

INTERVIEWING STRATEGIES

A.K.A.
HOW TO GET PEOPLE TO
TALK TO YOU !!

WHAT ARE WE TRYING TO ACCOMPLISH?

YOUR GOAL

- ✓ Collect complete and accurate info
- ✓ Begin a relationship with this person
 - + involves trust
 - + *hopefully* will continue to grow over time
- ✓ Help them learn about their health

MUTUAL GOAL

Optimization of their health

Comprehensive Health History

Subjective

- ✓ Something a person *chooses to tell you*
 - + How he/she perceives their health
- ✓ Remember: they may edit their information (a lot!)
 - + They remain in control of this area
- ✓ It takes skill to gather the information you feel is important

BEGINNING BASICS

- ✓ **Introductions**
 - + What was your name again?
- ✓ **Setting**
- ✓ **Your demeanor**
- ✓ **Your dress**
- ✓ **Your greeting**
- ✓ **Note taking**
- ✓ **Non-verbal messages**
 - + posture, gestures, eye contact, tone of voice, facial expressions
- ✓ **Be alert to special patient needs:**
 - + developmental needs
 - + disabilities
 - + cultural issues
 - + highly emotional situations

Effective Questioning...

- ✓ **Use open questions**
- ✓ **Try direct questioning**
 - + location, quality, quantity, chronology, setting, provocative, palliative, associated factors
- ✓ **Interpret**
- ✓ **Summarize**

Effective Questioning Pt 2..

- ✓ **Things to try...**
 - + Silence
 - + Clarification
 - + Reflection
 - + Reassurance
 - + Support
 - + Confrontation
- ✓ **Things to avoid...**
 - + yes-no questions
 - + complicated medical terms
 - + multiple questions

Special Communication Skills

1. This is NOT like talking to your friends!
2. Active **listening** is much more important than talking
3. Watch your language (& speech patterns!)
4. Try some introspection...

10 TRAPS

1. Giving false assurance or reassurance
2. Unwanted advice
3. Abusing your "Power" or authority
4. Using avoidance language
5. Distancing yourself
6. Overuse of medical terminology
7. Asking leading or biased questions
8. Talking too much
9. Interrupting
10. Asking "why"

As you exit...

- ✓ Summarize the communication
 - + (as you remember it!!)
- ✓ Ask that final question (get ready...)
 - + "Is there anything else you'd like to tell me?"
 - + "Anything else I should know to help in planning your care?"
- ✓ BAMM!! The door knob phenomenon...
 - + "Well, there is one thing..."
 - + The most helpful information often comes during the last 30 seconds...

Some final thoughts...

WHAT DOES THE **PATIENT** BELIEVE IS HAPPENING TO THEM?

WHAT DO **THEY THINK** WILL MAKE THEM BETTER?

Where the rubber meets the road: Effective Charting

Getting it down on paper is really the toughest part of the whole process...

- + What pieces go where?
- + What is a "nice to know" and what **MUST** be included?
- + What's the standard "industry" format?
- + What words do I use?
- + How to be complete and still brief...

DEMOGRAPHIC DATA

REQUIRED

- ✓ Pt identification
- ✓ Date of exam
- ✓ Age
- ✓ Race
- ✓ Sex

NICE TO KNOW

- ✓ Marital status
- ✓ Education
- ✓ Occupation
- ✓ Reliable source of information?
- ✓ Nationality
- ✓ Place of birth
- ✓ Referred by

CHIEF COMPLAINT (CC)

- ✓ A statement written in *“quotations”* stating why the patient is presenting to you for care
 - + “I’m here for an annual exam”
 - + “I have a sore throat”
 - + “I’m here for a Blood Pressure check”
 - + “I’m scheduled to have my gallbladder taken out today”
 - + “My daughter is pulling on her ears, I think she has another ear infection”

HISTORY OF PRESENT ILLNESS (HPI)

- ✓ The HPI is written in a narrative format
 - + It contains information concerning the Chief Complaint and any *RELEVANT* concurrent medical problem
- ✓ The problem should be described both
 - + *CHRONOLOGICALLY*
 - and in
 - + *APPROPRIATE DETAIL*

