Patient Interaction Training:
Differently Communication Accesses Patients

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Objectives

- Improve understanding of differently abled prevalence
- Improved understanding of communication technologies
- Identify & distinguish between helpful modifications for effective communication

Factors Impacting Communication

- Age of onset
- Etiology
- Type
- Language Skills
- Residual Hearing
- Speechreading Skills
- Speech Abilities
- Abilities Cognitive
- Personality Characteristics
- Family Environment
- Educational Background
- Personal Preference


Physical
Linguistic
Cultural
Barriers to Communication
Interpersonal
Organizational

People with Disabilities

- The Morbidity and Mortality Weekly Report (MMWR) has published a report describing the percentage of adults with disabilities in the 2013 Behavioral Risk Factor Surveillance System (BRFSS)
  - Over 53 million adults living in communities in the United States have a disability
  - The most common functional disability type was mobility disability, reported by about 1 in 8 adults

Mobility Patient’s Experiences

Blindness & Vision Loss

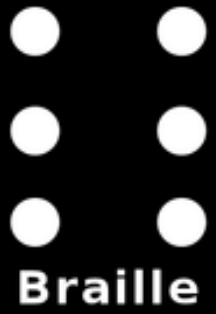
- More than 3.4 million (3%) Americans aged 40+ years are either legally blind or are visually impaired
- 17% of the age 65+ population report “vision trouble”
- 21 million Americans report functional vision problems or eye conditions that may compromise vision

Blind & Visually Loss Patients

- Always treat a blind person normally; speak first and introduce yourself
- Once in a conversation, never leave without saying you are doing so. Do not allow the blind person the embarrassment of talking into the air!
- Ask for details of where and how he/she would like to be guided. Go at their pace and , if there is space, walk side by side and always ‘hand to arm’
- Describe any sudden changes in the environment. It is also important to explain changes in ground surfaces

Blind & Visually Loss Patients

- Label patient chart with universally-recognized icon indicate blindness or communication needs



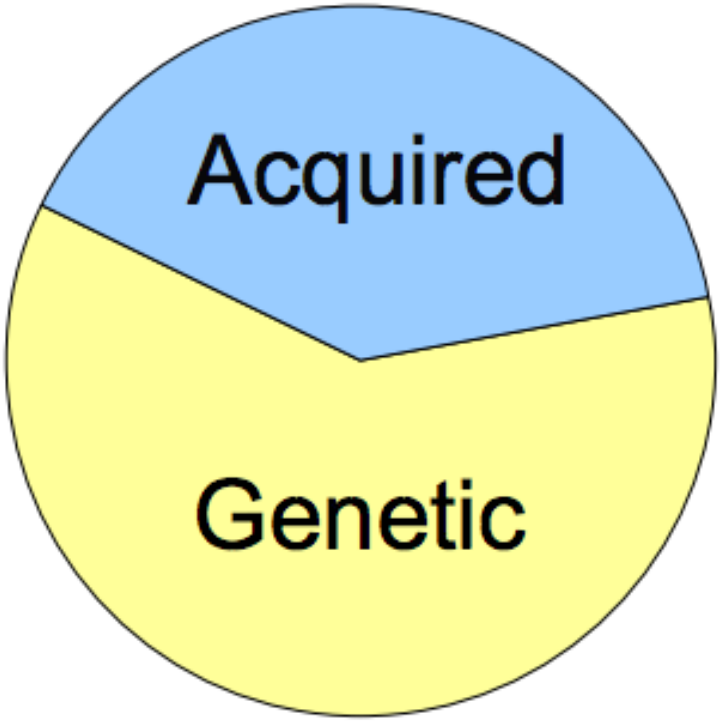
- When providing written information, make sure it is in a readable size and font and pass it to an attending sighted care giving for future reference

Hearing Loss Prevalence

- About 2-3 out of every 1,000 children are born with a detectable level of hearing loss in one or both ears
  - More than 90% of deaf children are born to hearing parents
- 37.5 million adults report some degree of hearing loss
- About 2% of adults aged 45 – 54
- 8.5% of adults aged 55 – 64
- 25% of adults aged 65 – 74
- 50% of adults aged 75+
- 2.1 million individuals are identified/diagnosed with hearing loss annually
- 28.8 million U.S. adults could benefit from using hearing aids

