

Prescription 2: Patient Relations

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Patient relations is a set of skills that enables you to work with and support community members effectively whenever they seek help from the center without breaking the confidentiality of their medical information.



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### **Lesson A: Confidentiality**

After completing this Lesson, members will be able to:

- Describe / define *patient confidentiality*.
- Define / describe *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*.
- Identify key behaviors that maintain confidentiality within and outside of the health center.
- Identify safe resources to debrief and find support for members when dealing with difficult situations.

### **Lesson B: Strategies for Effective Communication**

After completing this Lesson, members will be able to:

- Assess their own listening styles.
- Define *active listening*.
- Demonstrate paraphrasing as a tool of active listening.
- Discuss strategies for setting effective boundaries while serving in a health care environment.

### **Lesson C: Empowering vs. Enabling**

After completing this Lesson, members will be able to:

- Define *self-advocacy*.
- Define *empowering* and *enabling*.
- Give examples of what HealthCorps members can do within their service assignments to avoid enabling clients and to help empower them.
- Describe the ideal relationship between provider and patient.

### **Lesson D: A Case of Confidentiality**

### **Lesson E: If You Didn't Write It, It Didn't Happen**

After completing this Lesson, members will be able to:

- Discuss the importance of documenting each patient interaction, even when it is not strictly medical.
- Tell the difference between a good documentation and a poor one.
- Document an interaction in the third person (“the HealthCorps member”), including only facts, and including his or her name.

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**HealthCorps Reader**

***Part One: The Importance of Confidentiality***

Maintaining confidentiality should be emphasized as one of the foremost concerns of the health center when working with patients. It is critical that members understand that confidentiality extends to *all* aspects of conversation with other members, health center employees, family, friends, and strangers. At times members may feel compelled to talk about a patient they worked with or a house they visited, because the situation has brought up a lot of feelings for them; many times these experiences provide good discussion topics for the HealthCorps team as a whole. However, it is all right to talk about a case *only* when names and other personal identifiers are not used.

AmeriCorps members are responsible to the patients, the team, and the health center for protecting confidentiality.

Each health center should train all of its staff and volunteers, including AmeriCorps members, about its specific processes and rules concerning confidentiality. Thus, all members are responsible for asking any questions they have about confidentiality until they have sufficient understanding of the issue to meet all health center standards.

Situations may arise when the police, media, or outside agencies ask for information about a health center user. The health center should have policies in place naming a spokesperson or representative who speaks for the center as a whole. If a member is ever involved in such a situation, he or she should always consult the site supervisor or team coordinator.

Members should understand that referring to a patient by their illness could be a breach of confidentiality. For example:

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*John, an AmeriCorps member for the past 3 months, has been working with an outreach van to provide primary and preventive care to the homeless in the community. He knows many of the patients by their first names and has become close to some of them. One day, Alexandra, another HealthCorps member, came out on the van with John to observe. Prior to coming up to the first homeless person, John whispered to Alexandra, "He has AIDS and has been a drug user for ten years." Alexandra seemed a little startled, and when the homeless person began talking to her, she acted awkwardly. The homeless person quickly knew that Alexandra was afraid of his AIDS and felt uncomfortable. The homeless person did not come back to the outreach van for several weeks. Instead, he was found in an alley with pneumonia.*

Although this case may appear extreme, the message of the story is that John broke his confidentiality with the homeless person. Instead, John should have oriented Alexandra prior to going out on the van about the types of situation she might experience. Such orientation can include general descriptions of the homeless population served by the van, but not information about the individual patients.

The level of trust that a patient or other health center user builds with a member is based around the level of confidentiality provided by the member. Once that confidentiality is broken, the patient in turn may break off communication not only with the member but also with the health center as a whole.

### *HIPAA*

In 1996, the Federal government enacted a new law regarding patient confidentiality named the Health Insurance Portability and Accountability Act, or "HIPAA" as it is generally called. The law took effect on April 14, 2003.

As listed by the *Washington Post* the next day, HIPAA gives all patients the following rights over their own medical information:

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- To inspect, obtain a copy of, and request a correction of errors in their medical records.
- To ask doctors and health plans to disclose who else has seen the records.
- To request certain restrictions on the disclosure of medical data.
- To ask that information be delivered to a location other than the address of record.
- To bar hospitals from releasing information about inpatients to the public, including friends and family members.

