

Using Job Aids to Improve Client Provider Communication in Indonesia: Provider Self-Assessment and Client Education

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Ed Kelley: Adrienne Kols is a long-time consultant to the Johns Hopkins University Center for Communication Programs, and has also worked with PATH. She's collaborated with Dr. Young Mi Kim (with whom we've worked on the Quality Assurance Project) on research to improve the quality of client provider communication and reproductive health care via provider training and reinforcement, supervision, and client education. She co-authored a POP report on family planning programs improving quality, and also wrote several sections of the reproductive health outlook website that I know a lot of us use very frequently. She's going to talk about a specific area that came up when we were doing a needs assessment for this particular conference, which was self-assessment and its overlap and complementary to job aids and self-assessment as a job aid itself.

So Adrienne?

Adrienne Kols: We've tested a lot of different strategies to improve interpersonal communication between clients and providers in Indonesia. I'm going to be talking about two different studies today, but they were sequential and they did in fact involve the same set of providers.

The first one tested whether provider self-assessment could reinforce an ICC training workshop—that's Interpersonal Counseling and Communication training workshop—and improve providers' performance on the job. The supervision system in Indonesia was relatively weak, and we were trying to come up with a cost-effective way to reinforce the training.

Secondly, I'm going to talk about a different approach that looked at the client half of the provider/client dyad, and tested whether 20 minutes of coaching on communication skills in the waiting room, coaching the clients in the waiting room, increased their participation in family planning counseling sessions. Job aids played a key role in both of these interventions.

In evaluating both these studies, actual consultations with the providers and the clients were audio taped and then coded using the Rotor Interaction Analysis System. Indonesians who knew the local language listened to these audio tapes, and using a computer screen coded every sentence that the client and the provider uttered, and that's what we're analyzing.

Let's start with the provider self-assessment. We conceptualized self-assessment as a four-stage learning process that providers theoretically repeat as their skills improve. The idea was to take this and turn it into a job aid so they could do this by themselves. So the job aid that we designed to guide the providers through the process followed the model, a two-page job aid that started with a behavior checklist. Immediately after a consultation, the provider would sit down with the job aid and go through this checklist to rate their own behaviors, how well they've done very specific tasks. You want them to pay attention to the client, so they rated the client behaviors as well.

The next step was to reflect more deeply on the interaction, so you'd have a couple of questions asking respondents to think about things more deeply. Then they listed two very specific behaviors that they thought they were weak in and that they wanted to improve. The idea was that they'd practice these behaviors singled out for improvement, and there was space in the job aid for them to come back later and write down how well they thought they had done.

Now for this intervention, the providers were given a set of 16 different self-assessment forms, each two pages. There was really a set of eight that was duplicated so they used each job aid twice. Each form focused on a specific communication skill area, so one week with one job aid they might be working on their listening skills, another week they might be working on being responsive to clients. They used one of the job aids each week for 16 weeks in succession, so they conducted one self-assessment exercise every week. Each of the providers attended a five-day training workshop on

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interpersonal counseling communication to start. The providers in the intervention group had a half-day of training tacked on to that workshop to teach them how to use the self-assessment job aids.

Now the question is, did it work? We collected data before the training, then immediately after the training, and then four months later, after the providers in the intervention group ran through all 16 weeks of these self-assessment forms. The key variable we're measuring is provider facilitative communication. This was a set of communication codes that we thought were verbal behaviors encouraging clients to participate, things that would encourage clients to speak up, ask questions, express opinions.

Let's first look at the control group; as you can see, the training definitely did have an impact. After training, the amount of facilitative communication by providers went up. But then as is all too often the case, during the four months after training, slowly but surely their skills eroded and the levels went back down, though they were still above their pre-training levels.

Then we'll bring in the nice yellow line here for the group that was using the self-assessment job aids. Their skills improved with training, even more dramatically; I can't really explain that difference. But then you'll notice that after training, instead of their skills gradually eroding over time, that not only did they maintain their post-training levels but they continued to improve over this four-month period. Needless to say, we were extremely happy with these results.

So basically the self-assessment job aids helped the providers consolidate the skills that they learned and apply them once they got back onto the job. The job aids also had an indirect but significant impact on client behavior as well, so the clients were more actively participating when they were attended by providers who were using the self-assessment job aids. They were asking more questions, expressing worries, things like that.