(NIDCD, 2016)

Etiology of Hearing Loss



- Infection
- Drug-Related
- Acoustic trauma
- Acoustic exposure
- Structural
- Unknown

- Non-syndromic
- Syndromic
  - Recessive
  - Dominant
  - X-Linked

(NIDCD, 2016)

Health Literacy

- Deaf adults were found to have lower health literacy compared to their hearing counterparts**

- Environmental Factors
  - Incidental learning (cannot overhear radio/TV/spoken conversations)
  - Hearing families & lack of communication
  - “Dinner table syndrome” (i.e. Mom telling Dad about Aunt Pam’s stroke)

Continue Health Literacy

- Professional Factors
  - Language (e.g. interpretation of “HIV & test results”)

- Patient Factors
  - Insufficient communication (e.g. incorrect use of medication)
  - Illegal practices (e.g. signing consent forms without understanding)

** The Current State of Health Care for People with Disabilities by National Council on Disability, Washington, DC

Models of Deafness: Medical

- “deaf” or “hard of hearing”
  - Note the lowercase “d”
  - These individuals do not see themselves as members of Deaf culture
  - Some may know sign language
  - Primary language is spoken/written English
- “Deafened” (i.e. “late-deafened”)
  - Frequently used by post linguistically-deaf adults ages 20+
- “Hearing-Impaired”
  - Often used by media, healthcare professionals, & society in general to refer to people with a hearing loss
- A more acceptable generic phrase is “deaf and hard of hearing” to refer to all people with a hearing loss

Models of Deafness: Sociocultural

- Deaf People
  - Members of the Deaf community who share common values, norms, traditions, language, and behaviors
  - Do not perceive themselves as having lost something (i.e. hearing) and do not think of themselves as handicapped, impaired, or disabled
  - Celebrate and cherish their culture because it gives them the unique privilege of sharing a common history and language
  - Are considered a linguistic minority within the American culture. They have their own culture and at the same time live and work within the dominant American culture
  - Within the Deaf culture, the term “hearing impaired” often is seen as offensive. It suggests the Deaf people are “broken” or “inferior” because they do not hear.
    - Preferred term is “Deaf” or a person “with a hearing loss”

Barriers & Challenges

- Inadequate or insufficient technology
- Inadequate communication access in ASL
- Failure of medical training programs to adequately prepare medical staff to communicate with Deaf/Hard of Hearing individuals
- Deaf patient mistrust/misunderstanding of healthcare providers
- Differing cultural norms

Oral Deaf Patients

- Get attention before speaking
- Highlight key themes
- Define important words
- Speak slowly and clearly
- Keep area around mouth clear
- Maintain eye contact with Deaf person
- Use words “I and you” when speaking to Deaf person
- Avoid standing directly in front of light sources
- If asked to repeat, first repeat verbatim, then rephrase
- Don not assume all individuals can or wish to use pen/paper
- Look directly at Deaf person (facilitates patient-provider alliance)

Types of Interpreters

- Sign language / ASL Interpreter
- Oral Interpreter
- Multi-Lingual Interpreter
- Tactile Interpreter & Support Service Provider (SSP)
- Certified Deaf Interpreter (CDI)
- Pro Tactile DeafBlind Interpreter
- Video Relay Services (VRS)
- Video Remote Interpreting (VRI)
- CART: Communication Access Real-time Translation

ASL Interpreters

- Always use interpreter for informed consent
- When the interpreter is present, talk directly to the patient
- Avoid talking about the patient in their presence
- Avoid saying, “ask him” or “tell her”
- Maintain eye contact with Deaf patient
- Ask Deaf person to choose best seating for communication
- Interpreter will stand or he seated near primary speaker
- Allow time to view visual aids before offering explanations
- Slow down pace of communication slightly

Things to Avoid

- Avoid using family members!!!!!
  - Seldom objective
  - May be emotionally distraught
  - May be unable to deliver difficult news
  - Confidentiality is an issue
  - Their use is not legally defensible in a court of law for all but the most extreme emergencies and even then, only until a qualified interpreter can be sought

Video Remote Interpreting: When Is It Appropriate?

