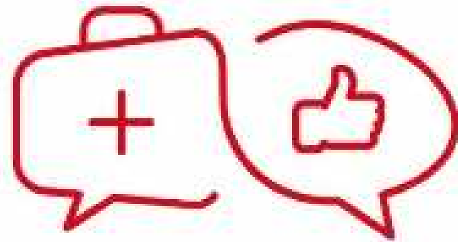

Gute Gespräche bringen allen was

Organisationale Gesundheitskompetenz und Qualitätsmanagement in der Gesundheitsversorgung

Webinar, 11. März 2024

Deutsches Netzwerk Gesundheitskompetenz e.V.

dngk.de

Jürgen Soffried

Institut für Gesundheitsförderung und Prävention GmbH

Dieser Foliensatz ist ein Auszug aus einem deutlich größeren Vortrag (siehe Literaturliste), der erstellt wurde von:

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Zitiervorschlag: Sator, Marlene (2023): Gute Gespräche bringen allen was. Kommunikationstrainings für Gesundheitsberufe. Grundlagenvortrag erstellt im Auftrag des Dachverbands der Sozialversicherungsträger, Wien

Auftraggeber, Financiers und Kooperationspartner

Haben wir ein Problem?

Gesprächsqualität in der Krise (1/3)

Empathie nimmt ab –

im Zeitverlauf und während der Ausbildung

- systematischer Review:
  In 17 von 18 Studien nimmt Empathie während der medizinischen Ausbildung ab [9-10]
- 63% der Angehörigen der Gesundheitsberufe geben Abnahme der Empathie in den letzten 5 Jahren an [11]
- Pflege: Am häufigsten als sehr oft bzw. oft weggelassene Pflegetätigkeiten wurden Interventionen angegeben, welche sich auf die
  a) emotionale Unterstützung sowie auf die
  b) Gesprächsführung mit Patient*innen und Angehörigen beziehen (mehr als 60%) [12]

Gesprächsqualität in der Krise (2/3)

Informationen sind wenig verständlich und kommen nicht an

- 22 % der Befragten haben Schwierigkeiten, zu verstehen, was ihre Ärztin/ ihr Arzt sagt [13]
- Verständlichkeit zählt zu den größten Schwierigkeiten [14]
- Patientenerleben bzgl. erhaltener Information im Rahmen der Gesundheitsversorgung [145]:
  - 20-25% geben an, keine oder nicht ausreichende Informationen erhalten zu haben
  - 25 Prozent erhalten keine oder unzureichende Informationen zur Bedeutung deren Untersuchungs- und Testergebnisse
  - Ein Drittel der Patientinnen/Patienten erhält keine bzw. unzureichende Information, bei welchen Zeichen einer Verschlechterung erneut eine Ärztin/ ein Arzt aufgesucht werden soll.

Gesprächsqualität in der Krise (3/3)

