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## Improving the patient experience through provider communication skills building

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### Abstract

The doctor's interpersonal skills are arguably the most important to clinical outcome and patient experience. A peer-facilitated, communication skills-building course for physicians has been provided twice annually since its inception in 2004. The course was designed to increase personal awareness, as well as to help physicians develop new communication and interpersonal skills. Satisfaction data from 3,561 patient surveys on 80 providers who attended the course between 2006 and 2010 were analyzed one year before and one year after course participation. After completing the course, the proportion of "excellent" ratings of provider service (the highest rating on a 5-point scale) increased by 2% to 5.6%. The most notable improvements in service attributes under the provider's control and covered in the course content were: involving the patient in care decisions ( $P < .001$ ), explaining medical condition ( $P = .002$ ), and the provider's knowing the patient as a person ( $P = .004$ ). Other improvements were noted in courtesy (by 3.4%,  $P = .027$ ), listening (by 3.5%,  $P = .036$ ), and overall quality of care from the provider (by 3.5%,  $P = .027$ ). Attributes not directly under the provider's control – nursing quality, teamwork, spending enough time, and likelihood to recommend – were included in the analysis; year-over-year changes in these were not significant. Further, providers who participated in the course, when compared to those who did not, experienced an 18-percent decrease in patient complaints. Improvements in perception of excellent provider communication and other service-related behaviors suggest this training approach may be useful in improving patient satisfaction, patient experience, and payment in value-based models.

### Keywords

Patient experience, physician communication skills, service quality improvement, continuous improvement

### Introduction

The patient experience can be thought of as a series of complex healthcare processes, each comprised of numerous critical points of interaction between patients and the organization. These "touch points" – eg. calling for an appointment, checking in at the reception desk, communicating with the physician, and receiving test results – are "moments of truth" at which patients form the most vivid impressions and perceptions about an organization.<sup>1</sup> At each touch point, patients evaluate the quality of care and, ultimately, decide if they will return or recommend the organization to others.

This article highlights three frameworks, spanning more than 40 years of research, which help us to understand how patients evaluate the quality of healthcare services. Today, in this era of value-based purchasing, these frameworks provide valuable insight into improving the total experience *from the patient's perspective*. In the mid-1960's, Donabedian proposed three elements of healthcare quality – amenities, technical quality, and interpersonal quality – in his conceptual model.<sup>2</sup> Of all the staff that

come in contact with the patient, the doctor's interpersonal skills are arguably the most important. The ability to connect, to understand the patient's expectations of the encounter, and to ask the right questions affects the quantity and quality of the information obtained during the patient interview.

In the mid-1980's, Parasuraman *et al.* also considered customer expectations when they proposed their conceptual model of service quality.<sup>3,4</sup> Patients, like any customers, compare their perceptions formed during or following the encounter with their pre-service expectations. If perceptions fall short of expectations, a negative gap results. This gap is a function of service deficiencies in an organization related to understanding customer expectations; designing processes and developing standards around the customer; hiring, educating, and training service-minded people; and communicating accurately about services. Most patients lack the technical knowledge to adequately judge healthcare quality so they rely on familiar service clues, such as staff responsiveness, facility appearance, and provider communication skills, when asked to evaluate

overall quality of care.<sup>5</sup> Better provider communication skills, not technical skills, have been significantly associated with higher global ratings of quality of care.<sup>6</sup>

Mayo Clinic Arizona (MCA) is a non-profit, integrated, multi-specialty medical practice. More than 400 employed providers and 5,000 allied health staff render services to approximately 100,000 patients each year. In 2008, a 7-prong, data- and accountability-driven model for improving service quality was developed and implemented at MCA (Figure 1). It incorporates these widely accepted service quality principles: (1) multiple data sources to drive improvement; (2) accountability for service quality; (3) service consultation and improvement tools; (4) service values and behaviors; (5) education and training; (6) ongoing monitoring and control; and (7) recognition and reward.<sup>7</sup> The focus of this article is Prong 5, education and training, as it relates to providers. We share the methodologies, tools, and resources used to improve their communication skills, service-related behaviors, and the patient experience.

**Figure 1. Mayo Clinic Arizona's data- and accountability driven model for improving service quality and the patient experience.**



### Education and Training for Providers

Numerous studies support the development of providers' communication skills. Communication has been shown to favorably affect clinical outcomes,<sup>8</sup> patient adherence to prescribed treatment,<sup>9</sup> patient satisfaction,<sup>10</sup> malpractice risk,<sup>11</sup> and occurrence of sentinel events.<sup>12</sup> Wofford *et al.* identified disrespect, mismatched expectations of care, inadequate information, and distrust as the most common

types of patient complaints about provider behaviors and suggested that these topics be included in curricula related to professionalism and communication skills.<sup>13</sup> In another study, patient perception of provider listening and explaining improved significantly when providers were made aware of the service behaviors being surveyed, regularly e-mailed their patients' ratings of these behaviors, and told about improvement resources to which they could self-refer.<sup>14</sup> Providers who received personal coaching, the most intense and frequent form of provider education and training, achieved the greatest improvements in patient perception of "excellent" service-related behaviors.<sup>7</sup>

In general, providers are highly motivated individuals with good intentions, high self-expectations, and wide-ranging interpersonal skills.<sup>15</sup> A number of factors contribute to provider variance. The practice of medicine is highly specialized, making different communication styles and methods necessary. Other reasons for variation include culture, language, and life experiences, as well as patient expectations of the provider and the clinical encounter.<sup>16</sup> Finally, increased patient throughput to offset declining revenues, as well as provider discomfort with technology in the exam room, may negatively impact the quality and amount of time a provider has to spend with a patient.