- Emergency Room: admissions information for triage to formulate treatment plan
- Pre-Op: to explain procedure, fill out hospital questionnaire, consent form, etc.
- Prior to a routine procedure, i.e. x-ray, MRI, CAT scan, physical therapy, etc.
- Short routine office visit (<30 mins)
- Doctor's rounds
- When medical staff needs to talk to a patient who is hospitalized for an update on patients' status
- Discharge planning

Deaf Patients' Experiences

Difficulties with telephone communication:

- "We just go right to the hospital. I wouldn't call my doctor at all. I just go right to the emergency room."

Lack of information, fear, feeling of mistrust:

- "I was still awake and the doctor kept…pushing me down to make me lay down. I just said 'I want to know what you're doing,' and he would say, 'Don't worry. You're fine. Lay down.'

Providers' reluctance to provide interpreters:

- "Some doctors refuse to pay…I request an interpreter and they refuse. They say writing is good enough, writing will do, but sometimes I get stuck and I'm uncomfortable with writing."

Outcomes of Effective Communication

- Shorter lengths of stay
- Fewer hospital readmissions
- Fewer emergency room visits
- Better treatment adherence
- Better medical follow-up
- Fewer unnecessary diagnostic tests
- Better healthcare outcomes
- Better patient health care self- satisfaction

Guidelines for Healthcare Providers

- Clearly identify individuals at-risk for poor communication
- Visual Medical Aids
- Providers who know basic sign language
- Establish an effective office communication policy
- Provide qualified sign language interpreters
- Know ineffective methods of communication
- Know effective communication approaches
- Know relevant laws

(National Association of the Deaf)

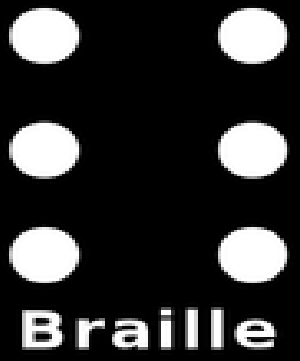
Clearly Identify Those At Risk

- Clearly identify at-risk individuals for poor communication
- Flag records to indicate at-risk patients
- Enable pop-up windows in patient charts through EMR
- Label patient chart with universally-recognized icon indicate deafness or communication needs

Examples of Useful Icons

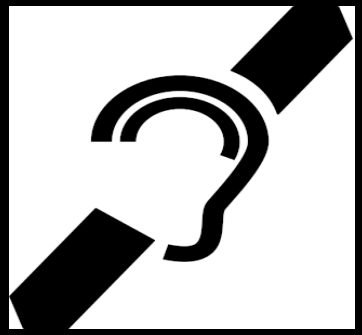
Mobility Need

Vision Impairment



Braille

Medical Interpreter



Deaf

Sign Language

Use Visual Medical Aids

- To facilitate patient education & communication
- To help explain certain concepts & basic anatomy
- Charts
- Diagrams
- Models
- Online resources to reinforce teaching and understanding

Providers Who Know Basic ASL

- Can enhance patient comfort; however:
  - Usually does not meet level of fluency required for effective communication
  - ASL fluency should be assessed by an accredited certifying body (e.g. Registry of Interpreters for the Deaf – RID, & Massachusetts Commission Deaf and Hard of Hearing-MCDHH)
  - Language fluency requires years of training
  - Necessity of honest self-assessment of ASL fluency
  - Importance of receptivity to feedback
  - Use of basic ASL skills as a last resort (i.e. emergency; until interpreter arrives)

Office Policies

- Front line staff should ask differently abled patients about communication needs
- Document patient preferences in EMR to facilitate future requests
- Provide clear documentation on how language or communication needs were addressed with patients at each visit
- If patients declined communication accommodations, document reasons why
- Maintain a database of qualified interpreters with expertise in medical settings

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