Patienten haben Schwierigkeiten Entscheidungen zu treffen

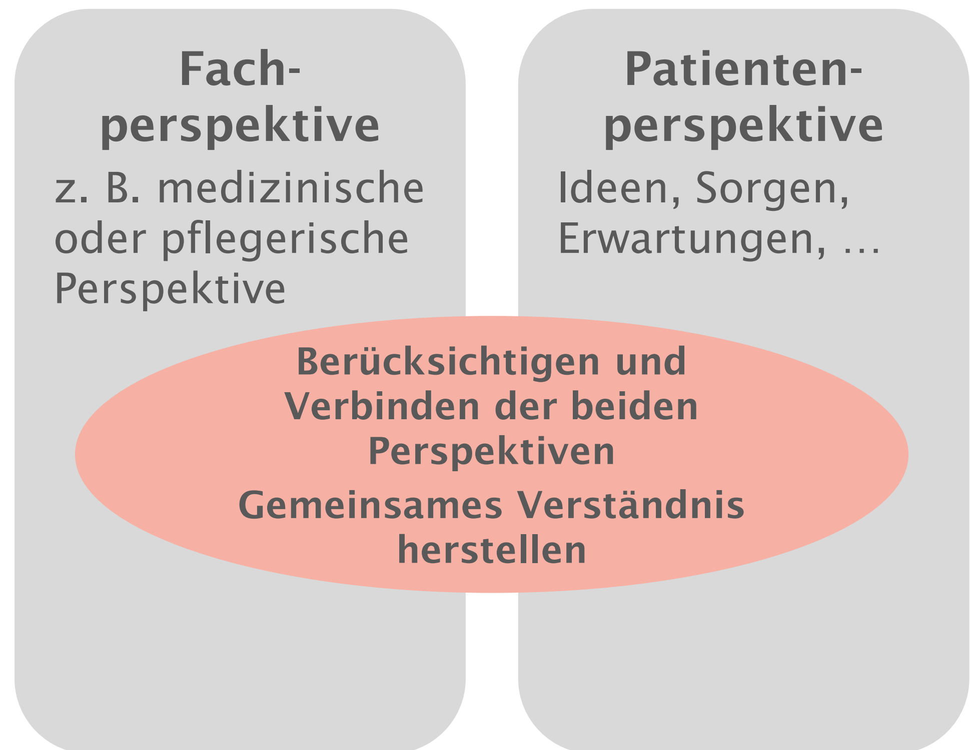
- 32 % der Befragten haben Schwierigkeiten dabei, mit Hilfe der Information, die sie von ärztlicher Seite erhalten, Entscheidungen bezüglich ihrer Krankheit zu treffen. [13]
- 34 % der Pat. bemängeln „keine ausreichende Einbindung in Entscheidungsprozesse“ [15]

Was ist patientenzentrierte Gesprächsführung?

Patientenzentrierte Gesprächsführung

Zentrale Elemente:

- biopsychosoziale Perspektive
- partnerschaftliches Rollenverständnis
- professionelle Allianz
- Perspektive der Betroffenen & fachliche Perspektive
- Berücksichtigen von Diversität und kulturelle Kompetenzen

