The Importance of Effective Communication in Healthcare Practice

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Abstract

Effective communication is of the utmost importance when delivering healthcare. Without it, the quality of healthcare would be impaired. Healthcare costs and negative patient outcomes would increase. There are multiple components to effective communication in a healthcare setting: healthcare literacy, cultural competency and language barriers. If any one of these components is compromised, effective communication does not occur. Effective communication is bidirectional between patients and healthcare systems. If either the patient or health care provider lacks clear understanding of the information conveyed, the delivery of care is compromised. The purpose of this review is to analyze the components of effective communication in a healthcare setting, cite current professional standards for each and propose solutions for improvement.

Effective Communication

Effective communication can be defined as verbal speech or other methods of relaying information in order to get a point across.¹ If communication cannot be effective. Effective communication within a healthcare setting is critically important. Workers of varying skillsets within a healthcare setting must communicate clearly with each other to best coordinate care delivery to patients. Some of these skillsets can be very different. For example, the role of a physician is very different from the role of an occupational therapist. However, both must communicate clearly with each other to ensure that appropriate care recommendations are met.

With regards to patient-system interactions, communication is bidirectional:

1) Patients need to be able to convey information about their health complaints to healthcare workers.

2) Healthcare workers must be able to adequately comprehend and interpret the information in order treat health complaints appropriately.

3) In order to decrease the risk of health complaints from recurring, healthcare workers must convey adequate information to patients to help them take preventative measures in order to maintain their health.

If any of the aforementioned step of this process is compromised, healthcare delivery becomes ineffective. Ineffective healthcare delivery increases the likelihood of negative patient outcomes. It also increases patient utilization of inpatient and emergency care. Consequently, the cost burden of the healthcare systems increases.

For example, if the necessity for taking statin medication is not conveyed to the patient, he/she will not realize its importance and his/her high cholesterol will go unchecked. If the complications of statin medication are not conveyed to the patient, he/she might not realize that his/her muscle aches and darkened urine are a rare complication from taking the medication.

Healthcare workers may make mistakes due to lack of comprehension of the patient’s concerns. The most likely scenario where this would arise is when taking the history of present illness (HPI) from the patient. Misunderstanding the timeline of the HPI can lead to healthcare workers focusing too much on a particular differential diagnosis. Or they may even discount a potential differential diagnosis entirely. For example, did a patient syncopize before or after their fall? If they syncopized afterwards, you simply need to be focused on mechanical complications from the fall. However, if they syncopized before, then you need to expand the differential diagnosis to include potential neurological and cardiovascular causes.

The Joint Commission defines a three-pronged approach to addressing effective communication in a healthcare setting. This approach requires that, healthcare systems incorporate methods to assess

1) Patient health literacy;
2) Cultural understanding and;
3) Language barriers.

The above methods should be standardized throughout the system. If any of these components is compromised, effective communication does not occur. Methods for assessing these three components should be integrated into healthcare systems on an individual and system-wide level. Merely performing assessments without integrating them into pre-existing workflow processes leaves room for ineffective communication to take place in other areas of the organization.

Assessments for diagnosing problems with components of effective communication should be standardized throughout all healthcare systems in order to ensure comprehensive and effective communication throughout.

The care coordination model employed by most healthcare systems is called the “Care Model.” After the implementation of the Affordable Care Act, this model was expanded to incorporate concepts from the Primary Care Medical Home. The current standard is presently called the “Expanded Care Model.” The core philosophies of the Expanded Care Model include: 1) patient self-management support, 2) healthcare delivery systems, 3) healthcare decision support and 4) clinical information delivery.

The design of all patient care services should be patient-centered, timely, efficient, evidence-

based, safe, and coordinated. The Expanded Care Model delineates the above guidelines for healthcare teams to be prepared and take proactive steps in ensuring positive patient health outcomes. Consequently, patients would be informed about healthcare processes and empowered to become active participants in decisions regarding their health.³

In its Health Literacy Universal Precautions Toolkit, the Agency for Healthcare Research & Quality describes the concept of “universal precautions”.⁴ Universal precautions imply that health care systems should approach all patients with the assumption that they are at risk for not understanding their health conditions or how to deal with them. Healthcare systems should confirm the patient’s understanding through use of assessments and add to the patient’s understanding if necessary;¹ doing so will help organizations isolate and address sources of ineffective communication more readily.

