

Communicating complex information

What do we want the workforce *to know* and
confidently *do*?

Prof Alf Collins

Clinical Director for Personalised Care

NHS England

All tribes communicate in their own language

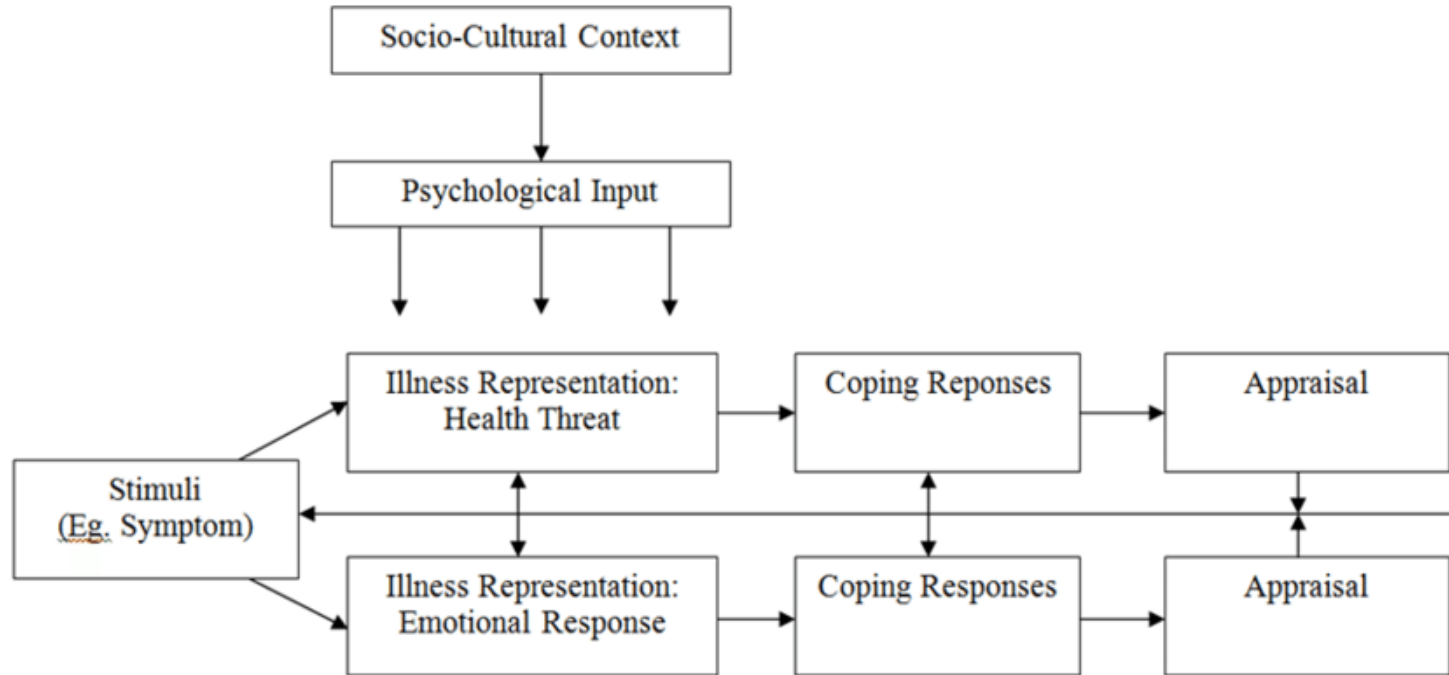


And professional groups use their own professional language to communicate with one another