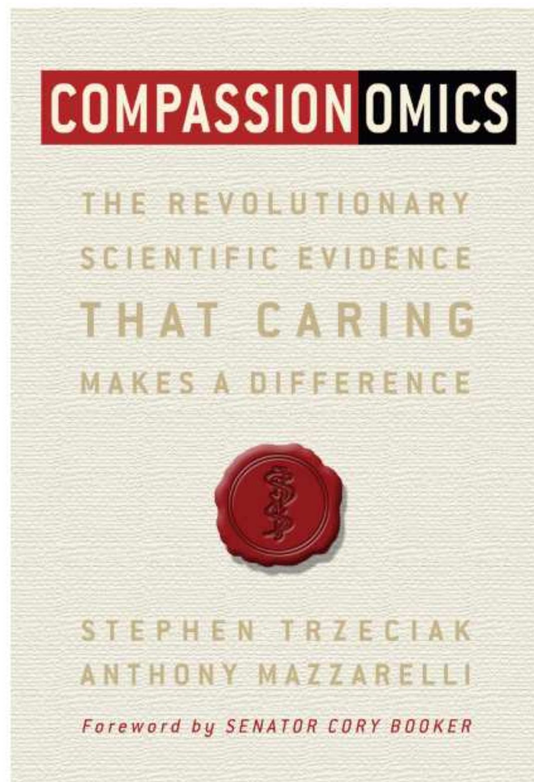


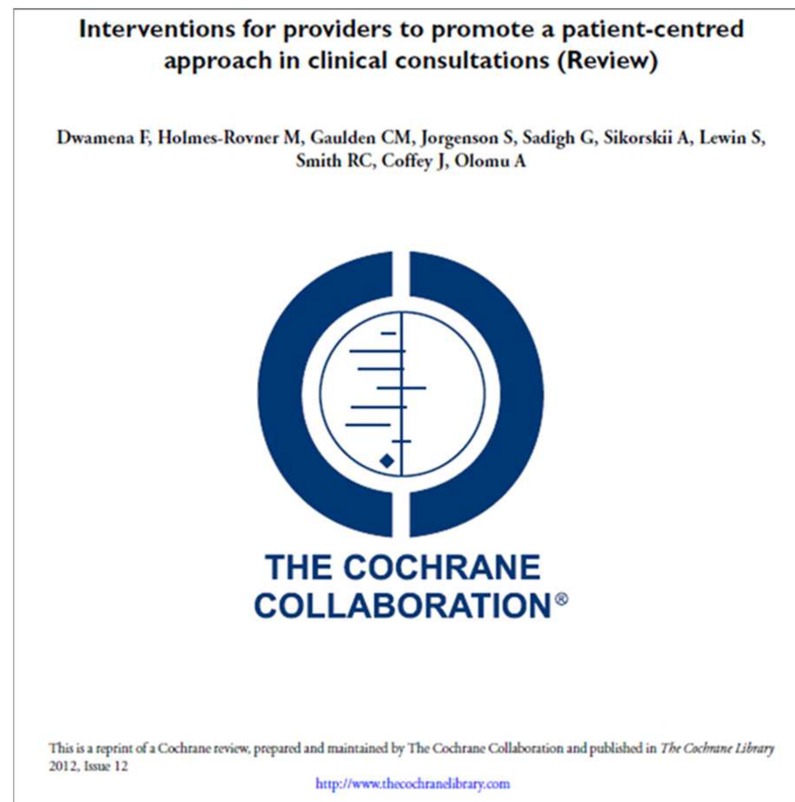
[3–8]

Gute Gespräche bringen allen was

Wozu patientenzentrierte Gesprächsführung?

Systematische Reviews: patientenzentrierte empathische Gesprächsführung ist Bestandteil evidenzbasierter Medizin!





Interventions for providers to promote a patient-centred approach in clinical consultations (Review)

Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, Lewin S, Smith RC, Coffey J, Olomu A

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2012, Issue 12

http://www.thecochranelibrary.com

[1–2]

Patientenzentrierte Gesprächsführung hat einen hohen Nutzen

Physiologische Effekte

Psychologische Effekte

Gesundheitsverhalten

Qualität der Versorgung

Patienten-zufriedenheit

Effizienz und Kosten

Mitarbeiter-gesundheit

Beispiel: Physiologische Effekte

Kontext	Effekte	Lit.
Post-operativ	• 50% weniger **Bedarf an Opiaten** • signifikante Verringerung der **Aufenthaltsdauer im Krankenhaus** • 50 % niedrigere **Werte auf Schmerzskala**	[16-17]

Beispiel: Psychologische Effekte

Kontext	Effekte	Lit.
Mitgefühl-basierte Interventionen **- *Meta-Analyse***	statistisch signifikante Effekte • auf die Linderung von **Depressionen**, **Ängsten** und psychischem **Stress** • sowie auf die Steigerung des **Wohlbefindens**	[40]

Gute Gespräche bringen allen was

Patienten mit chronischen Krankheiten nehmen ihre Medikamente in der Hälfte der Fälle nicht wie vorgeschrieben ein.

20 bis 30 Prozent der Medikamentenverordnungen werden gar nicht erst eingelöst.

Mit anderen Worten: Der Patient hatte niemals die Absicht, sie einzunehmen.

[1: 127; 55]

Beispiel: Effekte auf Adhärenz

Kontext	Effekte	Lit.
Unterschiedl. Erkrankungen	62% höhere Wahrscheinlichkeit, dass Patienten sich **an die Behandlung halten**	[56]

Gute Gespräche bringen allen was

Beispiel: Effekte auf Patientenzufriedenheit

Kontext	Effekte	Lit.
Krankenhaus	Bessere **Bewertungen** und größere Wahrscheinlichkeit, dass Patienten das KH **weiterempfehlen**	[74]
Medizin-studierende und Ärzte	Patienten beurteilen einfühlsame Ärzte als um ca. 15% **kompetenter**	[80-82]

