll trust you. They'll be more adherent to the plan of care, and they'll have fewer readmissions. Not to get too melodramatic, but I think spending that time, that first day, getting to know a patient and know what they care about, doesn't take that much time, but I think it really is so effective.

The VA pioneer, called My Life, My Story, where they have, often it's volunteers, listening to these patients while they tell their life story. Then, putting that into the chart. All we have to do is, then, read it. Then, reflect on it with the patients that we're taking care of. It's incredibly valuable. I think if medical students, or other people interested in healthcare, are the ones getting these stories, I think it's great for them. I think it's great for the patients. It's great for us when we learn that information. We do have to close the loop to form their relationship, but that's another way to get at this.

Dr. Ruth Adewuya, MD:

It's important that you mentioned that there are multiple ways that you can get at it, and the way you framed it, as an investment, and not just one more thing to do.

I think technology and telemedicine has also transformed our communication. How can we strike this balance between utilizing technology to improve communication, but not putting that barrier and still ensuring this human-centered approach to patient care?

Dr. Jeffrey L. Schnipper, MD, MPH:

We don't want patients talking to a robot, quite yet.

Dr. Ruth Adewuya, MD:

Exactly.

Dr. Jeffrey L. Schnipper, MD, MPH:

I don't think we're there. I think you're right. The pandemic forced us to use a lot more telemedicine. A lot of regulation and restrictions around it went away, mostly for the better. The world did not end, and telemedicine use exploded. It's mostly been a great thing. Especially for mental health, once there's already been a relationship with a provider, I think it's been incredibly helpful for patients, so much more convenient, less stigmatizing. Adherence with these telemedicine visits is way higher than I think it ever was with face-to-face. With internal medicine, I don't think we quite know when you can get rid of the laying hands on patients, entirely. I still think, probably, when you're first building a relationship with a patient, face-to-face is best. There probably is no substitute for it.

The dirty little secret in internal medicine is that most of the time the physical exam doesn't matter. I don't think patients are quite ready to accept that. Clearly, there are times when it does. So, "When is a telemedicine visit just not good enough, and when do we really need to examine the patient?"

Then, through efforts like home hospital, "Is it possible that another provider could be the one laying hands on the patient? You're getting the stethoscope sounds remotely." So, there's other things that we can do to try to bridge those gaps.

As far as electronic health records, the main thing is giving patients access to their own record. This whole movement of, "Nothing about me without me." It happened first in primary care. A lot of primary care physicians were worried that patients were going to read these notes and not understand them, or they would read this language and be offended. The world didn't end. Eventually, we all became more patient-centered in how we write our notes, which is probably a good thing, and writing less stigmatizing language, which is also a good thing. It really engages patients in their own care.

We now have it on the inpatient side. At the Brigham, we're using MyChart bedside, courtesy of Epic. I often walk into a room and the patient knows their lab results before I do. Great. I love it. Again, one more way to engage patients in their own care. You can go over their CAT scan image with them. You can show them their calendar of events for the day. They can see when their next test is.

Where else can we use technology? There's a lot of things. So, one of them is mobile technology. So, if I call a patient on hospital post-discharge day two, and they've got a new symptom, great. But, I'm only calling them once. What if they develop that new symptom on day four, or five, or 10? You can give somebody an app on their phone. The app can ask them patient reported outcomes every day. A little beep goes off and says, "How's your heart failure doing, today? How's your shortness of breath Are you using three pillows?"

That information, obviously, needs to get somewhere and action needs to be taken in response to it. It increases our ability to do post-discharge monitoring of patients. This is just the example of the transitional care setting, but I think there's lots of other uses for that.

Then, getting back to this idea that patients aren't really listening to us. What if we just audio record our discharge instructions? Then, they can listen to it after they go home. We're not worried that they're bothering anybody. They can just listen to it again, or again. These are simple things that EHRs could do well, but it's all about, as you said, having a human-centered approach to patient care. It's still human to human contact. It's still us talking to these patients where we're using technology in smart ways to gather more information, to bridge inconveniences in care, to make care more accessible to folks. Until

we get completely replaced by artificial intelligence, I think we'll still be talking to patients. Hopefully, that won't happen any time soon.