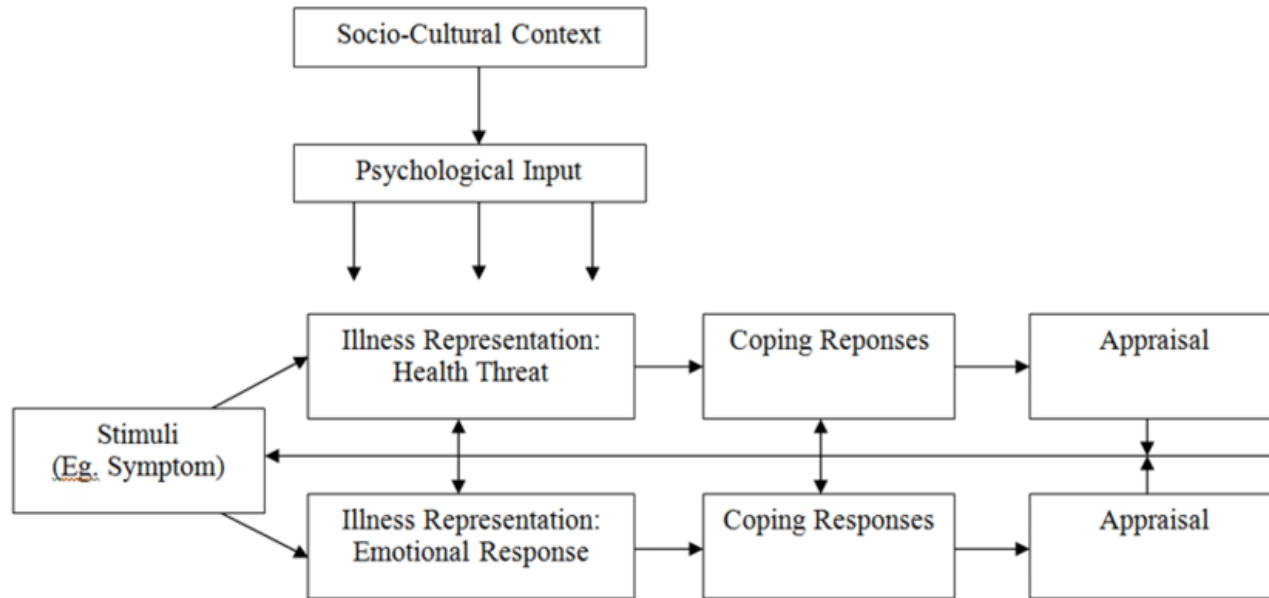
Update ESR12 re: COI/DOI



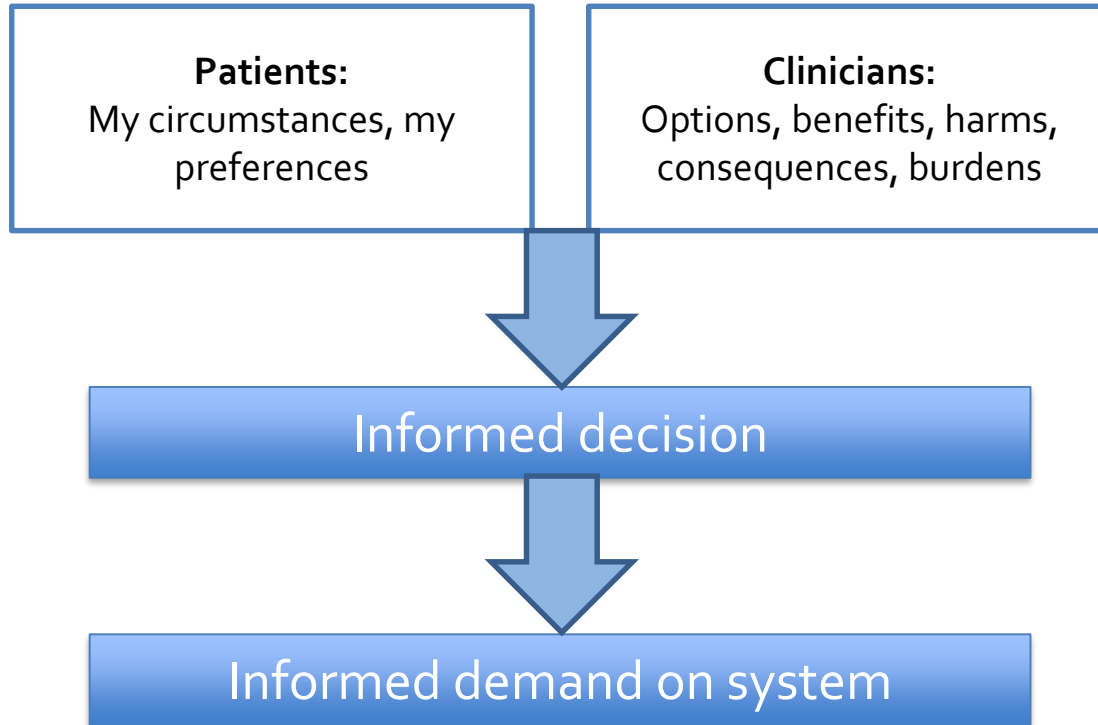
Illness as a threat to identity: the 'common sense model' of self regulation. *Leventhal H 1997*