Beispiel: Effekte auf Effizienz und Kosten

Kontext	Effekte	Lit.
Überinanspruch-nahme von Ressourcen	• Geringere Wahrscheinlichkeit, dass Patienten **Gesundheitsleistungen übermäßig in Anspruch nehmen** • um 51 % niedrigere **durchschnittliche Kosten pro Patient** • Ohne patientenzentrierte Kommunikation mehr **Überweisungen zu Spezialisten** und mehr **diagnostische Tests** (40%) • Zusammenhang zwischen der von Patienten wahrgenommenen Patientenzentriertheit und geringeren Anzahl von Überweisungen und diagnostischen Tests vor allem auf Wahrnehmung der Patienten zurückzuführen, dass eine "gemeinsame Basis" erreicht worden war.	[93-96]

Gute Gespräche bringen allen was

"A recent rigorous systematic review published in Burnout Research reported that the vast majority of published studies testing the association between compassion and burnout in health care providers found an ***inverse correlation****. Inverse! That is,* ***high compassion was associated with low burnout, and low compassion was associated with high burnout****."*

[1:296; 108]

Effekte auf Mitarbeitergesundheit

Kontext	Effekte	Lit.
Pflege	Pflegekräfte, bei denen die funktionelle MRT eine geringe Aktivität in den Zentren des Hirns für Anteilnahme nachwies, wiesen die höchsten Burnout-Werte auf.	[120]
Ärzte in Ausbildung	• gegenläufige Korrelation zwischen Mitgefühl und Burnout • Rückgang etwaiger Depressionssymptome; Die Auswirkungen auf ihre Depressionssymptome waren bei denjenigen am größten, die zu Beginn die stärksten Depressionssymptome aufwiesen, was darauf hindeutet, dass das Mitgefühlstraining denjenigen zugute kommt, die es am dringendsten benötigen.	[123-125]
Ärzte	• Ärzte, die mit der Qualität ihrer Patientenbeziehungen am unzufriedensten waren, hatten ein 22-fach höheres Burnout-Risiko	[126-127]
Allgemein-mediziner	• Weniger Burnout, Steigerung des Wohlbefindens und der beruflichen Zufriedenheit	[128-131]
Notfallambulanz	• höhere Scores für gesundheitliches Wohlbefinden der Pflegekräfte; • die Fähigkeit, Mitgefühl für Patienten aufrechtzuerhalten, war ein wesentliches Merkmal für die Zufriedenheit von Notfallmedizinern mit ihrer beruflichen Lebensqualität	[132] [72]