Complex assessments may be time-intensive and impractical to implement within busy practice settings. Assessments employed should be simple to administer and evaluate. Also data entry for the administered assessments should fit into pre-existing workflows. A 2008 study using Pfizer’s health literacy tool, called the “Newest Vital Sign,” concluded that minimal time was needed to implement the screening.⁵ The greatest proportion of time needed during day-to-day processes was related to scoring and data entry. Minimal time and cost were needed to program an additional field for score entry into their pre-existing electronic medical record. The study found that the most time-intensive component was the re-education of providers on screening tool processes. Without re-training, providers had a tendency to revert to their original method of care delivery and health communication.⁵ Staff buy-in is a considerable hurdle to cross since, staff quite often will be resistant to changing accustomed care delivery behaviors without proper incentive. For this reason, any new assessment implemented by healthcare systems should include the cost of added compensation for the staff. This incentive does not necessarily have to be financial in nature and should best suit the needs of the practice.

Patients at-risk for ineffective communication should be identified during the pre-visit chart review. Patients should be provided with patient information/assessments upon intake (preferably in dual visual and audio formats). While in the waiting room, patients will have the time to peruse patient information and complete assessments. Supplemental information typically acts as an impetus for patients to initiate dialogue with their healthcare provider. Before the end of the healthcare encounter, patient’s understanding should be gauged and any information discussed should be provided to the patient in a simplified format.

Health Literacy

Health literacy can be defined as the patient’s ability to obtain, comprehend, communicate and understand basic healthcare information

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³ AHRQ Health Literacy Universal Precautions Toolkit. 


⁵ Sudore RL, Schillinger D. Interventions to Improve Care for Patients with Limited Health Literacy. JCOM. 2009;16(1):20-29
and services. By possessing these abilities, individuals are better equipped to make appropriate healthcare decisions and, thus, improve their health outcomes. Health literacy does not simply involve managing disease. Through incorporating the concept of population health, health literacy can be broadened to encompass any-and-all topics which can influence healthcare outcomes (for example, finances, public policy, housing, trauma prevention, social awareness, climate change etc.)

The knowledge to navigate all societal structures impacts health outcomes both directly and indirectly. If someone has a financial hardship, such as bankruptcy or foreclosure, it might cause them undue stress that may negatively affect their health. If someone is making minimum wage and has to choose between keeping food on the table or healthcare, they may forego regular health maintenance and thus allow chronic health conditions to go unchecked. If someone lacks adequate knowledge of driving safety and defensive driving, it increases the likelihood that they meet with a potentially fatal car accident. If someone cannot read, they might not be able to understand the instructions to their medication and unintentionally misuse them. These are only a few examples of how healthcare touches every aspect of our lives.

Improving health literacy within a clinical setting should take a multi-step approach: 1) Assessment of baseline patient literacy 2) Provision of multi-format patient education 3) Ensuring that all members of healthcare staff provide quality communication to the patient 4) Confirmation of patient understanding. Each of these steps should be accompanied by an

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action plan.\textsuperscript{4,8,11,12} The Plan-Do-Study-Act (PDSA) method is typically used in creating an action plan. The PDSA method is a cyclic process performed periodically for continuous process improvement. This method involves: 1) performing an assessment of baseline capabilities, 2) setting benchmark goals, 3) implementation of interventions, 4) reassessment of outcome metrics periodically and 5) augmentation of approach if necessary.

All staff should receive periodic in-service education on their role within health literacy improvement processes.

**Assessment of Baseline Patient Literacy**

Assessment of baseline patient literacy is crucial since it creates an impetus for initiating dialogue between patients and healthcare providers that would not have existed otherwise. Low health literacy is not something that patients advertise. On the one hand, they may be unaware of the importance of certain healthcare matters. However, patients often feel stigmatized due to their low health literacy. For this reason, they may be less likely to disclose their lack of comprehension during healthcare encounters. In addition, studies have shown that healthcare providers tend to overestimate their ability to convey information to patients.\textsuperscript{8} Healthcare providers typically use methods based on subjective assumptions to assess health literacy. However, formal assessments would allow them to determine the underlying cause of a patient’s low health literacy without the influence of personal bias.