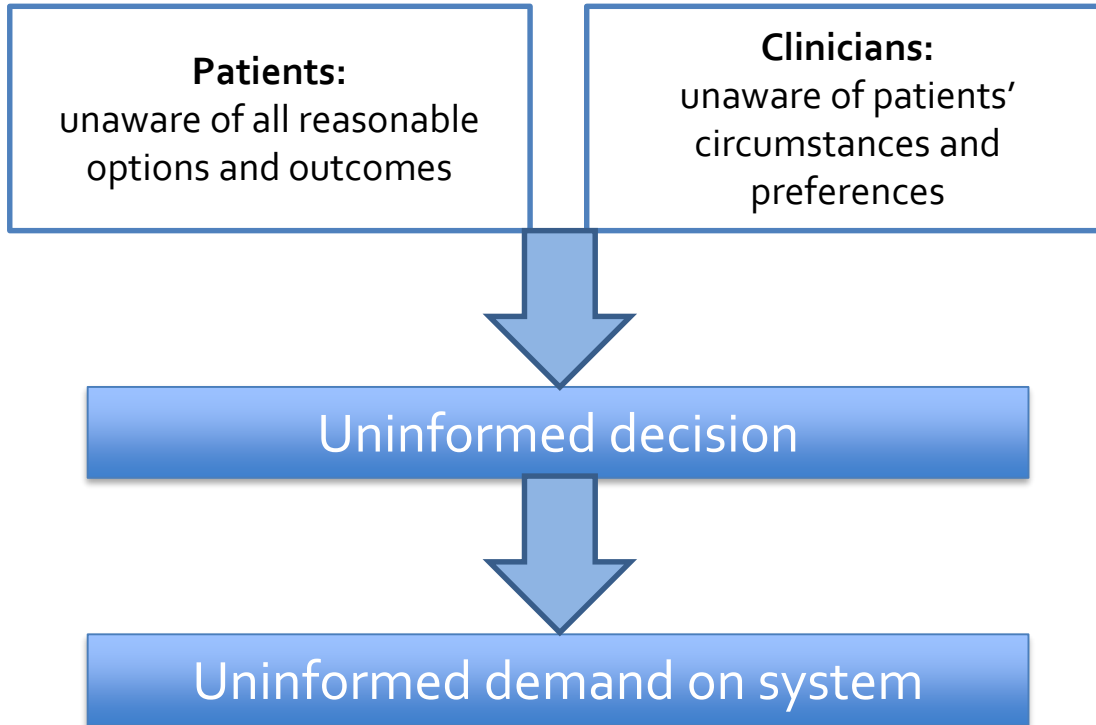
Health information can reinforce adaptive (coping) responses or maladaptive (anxiety/avoidance) responses