Dr. Ruth Adewuya, MD:

I want to go back to what you said, "How can we leverage technology?" Ultimately, even if you're using telemedicine, how you communicate to the patient, even through this technology portal app, or whatever, is still important so that the patient feels heard, feels acknowledged, and doesn't feel like they're bothering. So, that's a really key takeaway, what you said there.

I want to pivot a little bit. We've been talking, up until this time, about clinician-to-patient conversation. I think it's important to acknowledge that communication goes everywhere. So, this question is really to frame it with staff and clinicians being able to communicate internally to their organization about some of their concerns. What strategies can healthcare organizations implement to encourage staff to speak up about potential safety concerns, or communication errors, without that fear of reprisal?

Dr. Jeffrey L. Schnipper, MD, MPH:

That's a great question, and some of this is about the culture of the organization. Culture change is hard. It is slow. I don't expect it to change immediately. It has to start, as you said, with having a third party being an open conduit for these kinds of concerns. For people to feel comfortable that they can anonymously, or not anonymously, report those concerns and know that they are not going to go to their direct supervisor, their boss, that their name's not going to be used against them. There's not going to be reprisal. There has to be rules and regulations that are enforced to make sure that there are no reprisals that take place. One of those could completely squash any kind of reporting that goes on.

I think the other really key piece of this is that people have to feel that their concerns are being listened to so that there is feedback. That you go back to folks and say, "You said this concern. Here's the committee we brought it up with. Here are the actions that we're taking about it." If people feel like they're screaming into the void, they're going to stop screaming. So, they have to know that something is being done with their concerns. So, that close-knit communication is really, really important. Then, like I said, you put these things at arm's length so that there is no fear of reprisal. Again, you have to create an environment, actively, where people feel comfortable raising these concerns. If we don't raise them, they're never going to get fixed.

The first thing that's going to happen is that safety reports go up. You have to convince your C-suite that's a good thing. That means that people are no longer afraid to report. It doesn't mean the safety is getting less care. Care is getting less safe. It means that care is probably getting safer.

Dr. Ruth Adewuya, MD:

Reframing that metric in a way that is valuable for the organization. In the article that you wrote on this topic of improving patient safety, you talked about utilizing some structured communication techniques. Some of the training that you mentioned in there, like team steps and simulation-based communication, can you talk a little bit more about the value of structured communication practices? I imagine that will help clinicians be able to communicate some of their concerns, and ultimately, be able to alleviate the risk of patient safety concerns.

Dr. Jeffrey L. Schnipper, MD, MPH:

That's right. The higher stress the situation, the more there's a hierarchy, the more there's this need for structured communication. I think probably the best one that's out there, the one that's probably the

most used is SBAR, situation, background assessment, recommendation, which is sometimes called the assertive statement. I think probably, the original intent of it was, for example, a nurse raising concerns to a physician and worried about not being listened to. So, "I've got this structure. I'm going to clearly convey my concerns and maximize the chance that they're actually going to listen to me to take action." So those situations, that's when I think structure really helps.

I think we also need to teach not just different structures and information content for different situations, but more generalizable skills in communication. So, "How do you get everyone on the same page? How do you make sure that context has been communicated? How do you ensure that there's been a real understanding?" Using techniques like teach-back, to make sure that it's not just that you've conveyed information, but it's been understood. That there's a mutual understanding of what needs to happen, now. That can be generalizable across any situation. We probably all need a little bit of training in doing those things with some experts in the field.

Dr. Ruth Adewuya, MD:

Just following those lines, one of the things that we need to include in talking about communication is language barriers and health literacy. You mentioned it at the get-go. How can providers address these challenges? Obviously, we're not all skilled in all languages.

Dr. Jeffrey L. Schnipper, MD, MPH:

When it comes to language barriers, we really do need to use professional interpreters, unless we are fluent in that other language and have gotten official approval to be essentially a medical interpreter. My Spanish is what I call advanced mediocre. I used to use it a lot, and I can't anymore. I'm a little sad that I can't use it in the hospital, anymore, but I really shouldn't. I should be using an interpreter. Again, because of the pandemic, we started using iPad links to professional interpreters. There are still times where I use the in-person interpreters, especially patients with cognitive impairment, hearing impairment. There are situations where they are truly better. I would say, 80% of the time having an iPad with an interpreter, that I can get in about 30 seconds, who can speak any language, has been incredibly valuable, and lowered our barriers to instantly having good quality bilingual communication with patients.