Current assessment tools readily used to assess health literacy include the Wide Range Achievement Test, Rapid Estimate of Adult Literacy in Medicine and the Test of Functional Health Literacy in Adults. However, these assessments are very time-intensive and may be impractical to implement within a busy medical practice. Health literacy assessments should be easy to implement and fit seamlessly into pre-existing workflows. Pfizer’s health literacy tool, the Newest Vital Sign, is simple to implement. However, it only focuses on nutritional matters and fails to comprehensively address all aspects of health literacy. In short, healthcare systems should implement health literacy assessments that best suit the needs of their practice and are proven to be effective. Any health literacy assessment a practice chooses to implement should be continuous and not simply be relegated to a single encounter.

**Provide Multi-Format Patient Education**

All patients possess different capacities for learning. For this reason, patient information should be provided in multiple formats. Preferably it should be provided in dual visual and audio formats. In addition, patient material should be able to accommodate for visual, hearing and cognitive impairment. Patient information materials are of the utmost importance during healthcare encounters since they routinely prompt patients to ask questions of their healthcare providers that they might not have otherwise.

There is no clear consensus with regards to the level of difficulty information patient populations are able to comprehend. The Center for Disease Control and Prevention recommends that patient information should be no higher than an eighth-grade level. However, the American Medical Association and National Institutes of Health recommend that patient information should be no higher than a sixth-grade level. However, a 2007 study
concluded that grade level attainment is a poor predictor of patient health literacy. The study purported that reading fluency is a stronger predictor for adequate health literacy since grade level attainment did not account for lifelong learning or age-related declines in comprehension.  

In addition, patients are more likely to successfully interpret single-step directions over multi-step directions. In a study by Davis et al. (2006), patients had a higher likelihood of accurately interpreting single-step drug labels with low literacy scores than multi-step or higher literacy score labels.  

Several standardized assessments for readability of patient materials currently exist. Examples of such tools include the Flesch Reading Ease score, the Flesch Kincaid Grade, the Gunning Fog index, SMOG Readability formula, the Fry Readability Graph, The New Dale-Chali readability formula, the Suitability Assessment of Materials and the Lexile Framework. These assessments measure categories such as content, literacy demand, graphics, layout, typography, cultural appropriateness, word frequency, syllable count and sentence length. By giving the readability of patient information a numerical score, healthcare systems can better formulate appropriate material for their patient population.  

The general rule-of-thumb to improve readability of patient materials includes: 1) focusing material on a single message, 2) using a plain language standard and avoiding medical jargon, 3) using a conversational style as if talking to someone verbally, 4) using analogies that are culturally appropriate to your target patient population, 5) limiting the amount of details included in the material to only essential information, 6) placing relevant images that are culturally appropriate next to the corresponding text and 7) placing appropriate captions that highlight areas of interest next to the corresponding pictures.  

Patients with poor health literacy may not only have problems with reading. They also may have problems with conceptualizing risk factors. For this reason, representative individuals from the target patient population should be involved in the creation of patient materials as an additional quality assurance measure.  

**Improve Patient Communication with All Staff**  
All staff that comes into contact with patients has a role to play in the delivery of their healthcare. Poor communication with any member of the healthcare staff can disrupt a patient’s comprehension of healthcare matters. For this reason, it is important for all staff to buy into health literacy improvement processes. General strategies for clear communication include: 1) giving a warm greeting, 2) maintaining eye contact, 3) listening carefully, 4) being aware of the patient’s body language as well as their own, 5) speaking slowly and concretely in non-medical language, 6) using graphics and demonstrations when appropriate and 7) encouraging patient participation and questions.  

When conveying information to patients, it is important to address: 1) what is wrong, 2) what the patient needs to do and why, 3) how they

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do it, 4) what to expect (both pros and cons) and 5) alternatives (including no treatment).