Shared decision making



The Silent Misdiagnosis



The 3 talk model



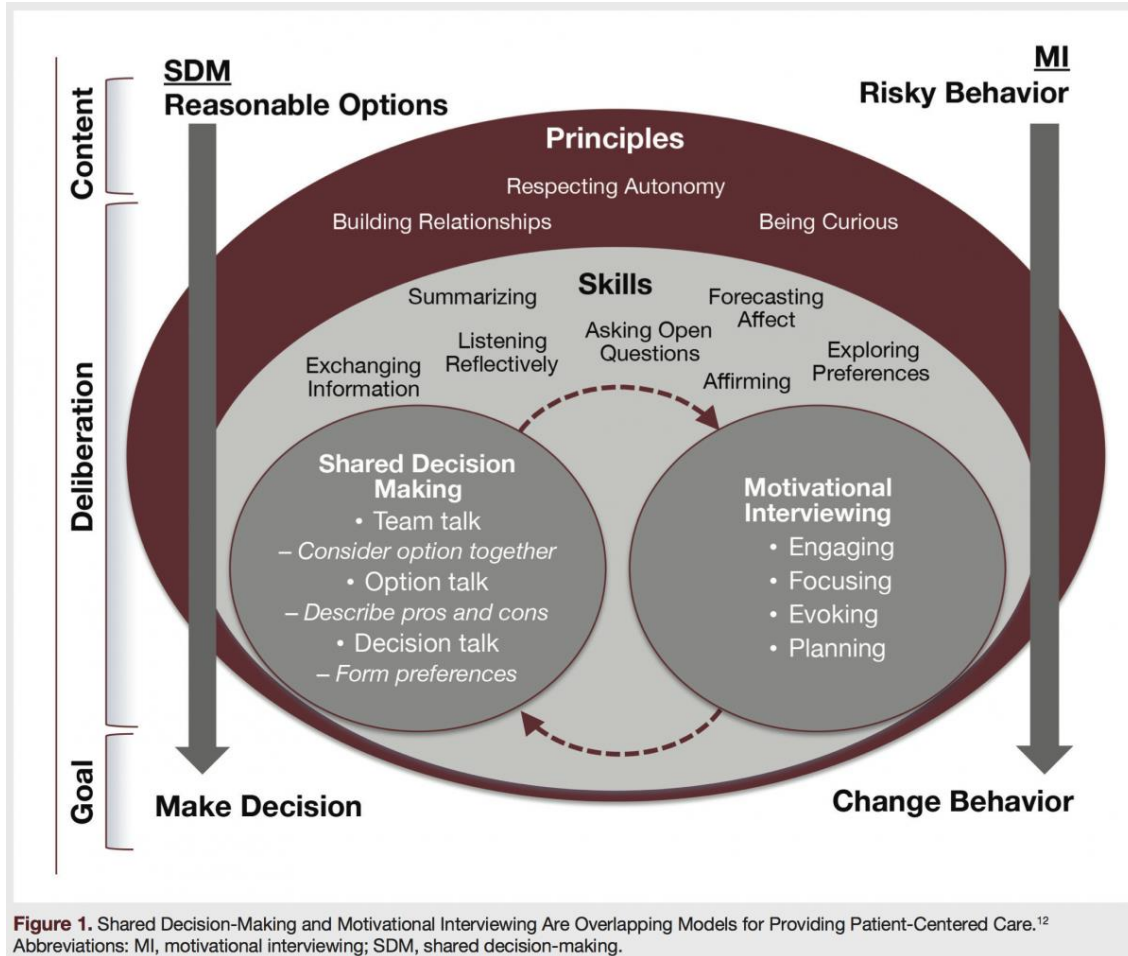
Team talk Explain the intention to collaborate and support deliberation

