The Impact of Organizational Culture Training on Patient-Provider Communication

Report Written by:
Zach Hidinger and Katie Nelson

Contributions by:
Carol Weidenhoffer, Carol Ross-Spang, Don Hutson, Justin Keeton, Sandra Greer, Janet Phillips and Michelle Collis

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Senn Delaney, The Culture-Shaping Firm
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• The impact service efforts have on patient and family experience
• The influence of culture on the overall healthcare experience
  and/or performance outcomes
• An integrated review of the impact these factors have in
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The Affordable Care Act (ACA), signed into law in 2010 and confirmed by the Supreme Court in 2012, has catalyzed a profound shift in the delivery of healthcare in the United States. The ACA seeks to improve patient care, outcomes and experience and demands reform of the fee-for-service model of care. Post-ACA, the emphasis for both hospital and physician level providers is no longer the individual patient (fee-for-service) but the entire panel or population of patients a system or provider serves (population health). This restructuring of the model of care has pushed hospital systems and individual providers and practices to align in pursuit of improved clinical quality, experiential quality and the continuity and coordination of patient care.

Since 2010, Methodist Le Bonheur Healthcare (Methodist Healthcare) has aligned with 27 primary care groups and 12 specialty practices totaling almost 250 physicians and mid-level providers in 28 specialties. This diverse set of physician-partners positions Methodist Healthcare to provide comprehensive multi-specialty care to the community it serves. In order to achieve the goals of improved clinical quality, experiential quality and continuity and coordination of care as set forth by the ACA, Methodist Healthcare has committed to creating a culture of patient and family centered care (PFCC) in both hospitals and clinics. “[T]he best way to improve the patient experience is to build better engagement with ... employees who, then, will provide better service and healthcare to patients” (Berret & Spiegelman, 2012).

To build a strong PFCC culture throughout the entire system, Methodist Healthcare enlisted the help of Senn Delaney, The Culture-Shaping Firm, to provide a process and methodology to guide the organization. This included diagnosing cultural strengths and opportunities and providing tools and training to define and reinforce the organization’s Power of One culture, emphasizing the power every Methodist Healthcare Associate has to positively impact our patients and their family members. The Power of One culture training was provided for our clinical group providers, starting in 2013 and continuing to present day. This study focuses on the effect of Power of One training for Methodist Healthcare-employed primary care physicians on their patient’s perception of overall quality of healthcare provided and physician communication as evidenced by the CAHPS Clinician & Group patient experience survey scores.

### The Power of One

At Methodist Le Bonheur Healthcare, our culture is defined as “The Power of One.” The Power of One embodies our faith-based mission, our core values, our guiding behaviors, and our deeply-rooted commitment to patient- and family-centered care. It also speaks to the power each of us possesses to make a difference in the lives of our patients, their families, and our fellow Associates: the power of one person, one team, one organization, and one community to deliver on the promise of exceptional health care.

Through years of work with Senn Delaney, we understand that our insights, thoughts and behaviors directly impact our results. When we positively change the way we think about the care we provide, our actions reflect the highest level of service. Our organization developed the MLH process—Make a Connection, Listen to Understand Needs, and Honor Commitments—to help us put our culture into action. By placing an emphasis on connecting with one another, listening beyond words, and following through on our promises, we will improve our behaviors and ensure that the result is us at our best: Power of One Service.

Designed based on patient feedback, MLH helps us make the distinction between customer service and Power of One Service. MLH reminds all Associates of who we are and guides the care we deliver in every situation. Following the MLH process helps us put our Power of One values and guiding behaviors in action, ensuring that we provide exceptional care and achieve outstanding results in patient experience, quality outcomes and Associate engagement.

Senn Delaney provided us with the DURAM™ culture-shaping methodology, comprised of five elements (Diagnose, Unfreeze, Reinforce, Apply and Measure), with which to shape the organizational culture of the entire Methodist Le Bonheur Healthcare system. Diagnose™ speaks to defining the “current and future” state of organizational culture. Once defined, the next step is to...
“shift [Associate] thinking and behaviors”, and this is accomplished with an Unfreeze™ (Senn Delaney, 2014).

All Methodist Healthcare Associates typically attend a two-day Power of One Unfreeze™ retreat, where Associates are introduced to a variety of concepts and exercises intended to enhance and shape aspects of Methodist Healthcare’s value-based culture to create healthier, high-performance teams. Sessions are not lecture-oriented; rather they are designed to be interactive. These Senn Delaney-developed sessions are designed to break down—or “unfreeze”—old values, traditions, and behaviors. (2014).