Gute Gespräche bringen allen was

Patientenzentrierte Gesprächsführung hat einen hohen Nutzen

Physiologische Effekte

Psychologische Effekte

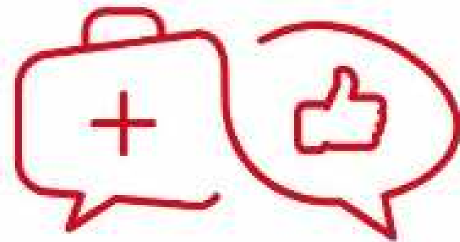
Gesundheitsverhalten

Qualität der Versorgung

Patienten-zufriedenheit

Effizienz und Kosten

Mitarbeiter-gesundheit



Gute Gespräche bringen allen was

Kommunikationstrainings für Gesundheitsberufe

Zielsteuerung-Gesundheit
Bund • Länder • Sozialversicherung

Verbesserung der Gesprächsqualität in der Krankenversorgung

Strategie zur Etablierung einer patientenzentrierten Kommunikationskultur

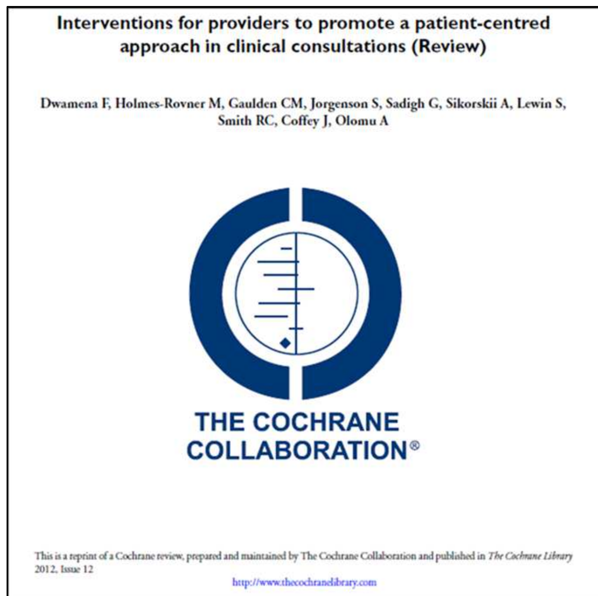
Beschlossen von der Bundeszielsteuerungskommission am 1. Juli 2016

[133]

- Ein strategischer Gesamtrahmen für Gesprächsqualität in Österreich der Bundeszielsteuerungskommission (2016)
- Umsetzung im Auftrag von Bund, Ländern, Sozialversicherung unter dem Dach der ÖPGK

Patientenzentrierte Gesprächsführung...

...ist lehr/-lernbar...



Interventions for providers to promote a patient-centred approach in clinical consultations (Review)

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http://www.thecochranelibrary.com

[1-2]

wird in der Ausbildung zunehmend gelehrt und geprüft...

Communication Competencies | OPEN ACCESS | This is the original (English) version. The translated (German) version starts at p. 14. | article

Desire and reality – teaching and assessing communicative competencies in undergraduate medical education in German-speaking Europe – a survey

Abstract

Objectives: Increasingly, communicative competencies are becoming a permanent feature of training and assessment in German-speaking medical schools (n=43; Germany, Austria, Switzerland – "D-A-CH"). In support of further curricular development of communicative competencies, the survey by the "Communicative and Social Competencies" (KusK) committee of the German Society for Medical Education (GMA) systematically appraises the scope of and form in which teaching and assessment take place.

Methods: The iterative online questionnaire, developed in cooperation with KusK, comprises 70 questions regarding instruction (n=14), assessment (n=48), local conditions (n=5), with three fields for further remarks. Per location, two to three individuals who were familiar with the respective institute's curriculum were invited to take part in the survey.

Results: Thirty-nine medical schools (40 degree programmes) took part in the survey. Communicative competencies are taught in all of the programmes. Ten degree programmes have a longitudinal curriculum for communicative competencies; 25 programmes offer this in part. Sixteen of the 40 programmes use the Basler Consensus Statement for orientation. In over 80% of the degree programmes, communicative competencies are taught in the second and third year of studies. Almost all of the programmes work with simulated patients (n=38) and feedback (n=37). Exams are exclusively summative (n=11), exclusively formative (n=3), or both summative and formative (n=16) and usually take place in the fifth or sixth year of studies (n=22 and n=20). Apart from written examinations (n=15) and presentations (n=9), practical examinations are primarily administered (OSCE, n=31); WPA (n=8), usually with self-developed scales (OSCE, n=19). With regards to the examiners' training and the manner of results-reporting to the students, there is a high variance.

Conclusions: Instruction in communicative competencies has been implemented at all 39 of the participating medical schools. For the most part, communicative competencies instruction in the D-A-C-H region takes place in small groups and is tested using the OSCE. The challenges for further curricular development lie in the expansion of feedback, the critical evaluation of appropriate assessment strategies, and in the quality assurance of exams.