AmeriCorps members should be trained in HIPAA regulations when their health center introduces them to site-specific rules and processes for insuring confidentiality. HIPAA rules are, in general, more rigid than health care providers observed prior to April 2003. In some cases, community health centers, hospitals, and private practices had to develop completely new office systems in order to meet the HIPAA standards.

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### ***Part Two: Working with Patients***

Patients want to be able to trust health center staff, volunteers, and AmeriCorps members. They do not want their personal situations known to the community at large. Experienced health care providers know that trust is absolutely essential if the patient (or the pediatric patient's parent) is going to be willing to describe physical and psychological symptoms, home and work environments accurately and thoroughly. How is such trust to be developed?

Following are basic tips for communicating in a manner that tends to develop trust with the other person. Employed from the beginning of a member-patient relationship, these techniques can go a long way in avoiding hurt feelings, embarrassment, and misunderstanding all around.

- The member builds empathy (the ability to understand another's point of view):
  - ✓ by putting him- or herself in their shoes.
  - ✓ by acknowledging family members, background, and household belongings as helps in relating to and understanding the family.
- The member seeks to understand non-verbal communication, both his/her own and that of the patient:
  - ✓ through awareness of how his/her body and face are reacting to the person speaking.
  - ✓ by not crowding someone when they are speaking, thus invading their personal space.
  - ✓ by observing the patient's body language and facial expressions.
- The member tries to find the right balance between listening and talking:
  - ✓ By allowing them to finish *their* thoughts before responding.

At the same time that members serve their patients and build positive relationships with them, there is always a line that members should not cross. On one side

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of that line, the member is assisting the patients in standing on their own feet, while on the other side, the member is doing for the patient what the patient must do for himself. Following is a way to define the difference between helping people gain power vs. preventing them from doing so:

- *Empowering patients* providing the information and skills necessary for the patients to make choices and ensuring that the patients act upon their choices.
- *Enabling patients* solving the patients' problems for them and not encouraging them to take control of their own situations.

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### ***Part Three: The Importance of Documentation***

Documentation of every medical encounter can become a “downside” of serving the community. “Nothing slows a day down like a good stack of charts.” Why do people do it? Why bother?

Doctors and nurses do it because they are deeply aware of how important the continuum of care is as patients move between different personnel in a health care setting; they do not want any patient to lose out on the opportunity for optimum and thorough care because of incomplete medical records. At the same time, providers know that the legal standards of sound medical practice require absolute accuracy.

Early on, members should be educated on the importance of documenting their interactions with patients. Every health center may have different policies on what a member can or cannot write on an actual patient record. Members should abide by their health center’s policies.

Below are two versions of a member’s documentation after conducting an environmental-health home assessment. Included are what the member saw and some important notes about what the patient told the member. The first is considered an ideal written account of the home visit, whereas the second shows how it can be done poorly.

#### **Version A – Ideal Documentation**

Home visit with client to discuss client’s daughter’s (Juliette) asthma. Client was smoking a cigarette when AmeriCorps member arrived. Client put out cigarette at AmeriCorps member’s request. AmeriCorps member observed household triggers such as an old living room rug that had not been recently vacuumed, mouse droppings near the kitchen stove, and the daughter’s bedroom with one small window for limited ventilation. AmeriCorps member and client discussed health center services for cleaning the home. Client stated he recognized the need for cleaning and was willing to make an appointment. AmeriCorps member scheduled an

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appointment for client's daughter with Dr. Taylor on Friday, May 20 at 3pm. Client stated he would attend appointment. Note for reminder call placed in chart. — Sally Jones, AmeriCorps member

### **Version B – Poor Documentation**

Upon arrival Mr. Einstein answered the door and invited me in for a tour of the house. I noticed that the house was dirty and it was very stuffy. I told Mr. Einstein about some stuff the health center can do for her. He was unclear and angry at me. I told him to come in later this week. I made a note to myself to call him on Thursday. I really felt that Mr. Einstein did not care about his daughter.