So, that's one thing. Health literacy is a different challenge. I use universal precautions. I assume that every patient has low health literacy. Patients who are health literate are not offended when you use tools and speak in terms that sort of assume low health literacy. If you make the opposite mistake, your patients and families will not understand what you're talking about.

I did a study with Sunil Kripalani, at Vanderbilt, a bunch of years ago, the Pill CBD study, where we created these discharge medication regimens using low health literacy friendly tool. So, next to the statin was a picture of bacon and eggs, letting them know this is their cholesterol med, and those kinds of things. It had a sunrise and a noon and a sunset and a moon, for different times of day. Then, we did a lot of training. Folks with low health literacy, in a effective way, how to do things like teach-back to ensure understanding. It turned out that the patients with low health literacy scores in our study benefited more than the other patients. If the gap towards you taking care of yourself, after you leave the hospital, is an information gap, and you can close that information gap by providing low health literacy friendly tools, then you have now improved their care. If there are other barriers to them taking care of themselves after discharge, where are you going to need to do additional things?

But, communication should never be the gap. We should be able to close it. Those patients had fewer post-discharge emergency room visits and readmissions because of the stuff that we did. But again, it

takes a little bit of training, doesn't take any extra time, I don't think. Creating the tools, probably takes a little bit of resources, again, upfront.

Dr. Ruth Adewuya, MD:

As you've done a lot of work in this area, have you also seen the need for cultural awareness, in terms of how patients show up and how they receive that information?

Dr. Jeffrey L. Schnipper, MD, MPH:

I think it is a need, and you are right. It is more than just a language barrier, or health literacy barrier. There are cultural barriers. One obvious point to make, but I'll make it, it's one reason why we need a diverse workforce. We need folks from as many backgrounds as possible, where patients can see themselves in the person that they are talking to. Training and cultural humility is again, important. I am not the expert in this area. I've certainly seen its importance, where I will leave a room and I'll say, "We weren't communicating effectively. There was a gap there. It was not the language I was speaking, or even the literacy level that I was using." We need to be humble about that. We need to try to bridge those gaps, but again, that takes time. As a hospitalist, we don't always have that time. We can't always find the perfect shit, in terms of another provider to take care of patients. I think we need to get help wherever we can and be a little humble about it.

Dr. Ruth Adewuya, MD:

I think it's important to recognize that the solution might not always be bringing in another provider who looks like your patient. The solution might just be a couple extra minutes, or using another resource, or maybe consulting in everything because the resources are not endless. As we mentioned, clinicians are already very stressed so the environment is already very, very fast-paced.

We've talked a lot about some of the issues that we've seen and the opportunities for improvement. I want to make sure that we also talk about some of the things that are going well. What are some examples that you've either seen, experienced, around interdisciplinary communication and collaboration that have really led to improved patient safety outcomes?

Dr. Jeffrey L. Schnipper, MD, MPH:

We've done a fair bit of work on, I guess I would use the term interprofessional collaboration, so this is physicians, PAs, nurses, pharmacists, therapists, working together with patients and their families to provide real team-based care. Again, was more successful before the pandemic. We had started doing a lot more bedside rounds with patients, with all of the care team members present.

Just getting the physicians and the nurses in the same room with the patient, in morning rounds, made a huge difference. It was more efficient. We spent more face time with the patients. The patients loved that, even if some of what we were doing was weeding off lab values off a computer in their room. Again, you didn't have to change the plan. You would come up with a preliminary plan and you'd examine the patient, "Oh, they're volume overloaded. Let's change our plan for the Lasix dose." You just do it once.

So, that worked really well. Mostly what it did was, it improved interprofessional communication. Everyone had their role in the things they were supposed to talk about, learning from each other, getting on the same page, reinforcing each other's messages was incredibly important.