**Confirm Patient Understanding**

Finally, the patient’s understanding of healthcare matters should be confirmed. Without confirmation, there is no guarantee that patients will be able to perform the complicated demands that the healthcare system expects of them. The most widely accepted method to confirm patient understanding is called the “Teach-Back Method.” The Teach-Back Method requires that healthcare workers ask patients to repeat all information conveyed to them during the healthcare encounters. Any misunderstandings should then be pointed out and corrected. The Teach-Back Method should be used as many times as necessary until the patient has a full understanding of the concepts. All staff within a healthcare practice should be using the Teach-Back Method. In addition, all information should be provided in a format that patients can take home. Self-maintenance and preventative tasks should be simplified and fit seamlessly within the patient’s lifestyle (for example, medication reconciliation, easy-to-interpret drug labels and pill-boxes for organization etc.). If possible, patients should be connected to resources within their communities to aid in self-maintenance and prevention.

**Cultural and Language Competency**

Cultural competency can be defined as a strategy to eliminate racial and ethnic disparities in healthcare. The Office of Minority Health includes the ability to meet patient’s linguistic needs in this concept. Cultural competency seeks to change the one-size-fits-all approach of the current medical practice and tailor healthcare delivery to the individual needs of a diverse patient population. Cultural competency does not pertain to the racial and ethnic disparities created by unequal access to healthcare services. A culturally competent healthcare system provides high quality care regardless of race, ethnicity, culture or language proficiency for patients who are already members of the patient population. Disparities in healthcare provision due to the lack of cultural competency are entirely created by the pre-conceived biases already present among healthcare workers. This inadvertently influences the way they deliver healthcare. Studies have shown that ethnic minorities are more likely to perceive that the healthcare staff had negatively judged them and treated them with disrespect due to their race, ethnicity or how well they spoke English. They are also more likely to be less satisfied with the care they receive and believe that they would have gotten better care if they belonged to a different race. Ethnic minorities of low socioeconomic status and elderly demographics tend to have more passive interactions with physicians and are not given the opportunity for shared decision-making in their healthcare. Most healthcare practitioners are not racists. However, they tend to assume that the aforementioned groups are less health literate due to an inability to relate to them on a cultural basis. Studies have shown that race-and-socioeconomic-status-concordant physicians had more meaningful interactions with their patients than those from different groups. Patients with race-concordant relationships with their healthcare provider tended to report greater satisfaction with the care than those who did not. Poorer health outcomes occur when sociocultural differences between patients and staff are not reconciled during the healthcare encounter. Current standards for culturally and linguistically

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appropriate services are set by the Office of Minority Health. These standards are divided into the following categories: 1) governance, leadership and workforce, 2) communication and language assistance and 3) engagement, continuous improvement and accountability.\textsuperscript{13}

Cultural and linguistic competency is necessary throughout every level of a healthcare organization. The first step in achieving cultural and linguistic competency is to perform a baseline community needs assessment of the organization's patient service area to determine typical patient demographics. One way to increase cultural and linguistic competency is to hire staff that are representative of target demographics for the organization. However, this strategy is not always feasible. Therefore, in-service cultural competency training should be mandated for all staff. Ideally, a representative member of the target population should be involved in the creation of the training curricula. Language services should be incorporated into the organizational structure and the staff should be trained to utilize the system. Language barriers are not always immediately evident. Patients can identify themselves as being fluent in English but only have an incomplete understanding of the language. The staff may believe themselves to be competent in conversing in another language when they actually are not. For these reasons, the staff should be trained to utilize language services each time any language discrepancy occurs. All cultural and linguistic concerns should be addressed in an action plan that determines baseline capabilities and tracks improvement.

Currently, formal screening to assess barriers to cultural and language understanding do not exist. Any assessment organizations wish to implement should meet the needs of the patient population and be proven to be effective.

Conclusion

Ineffective communication nullifies any attempt at care provision. The quality of care health workers provide does not matter if patients do not understand what they are being told. This leads to negative patient outcomes, increased utilization of emergency and inpatient services and a greater cost burden on healthcare systems. Effective communication includes health literacy, cultural competency and language barriers. Interventions to address each component should be incorporated into every level of healthcare organizations and fit seamlessly into pre-existing workflows. Corresponding action plans should be created for each component in order to determine baseline capabilities and track improvements. Optimizing all components of effective communication will improve patient outcomes and lead to greater monetary savings which can then be reinvested in the organization.