To accommodate physician’s busy schedules, the Power of One retreats were condensed to one day, rather than two, with particular focus put on leveraging Power of One principles to augment the patient-provider relationship. The physician unfreezing process is necessary because values and decision-making patterns develop over a long time, fix themselves firmly and become a habit. To improve physician results it is necessary to immerse our physicians in the unfreeze session so that they may have the opportunity to examine how their thinking impacts their behavior and from this, adapt their behavior to get even better results.

The rest of the DURAM methodology pertains to “reinforcing” (Reinforce™), for example with monthly MLH modules, and “applying” (Apply™) concepts to everyday practices; and ultimately “measuring” (Measure™) to the extent to which concepts were successfully applied (2014). The focus of this research project is on the Power of One Unfreeze™.

It’s important to note, though, that, although the focus of this research project is primarily on the Power of One Unfreeze™ for primary care providers, this is only one component for one subpopulation; and cannot be considered independent of an overarching organizational culture, which Methodist Le Bonheur Healthcare, with the help of Senn Delaney, has been working to shape for years.

### METHODS

This retrospective case study uses a quasi-experimental, nonrandomized, pre-post intervention study design, in which a pretest measurement was obtained prior to the intervention and the posttest measurement after the intervention. The objective was to assess the effect of Power of One training on patient’s perception of patient-provider communication, as measured by data derived from the Adult “Visit” Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (Clinician & Group Survey).

The dataset is comprised of 14,973 responses (N = 14,973) to the Clinician & Group Survey, ranging from January 1, 2013 to June 30, 2014. It only includes responses regarding primary care encounters. The survey was emailed to adult patients within days of an encounter with a MLH-employed primary care provider (PCP). Only those PCPs who participated in MLH’s Power of One training are included in the dataset (n = 56). Further, the definition of PCP was limited to those practicing at clinics characterized as either Internal or Family Medicine.

### Instrument

The “Visit” version of the Adult Clinician & Group Survey is one of the versions allowed by CMS for patient experience surveying. “[T]he Visit Survey is meant to capture information about a patient’s most recent visit. However, only questions about doctor communication and office staff ask about the most recent visit.” In terms of response scale, “[t]he only difference is that the questions about experiences at the most recent visit use a three-point expanded Yes/No scale: ‘Yes, definitely/Yes, somewhat/No.’” (AHRQ, 2014).

### Setting

Methodist Le Bonheur Healthcare-employed primary care groups across the Memphis, Tennessee metropolitan area.
Survey Respondents

The dataset is comprised of respondents in mostly “Good” (35.61%) or “Very Good” (38.01%) overall health, according to their own self-rating. The majority (60.54%) of respondents is at least 55 years of age; only 8.47% of respondents were below the age of 35 years. Slightly more than half of respondents (51.83%) indicated the highest level of education completed was at least a 4-year college, with only 1.54% indicating less than “Some high school, but did not graduate.” The CAHPS Consortium indicated potential biases inherent among certain demographics. In particular, “[i]ndividuals in better health and older individuals tend to rate their care, plans, and providers higher. There is also evidence from a number of studies that education affects ratings, with more educated individuals giving lower ratings” (AHRQ, 2014). It should be noted, though, that no exclusions were made on the basis of demographics. Accordingly, any perceived bias will be addressed in the “Discussion” section.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>N-Missing</th>
<th>Level</th>
<th>Count (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Health Status</td>
<td>13,666</td>
<td>1,307</td>
<td>Excellent</td>
<td>2,084 (15.25%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Very Good</td>
<td>5,195 (38.01%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Good</td>
<td>4,867 (35.61%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fair</td>
<td>1,331 (9.75%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Poor</td>
<td>188 (1.38%)</td>
</tr>
<tr>
<td>Age</td>
<td>13,666</td>
<td>1,307</td>
<td>18-24</td>
<td>302 (2.21%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25-34</td>
<td>855 (6.26%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>35-44</td>
<td>1,535 (11.23%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>45-54</td>
<td>2,702 (19.77%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>55-64</td>
<td>4,064 (29.74%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>65-74</td>
<td>3,228 (23.63%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>75 or older</td>
<td>980 (7.17%)</td>
</tr>
<tr>
<td>Highest Level of Education Completed</td>
<td>13,666</td>
<td>1,307</td>
<td>8th grade or less</td>
<td>52 (0.38%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Some high school, but did not graduate</td>
<td>158 (1.16%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High school graduate or GED</td>
<td>1,739 (12.73%)</td>
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<td></td>
<td></td>
<td></td>
<td>Some college or 2-year college</td>
<td>4,634 (33.91%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4-year college</td>
<td>3,080 (22.54%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>More than 4-year college</td>
<td>4,003 (29.29%)</td>
</tr>
</tbody>
</table>

Figure 1: Selected Characteristics of Respondents
**Intervention**

All Methodist Healthcare-employed PCPs, along with all office staff and corporate administrators, were invited to attend a condensed, one-day Power of One Unfreeze™. Of those invited, the vast majority were able to attend one of the four one-day sessions that were held during fourth quarter 2014. In total, fifty-six PCPs were trained, including forty-two (75 percent of attendees) doctors of allopathic medicine, two (4 percent) doctors of osteopathic medicine, twelve nurse practitioners (21 percent).