Option talk Compare alternatives

Decision talk Elicit preferences & integrate into subsequent actions

Three Talk Collaborative Deliberation Model ©

Glyn Elwyn 2015



Risk communication



Absolute and relative risk

RELATIVE RISK

*New drug
reduced cancer
incidence by
50%*

ABSOLUTE RISK

*New drug reduced
cancer incidence
from 2 per 1000 to
1 per 1000*

Absolute risk is more useful at communicating the true impact of an intervention, yet it's often not reported in the research and the news

Communicating risk- tips

- Use a clear and consistent lexicon
 - *Benefit*
 - *Harm*
 - *Uncertainty*
 - *Risk* has a statistical meaning for most clinicians; the meaning for most patients is *possible threat*
 - *Chance or likelihood* preferable for patients

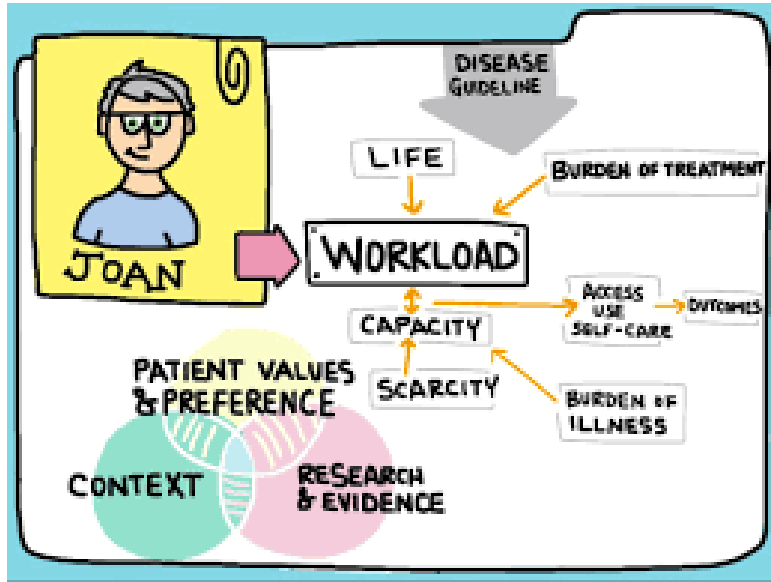
Use natural frequencies with the same denominator

- 1 person in every 1000 develops...
- 3 people in every 1000 develops...
- However we know that $1/10$ is seen as less risky than $10/100$

Link in to every day experience and everyday language



Don't forget *consequences* and *burdens*



ANALYSIS

We need minimally disruptive medicine

The burden of treatment for many people with complex, chronic, comorbidities reduces their capacity to collaborate in their care. **Carl May, Victor Montori, and Frances Mair** argue that to be effective, care must be less disruptive.

Chronic disease is the great epidemic of our times, but the strategies we have developed to manage it have created a growing burden for patients. This treatment burden induces poor adherence, wasted resources, and poor outcomes. Against this background, we call for minimally disruptive medicine that seeks to tailor treatment regimens to the realities of the daily lives of patients. Such an approach could greatly improve the care and quality of life for patients.

Non-adherence, culpability, and susceptibility
 Poor adherence to medical advice and drug regimens is a global problem with a long history. Non-adherence is important because many therapeutic interventions are effective only if used correctly, which requires continuous personal investment of time and effort from patients. The epidemiological transition from acute diseases, where the emphasis was on cure, to chronic illnesses that instead require management also means that patients take on a lifetime burden. Poor adherence can lead to complications in professional-patient relationships, additional ill health and expenditure for patients and their families, and the waste or misallocation of healthcare resources.^{1,2}

The aetiology of non-adherence is complex, but individual culpability has been assumed to play an important part.³ People with chronic (and other) illnesses who do not adhere to treatment generally say that they recognise that they ought to do otherwise but that they lack the capacity, skills, and understanding to do so. In one study, 45% of patients gave such reasons for intentionally not adhering to treatment for chronic illnesses.⁴ Recent research on adherence has focused, therefore, on interventions. The aim of these interventions is twofold: to improve patient uptake of treatments by giving them tools to share in understanding the relevance and importance of certain behaviours and treatments; and to encourage them to “buy in” to those behaviours and enhance their ownership of therapeutic regimens. Much of the research has been done in the context of randomised controlled trials of treatments

for quite narrowly defined patient groups. This our understanding of adherence is of limited applicability to usual care.^{5,6}