Keywords: medical studies, communicative competencies, instruction, assessment, longitudinal curriculum

GMS Zeitschrift für Medizinische Ausbildung 2015, Vol. 32(5), IS

Kommunikative Kompetenz | OPEN ACCESS | This is the German version. The English version starts at p. 1. | Leitartikel

Themenheft zur Vermittlung sozialer und kommunikativer Kompetenzen – Status quo

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Rolf Kienle[2]
Claudia Kiessling[3]
Henriette Löffler-Stastka[4]
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GMS Journal for Medical Education 2021, Vol. 38(3), ISSN 2366-5017 6/10

[134–135]

...aber geht im beruflichen Alltag wieder verloren

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Dis-integration of communication in healthcare education: Workplace learning challenges and opportunities

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Faculty development

ABSTRACT

The purpose of this paper, based on a 2016 Heidelberg International Conference on Communication in Healthcare (ICCH) plenary presentation, is to examine a key problem in communication skills training for health professional learners. Studies have pointed to a decline in medical students' communication skills and attitudes as they proceed through their education, particularly during their clinical workplace training experiences. This paper explores some of the key factors in this disintegration, drawing on selected literature and highlighting some curriculum efforts and research conducted at the University of Iowa Carver College of Medicine as a case study of these issues. Five key factors contributing to the disintegration of communication skills and attitudes are presented including: 1) lack of formal communication skills training during clinical clerkships; 2) informal workplace teaching failing to explicitly address learner clinical communication skills; 3) emphasizing content over process in relation to clinician-patient interactions; 4) the relationship between ideal communication models and the realities of clinical practice; and 5) clinical teachers' lack of knowledge and skills to effectively teach about communication in the clinical workplace. Within this discussion, potential practical responses by individual clinical teachers and broader curricular and faculty development efforts to address each of these factors are presented.

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[136]

Wie können Kompetenzen zur Gesprächsführung weiterentwickelt werden?

Wissen, Einstellungen

- Vortrag
- E-learning
- Leitfaden
- Etc.

Fertigkeiten/Skills

[137–141]

Effektives Skillstraining für patienten-zentrierte Gesprächsführung (1/4)

Evidenzbasiertes Kommunikationsmodell:
Calgary Cambridge Guides

- kommunikative Fertigkeiten integriert mit Herausforderungen des klinischen Alltags
- umfassend: Struktur und Fertigkeiten
- verhaltensorientiert

[140; 142–143]

Effektives Skillstraining für patienten-zentrierte Gesprächsführung (2/4)

Evidenz- und erfahrungsbasierte Didaktik: ALOBA

- hohe Lerner-Zentrierung
- praktisches Üben mit SPs, Feedback, theoretische Modelle, wiederholtes Üben und Reflexion
- Aktivitäten zur Festigung, Auffrischung und Verstärkung des Gelernten und solche, die den Transfer in die Praxis unterstützen

[140; 142–143]

Trainingsdesign

- auf die Zielgruppe zugeschnittenes,
- longitudinales Trainingsdesign,
- das spiralförmiges Lernen ermöglicht

[140; 142–143]

Effektives Skillstraining für patienten-zentrierte Gesprächsführung (4/4)

- zertifizierte Trainerinnen und Trainer,
- qualifiziert nach Qualitätsstandards der ÖPGK und der International Association for Communication in Healthcare (EACH)

ÖPGK-Trainer-netzwerk

[140; 142–143]

Angebote des ÖPGK-Trainernetzwerks

https://oepgk.at/schwerpunkte/gute-gespraechsqualitaet-im-gesundheitssystem/trainingsangebote-nach-each/

Impuls-Workshop zum herausfordernden Patientengespräch: Der empfohlene Einstieg

- Ziel: Impulse und praktisch umsetzbare Anregungen für herausfordernde Patientengespräche
- Dauer: 4 Std.

Kommunikationstraining für Gesundheitsberufe nach ÖPGK-tEACH-Standard: Das nachhaltige Training