**Measures**

The “Visit” Clinician & Group Survey contains information on patient demographic characteristics; the ability to get timely appointments, care, and information; helpfulness and courteousness of office staff; how well providers communicate with patients; and the patient’s rating of the provider. This study is primarily interested in questions pertaining to the latter two domains: patient-provider communication and rating of the provider.

Responses to questions pertaining to patient-provider communication and the rating of the provider domains were transformed into categorical variables with two levels (“top box”, “non-top box”) to be consistent with CMS standards for public reporting of patient experience data. The “top-box” is the most positive response to survey questions (AF4Q, 2007). Any response of “9” or “10” to the Overall Rating of the Provider or “Yes, Definitely” to all other provider-related questions is considered “top box.” All other responses were dichotomized as “non-top box” (for the rating of the provider, responses ranging from “0” to “8” and, for patient-provider communication questions, responses of “Yes, somewhat” or “No”). A “Provider Communication” composite was then created by aggregating “top box” and “non-top box” levels of all provider communication-related variables, which does not include the Overall Rating of the Provider. Figure Two summarizes all variables of interest.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Variable</th>
<th>“Visit” CG-CAHPS Question #</th>
<th>Type</th>
<th>N</th>
<th>N-Missing</th>
<th>Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of the Provider</td>
<td>Overall Rating of Provider</td>
<td>25</td>
<td>Categorical</td>
<td>12,527</td>
<td>2,446</td>
<td>Non-Top Box 2,053</td>
<td>Top Box 10,474</td>
</tr>
<tr>
<td></td>
<td>Explanation easy to understand</td>
<td>16</td>
<td>Categorical</td>
<td>12,760</td>
<td>2,213</td>
<td>Non-Top Box 704</td>
<td>Top Box 12,056</td>
</tr>
<tr>
<td></td>
<td>Listened carefully</td>
<td>17</td>
<td>Categorical</td>
<td>12,760</td>
<td>2,213</td>
<td>Non-Top Box 752</td>
<td>Top Box 12,008</td>
</tr>
<tr>
<td></td>
<td>Provide info about health questions/concerns</td>
<td>19</td>
<td>Categorical</td>
<td>11,832</td>
<td>3,141</td>
<td>Non-Top Box 769</td>
<td>Top Box 11,365</td>
</tr>
<tr>
<td></td>
<td>Showed respect</td>
<td>21</td>
<td>Categorical</td>
<td>12,655</td>
<td>2,318</td>
<td>Non-Top Box 526</td>
<td>Top Box 12,129</td>
</tr>
<tr>
<td></td>
<td>Spent enough time</td>
<td>22</td>
<td>Categorical</td>
<td>12,527</td>
<td>2,446</td>
<td>Non-Top Box 1,050</td>
<td>Top Box 11,477</td>
</tr>
<tr>
<td></td>
<td>Provider Communication Composite of 16,17,19,20,21,22</td>
<td>75,189</td>
<td>Categorical</td>
<td>75,189</td>
<td>14,649</td>
<td>Non-Top Box 5,091</td>
<td>Top Box 70,098</td>
</tr>
</tbody>
</table>

Figure 2: Variables of Interest
Dependent variables explored include the “Training Status” and “Utilization Level (Figure 3).” “Training Status” refers to whether a patient encounter occurred “Pre” or “Post” intervention, based on the date of survey complete. “Utilization Level” refers to the amount of outpatient visits within the last twelve months, where ordinal responses were transformed into a categorical variable with two levels (“Low”, “High”), based on the utilization of healthcare services over a 12-month period. Here, “Low” indicates less than three outpatient encounters, and “High” indicates at least three. It should be noted that outpatient utilization is self-reported by respondents.

Analysis

This retrospective case study uses a quasi-experimental, nonrandomized, pre-post intervention study design.

For each provider-related variable, with the exception of the overall rating of the provider, the proportion of “top box” responses received prior to the intervention (X = “Pre”) was compared to the proportion of “top box” responses received after the intervention (X = “Post”) using a two-proportion test to determine whether there was any statistically significant difference at the 95% confidence level, where \( \alpha = 0.05 \).

\[ H_0: p_{pre} = p_{post} \]

The CAHPS Consortium recommends reporting data for global ratings, such as the Overall Rating of Provider, according to outpatient utilization. Therefore, this same analysis was then performed on two sub-groups, “Low” and “High” utilizers of healthcare services, respectively, however, this time with the inclusion of the overall Rating of the provider.