A colleague of mine, Jason Stein, does cyber rounds, as he calls it, structured interdisciplinary bedside rounds where every member of the team has a script. They have a sequence in how they do the rounds,

and who says what, when. Again, they can be pretty fast, but it gets everybody on the same page. We're not talking in silos. We're learning from each other. We're delivering better care, frankly, because we have so much to learn from our other colleagues.

Dr. Ruth Adewuya, MD:

It's really encouraging to hear the many ways that people are doing it. Right? There's two things. One is that your ability to do that, and do that successfully, is dependent on the culture and the environment of that organization. You can't bring together people who don't want to work together, or don't want to speak to each other, and bring them into a room, basically duke it out. But also, on the flip side, bringing teams together can help improve the culture and help to foster that better communication. Those are really great examples that you've surfaced, there. Just wrapping up, How can providers manage communication effectively during high stress situations so that they can avoid errors and ensure patient safety?

Dr. Jeffrey L. Schnipper, MD, MPH:

In the hospital, I feel like every situation is high stress. Right? As we said a little bit before, the higher stress the situation, the more there is need for structured communication tools that we can fall back on, to make sure that we're not missing anything. Using read back effectively or synthesis effectively, if you're using iPass for a handoff, to make sure that questions have been answered and the information has been understood.

When pilots talk to each other in the cockpit, you better believe they do read back. I wouldn't get on a flight without it. Yet, with healthcare, we do all kinds of communication, all the time, without ensuring in any way, shape, or form, that the recipient has understood what we're talking about, and there's a shared understanding. So, structured communication with read back, I think, is incredibly important, especially in these high stress situations.

Then, the issue of time is always going to be our biggest barrier with all of this. "I don't have the time to spend." If you don't spend the time up front, you'll be spending the time later. So again, this idea of investment, I think, is a frame shift, takes a little bit of cultural change, but is incredibly important. We need to be spending our time with our patients, communicating with them, or with each other as collaborators.

Technology can help. We need to think about, "What could we get rid of in our day, to make this a priority?" Maybe, AI can write our notes for us, while we're talking to the patient.

Dr. Ruth Adewuya, MD:

I mean, maybe. If that means that we can spend more time with the patients. I hear what you're saying about the investment. It is an investment. It is time. How you choose to spend your time, hopefully with the most rewards at the end, I think is something that every clinician will have to think about. I think a lot of what we talked about has been this idea of bringing in the patient into the journey of their care. Communication is such a huge part of that. Also, recognizing that the clinicians and the healthcare providers are the ones that have the expertise. So, how can healthcare providers balance their expertise with this need to also have this shared decision-making with the patient, so that ultimately they're well-informed, they're actively involved, and they actually execute on their treatment plans?

Dr. Jeffrey L. Schnipper, MD, MPH:

Yeah. One minor edit to your question, which is, "as actively involved as they want to be." There is still generational differences, cultural differences, around how active patients want to be in their own care.

Dr. Ruth Adewuya, MD:

Yeah.

Dr. Jeffrey L. Schnipper, MD, MPH:

Some are still happy to say, "Whatever you say, doc, is what I'll do." Or, some will say, "What would you do if it was your mom, with this decision?" But, in general, we are certainly moving. A lot of people want us to move towards being involved in their own care. It gets a little bit back to this. We need to start by understanding what's important to them. What patients are experts in is how they feel, their own values, their own agendas. If we understand those, then hopefully, they will let us provide the expertise on how the medical details can help them achieve what's important to them.

Then, patients are still going to have the right to do what they want, and we have to acknowledge that. They're not all going to do what [inaudible 00:27:01], and that's okay. But, if we can help them achieve the goals and the values that are important to them, and explain to them what we think in our opinions are the best ways to get there, hopefully they see that we have their best interests at heart, so they put their trust in us, and maybe, do take the time to listen to our expertise. But again, they can always choose not to, and that is certainly their right.

In the end, that's what patient-centered care is really about. Right? It's about achieving the goals that are important to our patients. Again, it starts with active listening and a little humility and a little bit of time. Hopefully, we can get there.

Dr. Ruth Adewuya, MD:

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