### Provider Communication Skills Building at MCA

During the 2000-01 academic year, a visiting scientist (and internationally renowned service quality expert) spent several months on sabbatical at MCA, immersed in the organization while studying the patient experience.<sup>17</sup> With patient and provider consent, interpersonal quality was studied in the exam room. The outcome of this research confirmed the importance of the provider-patient relationship in the perception of quality at MCA. Nearly concurrent with this work, two MCA physicians collaborated with faculty members of the American Academy on Communications in Healthcare (AACH) to develop a peer-facilitated Communication in Healthcare (CIH) course. In addition to supporting the course, MCA's administration provided for these physicians to participate in the Facilitator in Training (FIT) program of the AACH, culminating in their faculty status with that organization. This training enabled them to assume full responsibility for the course and for the training of additional course facilitators.

MCA's physician communication course is delivered in a facilitated, group-learning model and includes providers from different specialties and disciplines. Course design and instructional methods are based on adult-learning theory and create an experience that attends to participant psychological safety. The course is active, engaging, learner-centered, and inclusive.<sup>18,19</sup> Through didactics and role-play simulations, participants have the opportunity to increase personal awareness and develop new

communication and interpersonal skills. Through sharing of individual experiences, perspectives, challenges and strategies, participants learn from one another.

This full-day course is isolated away from the clinical setting. Participants are relieved of patient care responsibilities in order to be free from distractions and fully present. At the opening, participants gain an understanding of the rationale for communication skills training and are introduced to the provider-specific items measured in the patient satisfaction survey (eg. listening, explaining, showing respect, spending enough time, involving the patient in care decisions, etc.). One or more facilitators guide small groups of eight participants through the course. Topics include active listening and reflection, eliciting and negotiating an agenda, and relationship building with the use of PEARLS (**P**artnership, **E**mpathy, **A**pology, **R**espect, **L**egitimation, and **S**upport).<sup>20</sup> The course is taught with combined didactics and role-play simulations. In addition, participants share challenging experiences and have the opportunity to engage in role-play simulations, followed by a facilitator-guided debriefing. Other participants and the facilitators can offer their perspectives and strategies from similar situations. In this way, the group learns with and from each other. The goal is not to be prescriptive. In a spirit of continuous learning and improvement, providers are encouraged to incorporate, as appropriate, those skills and behaviors that they find most useful for their practices.

The course has been offered twice each year since 2004; reasons for attending vary. Providers may self-refer; new physicians are required to attend as part of their orientation process; department chairs may encourage provider attendance as part of the Joint Commission's standards for ongoing professional practice<sup>21</sup>; or the course may be recommended during service consultation. Promoting the course as an ongoing faculty development opportunity removes any stigma of being referred for remediation, and the participant referral source is unknown to the course facilitators. In addition to promoting effective interpersonal and communication skills, the course fosters collegiality when providers, who often collaborate in patient care, get to know each other at the course. This experience creates opportunities for providers to build empathic, respectful, and supportive relationships with one another.

### Measurement and Data Analysis

Telephonic patient satisfaction surveys were conducted weekly by Professional Research Consultants (PRC), a national vendor with more than 30 years of experience in measuring patient satisfaction. Data files of MCA's patient population were securely transmitted to PRC weekly. The vendor randomly selected patients for surveying, and those who opted to participate were stratified by department and

surveyed once annually. The average annual response rate was 70%.

On a 5-point scale (excellent, very good, good, fair, poor), patients were asked to rate the quality of various service attributes. Survey questions specific to the provider included: thoroughness of the physical exam, spending enough time, listening to concerns, using understandable words and terms, involving the patient in care decisions, courtesy, impression of medical skills, being on time, giving clear instructions, explaining medical condition, knowing the patient as a person, and overall quality of care received from the provider.