These gains came at a relatively low cost. Training was expensive; you have to pull these people out and bring them in. It cost \$69.00 per provider for this five-day training workshop at that point in Indonesia. And in contrast, the self-assessment cost \$1.60, ten cents to photocopy each of these sheets for the provider. At the time, just to give things a broader context, the provider's monthly salary was \$76.00. Essentially what we found is that a relatively tiny investment in these self-assessment job aids made a great impact when they followed the training. Otherwise the \$69.00 you expended on the training ended up, over the long run, not really having much of an impact.

So from this study and others we've learned the importance of keeping self-assessment job aids simple and easy to follow, partly because the forms were simple. Nearly all of the providers in Indonesia completed the 16-week series. They conducted the self-assessments in total isolation, only one provider at each clinic participated in the intervention, so there was no one else at the clinic who knew what they were doing and could help them out. There was pretty much no supervision or any kind of outside support either; they were really on their own.

The providers also found other kinds of support materials helpful, and this was something that we did not do in Indonesia but did do in a succeeding study in Mexico. In Mexico, the providers who were conducting the self-assessment were also given some supplemental job aids. These were simple little leaflets that outlined, defined, the key communication skills we were trying to reinforce and also gave specific examples of good and bad behaviors and they found them very helpful.

Obviously, training is absolutely necessary to be able to use a self-assessment job aid, especially since you really are working completely on your own. On the other hand, it didn't take all that long; the half-day of training that we provided on that seemed to be sufficient. Self-assessment was an effective tool in reinforcing training.

Now I'm going to switch to something completely different. This is a model for the smart patient client education. One of our goals was to increase client participation, make them more active participants in family planning counseling sessions. In Indonesia, as elsewhere in the world, clients tend to be passive. Women just sit there and answer questions when they're directly asked them, in as few words as possible. But they really say very little.

Instead of just working on the providers to encourage client participation, we took the next step and went directly to the clients. We took this learning model and developed this job aid. A client educator used it for 20 minutes, worked individually with clients in the waiting room and covered these four areas: that the women had the right to seek

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information, to talk up, speak out to the providers, that they should ask questions, to express any concerns, worries, or opinions that they might have, and also to ask for clarification when they didn't understand things. As part of this, the client educator used the leaflet, they read the leaflet together, the provider and the clients. There were spaces in the leaflet for the clients to write down the questions that they wanted to ask the provider that day or their concerns or worries.

What we found was that the coaching did, in fact, have an impact on client communication. The clients who had smart patient coaching asked about one and a half more questions than other clients, still relatively low levels but a distinct increase. In addition, they expressed one more concern or opinion. There was no significant difference in the request for clarification, but we found that the women said they really didn't have any difficulty understanding the provider and they didn't think that was a problem.

Further analysis that we're doing at the moment seems to show that what's nice about this is that the leaflet and coaching has a greater impact on the women who are the least likely to talk under normal circumstances. So, older women, women who come in without a specific complaint, less assertive women, they all seem to get more of an impact from the coaching.

We found that because clients were asking more questions and bringing up their own personal worries, the providers were giving more tailored informational counseling. There was no change in generic information given, typical family planning information, but just on things like counseling and discussing their personal issues.

So we feel that the job aids contributed to Smart Patient in three different ways. They helped legitimize the client's right to speak out, that not only was the educator telling them that they had this right, but there was this glossy, official-looking brochure that put it in writing. In addition, the leaflet definitely helped the educators cover the key client communication skills; it led them through the series of structured exercises with the clients. It also helped clients formulate questions and concerns.

In this rush here, I overlooked that there was a second job aid, it was just a list of common questions and concerns relevant to every specific family planning method that, when women couldn't think of anything to ask, that the educator could use to prompt them.

Everyone in Indonesia is very interested in Smart Patient, but we're trying to figure out ways to use it that would not mean employing high-end, specifically trained client educators in the waiting room. One possibility that we've been thinking about is to give a short version of the job aid to providers to use with clients. It might also be used by community health workers. Every woman in Indonesia sees a community health worker before they're sent on to the clinic for family planning, so it can be used in the community.

We're also thinking about using picture checklists of common questions and concerns for clients. There's a language problem in Indonesia. Not so much that they're not able to read and write, it's not really literacy. Partly it was this incredible concern the women had with the grammar and their handwriting and their spelling when they were asked to write down questions. They were so distracted by that, they couldn't really focus on the content. Part of the problem is that these women spoke Javanese orally and in the course of consultations with providers, but the written language there is Bahasa Indonesian. So if you listen to the audiotapes, you find women have a consultation in Javanese, then when they went to their prepared questions, they had to switch to Bahasa Indonesian, so it was an interesting local language problem.