HPI (2)

- ✓ Relevant means:
 - + information necessary to further clarify the chief complaint
 - + information that helps contribute to making the diagnosis
- ✓ Concurrent means:
 - + first episode to present
 - + describe the impact of the illness on the patient

HPI (3)

- ✓ **Appropriate detail means:**
 - + **full characterization of the symptoms**
 - Quality, quantity, location, radiation; precipitating, aggravating and relieving factors
 - + **Any and all other information that may relate to the CC should be addressed**
 - Personal, life style, travel, environmental, occupational

PAST MEDICAL HISTORY (PMH)

- ✓ **This section deals with MAJOR problems that:**
 - + have resolved
 - + are currently inactive
 - + active but currently stable
- ✓ **Active problems pertaining to the HPI should be discussed in that section**
- ✓ **Unrelated problems with symptoms should be recorded in Review of Systems**

PMH (2)

- | | |
|---|--|
| <ul style="list-style-type: none">✓ General Health<ul style="list-style-type: none">+ How they see their health<ul style="list-style-type: none">● excellent, good, average, poor, etc+ Can they perform ADL's?+ Live independently?+ etc... | <ul style="list-style-type: none">✓ Childhood illnesses:<ul style="list-style-type: none">+ childhood conditions that may have long-term sequelae+ infectious+ developmental+ traumatic+ fractures |
|---|--|

PMH (3)

- ✓ **Adult illnesses ***
 - + infections
 - + cardiovascular
 - + GI
 - + Misc:
 - DM, CVA, CA, Anemia, Thyroid, Renal, Derm.
- * Each disease should be asked about and if present, clearly documented
- ✓ **Surgical History**
 - + Procedures
 - + Dates
 - + Complications
 - + Outcomes
- ✓ **Psychiatric History**
 - + Diagnosis
 - + Hospitalizations
 - + Medications
 - + Course
 - + Outcomes

PMH (4)

- ✓ **Obstetrical History***
 - + Mode of delivery
 - + Complications
 - + Gravidity = Lifetime total number of pregnancies
 - + Parity = Term, Preterm, Abortion, Living
- ✓ "24 y/o G1 P1001, uncomplicated vag delivery"

CURRENT HEALTH STATUS

- ✓ **Medications - Rx**
 - + Generic name
 - + Dose
 - + Duration
 - + Reason for use
 - + Compliance
- ✓ **Medications - non-Rx**
 - + What used
 - sleep, diet, NSAID, antacids, laxatives, cold medications
 - + How often
 - + Last used
 - + Effectiveness

CHS (2)

- ✓ Allergies
 - + Food, Drug, Seasonal
- ✓ Substance use
 - + CAGE questions
- ✓ Transfusions
 - + Number, dates
- ✓ Trauma
 - + Major
 - + Dates
 - + Outcomes
- ✓ Immunizations
 - + Primary & Secondary
- ✓ Tobacco use
 - + Type
 - (Cigarette, pipe, cigar, snuff, chewing)
 - + Duration
 - + Amount

CHS (3)

- ✓ Diet
 - + 24 hour recall
 - composition, timing
 - frequency, excesses
 - restrictions
 - + Disorders
 - allergies, intolerance, vomiting (induced)
 - + Change in appetite or weight
 - + Coffee, Tea or other Xanthine's
- ✓ Preventive Exams
 - + Dental, Eye, Hearing, EKG, CXR, Pap, Mammogram, Prostate, Occult Blood, Colonoscopy etc...
- ✓ Sleep Patterns
 - + Insomnia
 - + Sleep apnea
 - + Medication use

CHS (4)

- ✓ Exercise
 - + Frequency
 - + Type
 - + Length
- ✓ Leisure
- ✓ Hobbies
- ✓ Safety
 - + Bicycle helmets
 - + Seatbelt use
 - + Shingards, elbow pads etc..
 - + Lifejackets
 - + Child proof environment

FAMILY HISTORY (FH)

✓ Use of a genogram helps tremendously here. Be sure to include:

- + Key
- + Identify patient
- + Note ages of family members
- + Note if they are living or deceased
- + Specify if possible, cause of death
- + List familial diseases