Chronic illness and chronic workload
 Studies that examine adherence often exclude two large groups of patients that health professionals encounter in real life: people who have diminished capacity to cope with therapeutic regimens because of cognitive impairment and people with multiple chronic comorbidities. Both groups often present complex social problems that are related to their illness and confound treatment.⁷ Perhaps more than 60% of older people have multiple chronic conditions, representing an increasing proportion of people who need health care.^{8,9}

The burden of chronic illness falls not only on health services but also on patients and carers, as the work of managing chronic disease increasingly shifts from the clinic to the home. They must cope with increasingly complex treatment regimens and work to normalise these in their daily lives (see example 1 in box).¹⁰

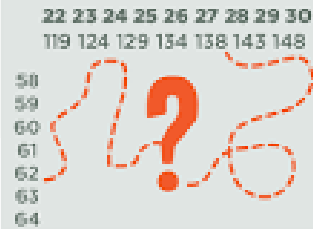
Other factors exacerbate this situation. Treatment burdens are often imposed on patients with little coordination between, or even within, clinics dealing with different conditions and little explicit recognition that treatment regimens are demanding in time and effort. In addition, evidence-based guidelines provide disease specific guidance for doctors but often fail to acknowledge multiple modalities as management



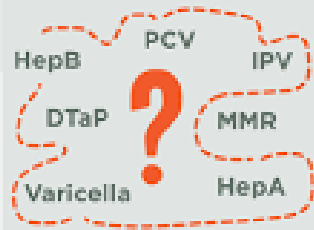
Health literacy

-----> **More than 1 in 2 adults can't:** <-----

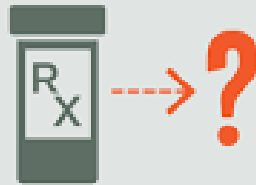
Use a BMI graph to find their healthy weight



Understand a vaccination chart



Read a drug label



MORE THAN 80% of health information provided in a doctor's office is forgotten before patients or parents get home.

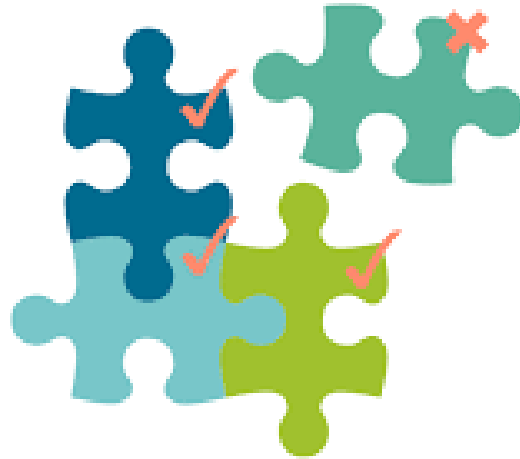
MORE THAN HALF of the recalled information is remembered incorrectly.^{1,2}

3 simple steps to improving health literacy

1. Remember Leventhal: use 'common sense' and helpful/positive/optimistic information that runs a low chance of being misinterpreted:
 - Health professionals tend to speak the language of illness/pathology (arthritis/risk/infection) and much of that language has 'folk meanings' that reinforce the health threat axis of the common sense model

3 simple steps to improving health literacy

2. Use ***chunk and check*** and pick up on behavioural cues.
Consider rephrasing if necessary



3 simple steps to improving health literacy

3. Use *teach back*.



*'I want to check I've explained this well enough:
Could you tell me/show me what you have learned/what you plan to do?'*

Thank you

Alf Collins

Alf.collins@nhs.net