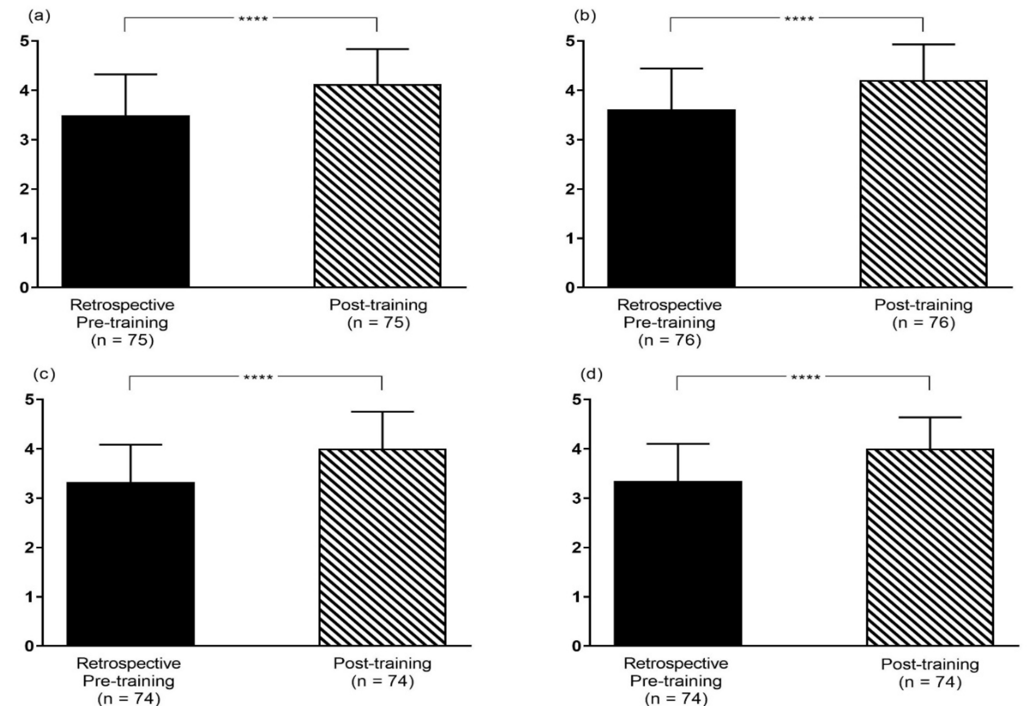
- Ziel: nachhaltiges Training kommunikativer Fertigkeiten
- Dauer: 12 / 16 / 20 Std.

Image-Video: https://oepgk.at/schwerpunkte/gute-gespraechsqualitaet-im-gesundheitssystem/
Etwas nach unten scrollen zum Video

Effektivität Kommunikationstrainings

- hohe **Zufriedenheit** der TN (n=85)
  - Schulnote (1-5): 1.2 ± 0.5

- **Selbstwirksamkeit** nach dem Training signifikant höher in allen 4 Kompetenzbereichen:
  a) Informationssammlung
  b) Verstehen der Patientenperspektive
  c) Übermitteln der korrekten Menge und Art von Informationen
  d) Erleichtern von Erinnern und Verstehen



Anmerkung: höhere Werte bedeuten eine höhere Selbstwirksamkeit

[144]

Impact und Effektivität

- **7.000 Gesundheitsprofis** in der Aus-, Fort- und Weiterbildung trainiert (2019-2023)
- **90 Gesundheitseinrichtungen** erreicht (2019-2023)
- **60 Trainer:innen bundesweit** (2024)
- Evaluationen ergaben **sehr hohe Zufriedenheit (Schulnote 1,2)** und signifikante Steigerung der **Selbstwirksamkeit** der Gesundheitsprofis

Gute Gespräche
bringen allen was

Ammentorp et al. 2021; Sator/Holler/Rosenbaum 2021; Sürth/Soffried 2023a; Sürth/Soffried 2023b

Gute Gespräche
bringen allen was

Beispiel: Effekte auf Effizienz und Kosten

Kontext	Effekte	Lit.
Kosten-effektivität von Kommunikations-trainings	• 8 von 10 Studien zeigen, dass ein Kommunikationstraining gesundheitsrelevante Outcomes verbessern kann. • 5 davon kommen zu dem Ergebnis, dass es nicht nur höhere Effekte erzielt, sondern auch zu **geringeren Gesamtkosten** führt als ein vergleichbares Vorgehen ohne Kommunikationstraining.	[103]

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