FH (2)

✓ Ask about the following diseases (add more as needed)

- + DM
- + CA (esp. breast, colon, prostate, ovarian)
- + Rheumatologic disease
- + Renal disease
- + HTN
- + Atherosclerotic disease
- + Emotional disorders
- + Abuse (Substance, Child, Spousal: verbal, physical)

PSH

✓ General outlook on life - present/future

✓ Living Situation

- + Type housing
- + # people in home
- + relationship to pt
- + # of bathrooms
- + Heating/cooling
- + Steps
- + Phone
- + Problems

✓ Occupation

- + Employed?
- + Current work situation
- + Type of work/position
- + Reason for change
- + Exposure to hazardous materials
 - asbestos, radiation
- + Child care provider?
- + Spouse employed?
- + Retired

PSH (2)

- ✓ **Financial Status**
 - + combined salary
 - + Social Security
 - + Welfare, ADC
 - + Total In = Total Out?
- ✓ **Recent Stressors**
 - + death
 - + illness
 - + financial
 - + school (grad school?)
- ✓ **Sources of Anxiety, Guilt etc..**
 - + financial
 - + family
 - + occupation
 - + health
- ✓ **Ever sought counseling?**
 - + type
 - + duration
 - + success?

MILITARY HISTORY

- ✓ **Consider asking about this:**
 - + Rank
 - + Responsibilities
 - + Previous assignment details:
 - geographic locations
 - duration
 - dates

REVIEW OF SYSTEMS (ROS)

- ✓ Final, systematic checklist to make sure that no significant problem has been overlooked
- ✓ Clearly instruct patient:
 - + yes-no answers
 - + clear time frame (1 year, 6 months, lifetime)
- ✓ Active problems NOT related to HPI should be addressed here
- ✓ Any *major* new problems needs to be addressed separately

SEQUENCE FOR PE WRITE UP

1. Vitals (P: rate & rhythm, BP: location & position)
2. Skin (general condition & specific lesions)
3. HEENT
4. Neck
5. Chest & Lungs
6. Cardiovascular
7. Breasts
8. Abdomen
9. Musculoskeletal
10. Lymph Nodes

SEQUENCE (cont)

11. Neurological (including Mental Status)
12. Genital (rectal and occult blood findings noted here in female exam)
13. Rectal (prostate and occult in male exam)

ASSESSMENT

This is where you really have to **“commit yourself”** on paper (for the entire world to see)!!

Keep it BRIEF - 2-5 words is plenty

When looking at a note, most providers **START** here and then go backward to review the objective and subjective data.

People usually save the **“Plan”** for last.

ASSESSMENT (CONT)

Some Sample Assessment Statements:

- + F/U HTN
- + Rt Otitis Media
- + Bacterial Conjunctivitis
- + NL GYN exam
- + R/O MI
- + R/O Appendicitis
- + Rt Ankle Strain
- + Pre-op Physical - NL findings

PLAN

Systematically Written:

1. Diagnostic measures you initiate:

- + CBC
- + Pap Smear
- + CXR
- + CT of the sella turcica
- + Abdominal MRI
- + Consult to Dermatology/Radiology etc..

PLAN (cont)

2. Pharmacologic Measures:

- + Flagyl 375mg po BID x5 days, NR
- + Amoxicillin 500mg po QID x10 days, NR
- + etc..

3. Therapeutic Measures

- + Physical Therapy QD x 2 wks
- + Splint stabilization L4 wrist
- + Accupuncture QOD

PLAN (cont)

4. Teaching

- + Indepth Preconceptual counseling done: handouts given
- + Otitis externa prevention sheet given and explained
- + Breast Self Exam teaching done: handout given

PROBLEM LIST

- ✓ This is **VERY OFTEN** forgotten by students: we look for this and grade it!!
- ✓ All problems should be included:
 - + Physical, Psys-Social, Historical, Laboratory
- ✓ List problems in order of importance to CC
- ✓ Include active and chronic problems
- ✓ Should try to identify as **MANY** problems as possible for each patient

PROBLEM LIST

Problem #	Date	Problem	Active	Resolved	Initials