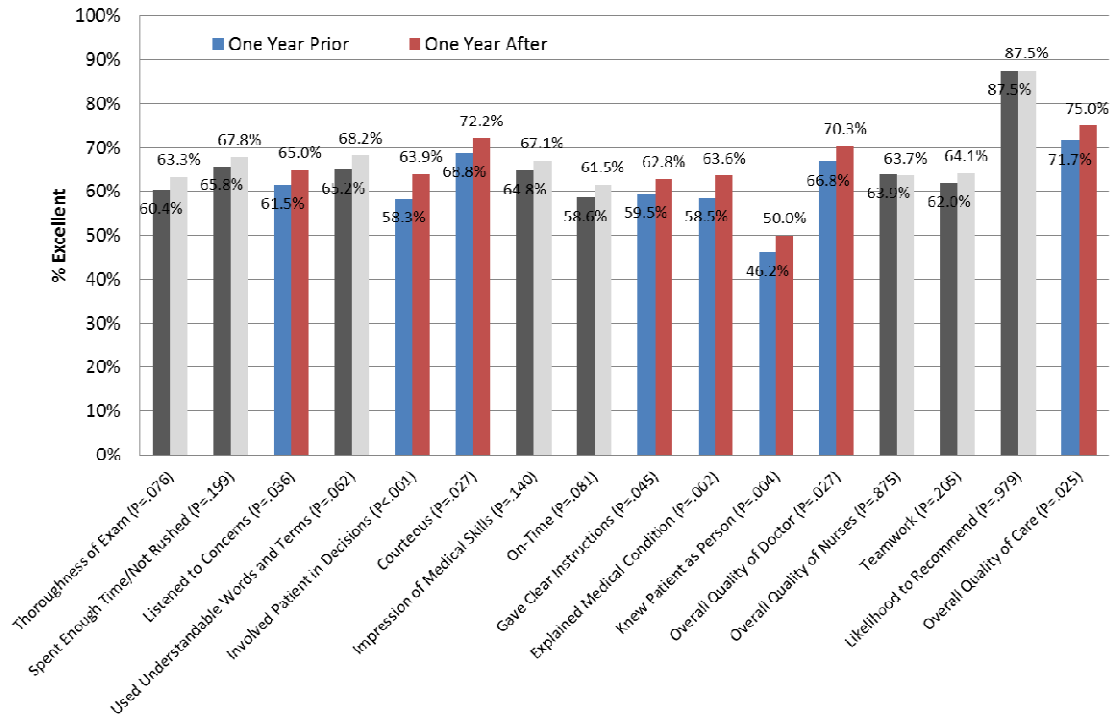
Satisfaction data from 3,561 patient surveys for 80 providers attending the course between 2006 and 2010 were analyzed one year before and one year after their participation. Statistically significant improvements in patient perception of "excellence" were noted for those survey questions directly related to provider communication and completely under the provider's control. Before and after course data, as well as P values, are noted in Figure 2. Attributes not directly under the provider's control – nursing quality, teamwork, spending enough time, and likelihood to recommend – were included in the analysis. Year-over-year changes in patient perception of these service attributes were not significant, suggesting that improvements in provider-specific service were related to the course content and training approach. In addition to improved patient satisfaction, providers who participated in the communication course, when compared to those who did not, experienced an 18-percent decrease in patient complaints.

### Service Consultation and Improvement

During performance reviews, providers may be shown their data trends and rankings relative to their peers. Providers with scores below the goal work with their department chairs to develop individual improvement plans that may include service education and training, personal coaching, other forms of mentoring, and/or participation in the physician communication skills-building course.

MCA's Service Administrator complements the communication course by recommending it as an improvement resource, when the data indicate, and by offering service quality education and training to providers in their department meetings. Department-level patient satisfaction data are presented first, in a stoplight color-coded scorecard, to readily identify opportunities for improvement.<sup>22</sup> Drivers of perception of overall quality, patient comments, and aggregated provider data also are presented and discussed. Blinded, provider-level data may be graphed so each provider sees his/her score and ranking, relative to colleagues who care for similar types of patients, and the goal.

**Figure 2. Percentages of patients (N= 3,561) who rated the service attributes of 80 providers as “excellent” one year prior to and one year after participating in the full-day provider communication course, between 2006 and 2010.** Note: Bars in color represent statistically significant improvement. Grey bars are not significant.



## Looking to the Future

Value-based payment, new care delivery models, and provider-level patient satisfaction data are designed to enhance not only the technical quality of healthcare but also the patient experience. Mandated use of the CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) survey in outpatient care settings is imminent. Like the hospital version (HCAHPS), the outpatient survey includes several questions specific to provider communication and service-related behaviors.<sup>23</sup> Successful performance in this new environment is dependent, in part, on the quality of the communication between provider and patient. To support proactive improvement, a web-based scorecard with several types of provider-specific data, including patient satisfaction data, is being developed. Motivated providers can use this information to improve proactively. They may self-refer to the physician communication course, or they may access online educational resources that complement the course. Lastly, an individual provider coaching program is being developed for those that may need a more intensive learning opportunity. This suite of resources is intended to allow varying levels of resource utilization relative to a provider's learning needs.

Many patients carry the burdens of illness, such as pain, disability, loss of control, and fear. They often take time away from work and family and incur significant expense to receive care. They have expectations of their doctors and prefer those who are forthright and thorough yet, at the same time, empathetic and humane.<sup>10</sup> By cultivating their interpersonal and communication skills, as well as their technical skills, providers can help alleviate their patients' burdens and help create the best possible patient experience.

Organizations enhance the patient experience by understanding patients' expectations, listening to their preferences, developing programs to improve provider communication and interpersonal skills, measuring service quality, and providing feedback and tools for continuous improvement. Improving the experience is the right thing to do for the patient and, in a value-based payment model, helps sustain an organization into the future.

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