In Version B, the member wrote in the first person (“I”) and let several personal opinions enter the medical record. Also, she did not enter her name. In comparison, Version A is written in the third person (“the AmeriCorps member”), is a record of the facts, and includes the member's name.

Members should be encouraged to be detailed as in the first version. In the beginning, members should be encouraged to write everything they see or do to avoid leaving out the most important facts. With practice members will learn medical coding and abbreviations to make the record more brief and to the point without omitting anything of importance.

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**Lesson A: Confidentiality**



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**Lesson C: Empowering vs. Enabling**

**Worksheet: Can You Decide?**

*Instructions:*

- 1. Individually, read the 5 scenarios and write out your answers to the questions.*
- 2. With one or more other members, review each scenario and discuss your answers. If your answers differ from theirs, work to see if you and they can come to some agreement. If not, leave your answers as they are.*
- 3. Share with the Team any answers on which your group found agreement.*
- 4. Then share your differences.*

**A. Pam is a HealthCorps member** who helps people get free or low-cost transportation for health center appointments. One day, a health center patient comes to her, because he has no way to get to the Food Pantry. He states that he needs the food immediately for his wife and three kids. **What should and shouldn't Pam do to help him? Why?**

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**B. Jesus is a HealthCorps member** who helps clients complete Medicaid applications. An elderly, illiterate client seeks him out one day to ask for help completing a lengthy senior housing program application. **What should and shouldn't Jesus do to help? Why?**

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**C. Keisha is a HealthCorps member** who serves as a diabetes educator, helping clients learn to manage their chronic disease. During one visit, the patient states that she has trouble checking her blood sugar and injecting her insulin. She wonders if someone could come to her home and help her. **What should and shouldn't Keisha do and say to this patient?**

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**D. Donna is a HealthCorps member** who helps pregnant women obtain resources for themselves and their newborns. At the last visit with a client named Lacey, Donna provided a list of different places Lacey could call to try to get a free car seat before the baby arrives. (The hospital will not allow the baby to be taken home unless there is a car seat installed in the family car.) At this visit, Lacey says that she did not make any of the calls, because she wanted Donna to do it with her so she'd know what to say. **How should Donna handle this?**

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**E. Cal is a HealthCorps member** who helps provide free eye screenings to clients. One of his clients, Dwayne, has missed three scheduled morning appointments. Dwayne calls again — this time asking for an afternoon appointment, because he can't seem to get up early enough to make the morning times. However, the eye screening is done only in the mornings. **What should and shouldn't Cal do? Why?**

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**Lesson C: *Empowering vs. Enabling***

**Worksheet: 3 E's of Empowerment**

*Instructions: During brainstorming, enter every idea suggested (including your own) in the appropriate section below.*

EDUCATE

ENCOURAGE

EVALUATE

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**Lesson E: *If You Didn't Write It, It Didn't Happen!***

**Worksheet: *Recording Star!***

*Instructions:*

1. *Read the two scenarios carefully.*
2. *Rewrite each as a one-paragraph "encounter documentation."*
3. *Meet with another member to discuss your different versions.*
4. *Combine them into an even stronger version.*
5. *Share it with the Team to show that you are a Recording Star!*

**Encounter #1: *Health Education***

You are assigned to pre-diabetes health education. Primarily, you meet with health center patients who have been identified as having high risk factors for diabetes, such as obesity, poor nutrition, and lack of exercise. Your tasks involve using a checklist with the patient to find out their current lifestyle habits and counsel them on improving these habits where necessary.

You have just had a visit with a "new" patient — that is, you have not worked with him before. Tim Sutton arrived about 5 minutes late. He told you everything that the doctor had told him about his pre-diabetes. (You already knew most of it from the doctor's documentation in Mr. Sutton's file, but that's OK.) He was very eager to learn what to do about his weight, but he kept interrupting you as you asked him the questions from the checklist and as you started providing him with the appropriate information and printed materials. In fact, he was *so* talkative that educating him was really difficult. You decided not to worry about how much information he understood from this first visit, but you did set a boundary to lay the ground rules for his second visit: you complimented him on being so eager to learn but also told him that you can't help him if he won't listen.

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