Utilization Level = “Low” \[ H_0: p_{pre} = p_{post} \]

Utilization Level = “High” \[ H_0: p_{pre} = p_{post} \]

“Pre” and “post” intervention encounters overall, as well as for both “low” and “high” utilizers of healthcare services, were similar with respect to overall health, overall mental or emotional health, age, gender, level of education, ethnicity and race.

To aid the analysis, the six Clinician & Group Survey patient-provider communication questions were attributed to one of the three elements of our the Power of One Service Model called MLH (Make a connection, Listen to understand needs, and Honor commitments), as shown by Figure 4.

Minitab 17 was used to conduct all statistical analysis.
RESULTS

Figure 5 shows, for all responses to the Clinician & Group Survey, “pre” and “post” intervention scores by metric, in addition to the results of two-proportion tests comparing “pre” versus “post” intervention scores. Among all respondents, post-intervention, there was improvement for each of the six provider-related questions, as well as the composite. The largest estimated improvements pertained to listening, providing information about health questions or concerns, and knowledge of medical history. For each of which, post-intervention scores were significantly different at the 95% confidence level. Further, the “Provider Communication” composite of all six questions was also significantly different at the 95% confidence level (p-value < 0.001).

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Pre-Training Score</th>
<th>Post-Training Score</th>
<th>95% CI for Difference</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explanation easy to understand</td>
<td>94.17%</td>
<td>94.77%</td>
<td>(-0.0020, 0.0139)</td>
<td>0.142</td>
</tr>
<tr>
<td></td>
<td>Listened carefully</td>
<td>93.57%</td>
<td>94.60%</td>
<td>(0.0021, 0.0185)</td>
<td>0.014*</td>
</tr>
<tr>
<td>Patient-Provider Communication</td>
<td>Provide info about health questions/concerns</td>
<td>92.88%</td>
<td>94.08%</td>
<td>(0.0031, 0.0209)</td>
<td>0.008*</td>
</tr>
<tr>
<td>Communication Questions &amp;</td>
<td>Knowledgeable of medical history</td>
<td>89.07%</td>
<td>90.50%</td>
<td>(0.0037, 0.0249)</td>
<td>0.008*</td>
</tr>
<tr>
<td>Composite</td>
<td>Showed respect</td>
<td>95.57%</td>
<td>96.09%</td>
<td>(-0.0018, 0.0122)</td>
<td>0.143</td>
</tr>
<tr>
<td></td>
<td>Spent enough time</td>
<td>91.23%</td>
<td>91.98%</td>
<td>(-0.0022, 0.017)</td>
<td>0.130</td>
</tr>
<tr>
<td></td>
<td>Provider Communication Composite</td>
<td>92.75%</td>
<td>93.67%</td>
<td>(0.0056, 0.0128)</td>
<td>0.000*</td>
</tr>
</tbody>
</table>

* Indicates a statistically significant difference in pre vs. post score

Figure 5: Pre vs. Post Scores among All Respondents

Figures 6 and 7 show results by level of outpatient utilization. Among those with a “low” number of outpatient encounters within a 12-month period, post-intervention scores were higher than pre-intervention scores for each metric. Five of the six provider-related questions improved significantly post-training (α = 0.05). The post-intervention score for the patient-provider communication composite significantly improved (p-value < 0.001). The 95 percent confidence interval for the difference between “pre” and “post” composite scores is 0.011 to 0.21 percentage points.

For overall rating of the provider, it can be said with 95 percent confidence that the difference between “pre” and “post” intervention scores is 0.006 and 0.044 percentage points; and this difference is significantly different (p-value = 0.012).
### Domain Description Pre-Training Score | Post-Training Score | 95% CI for Difference | p-value
--- | --- | --- | ---
**Rating of the Provider**
- Overall Rating of Provider 80.57% | 83.03% | (0.0055, 0.0438) | 0.012*

**Patient-Provider Communication Questions & Composite**
- Provider explanation easy to understand 93.72% | 94.70% | (-0.0017, 0.02124) | 0.096*
- Listened carefully 93.08% | 94.33% | (0.0005, 0.0244) | 0.041*
- Provider info about health questions/concerns 92.01% | 93.77% | (0.0043, 0.0308) | 0.009*
- Provider knowledgeable of medical history 85.12% | 88.03% | (0.0122, 0.0458) | 0.001*
- Provider showed respect 95.07% | 96.22% | (0.0014, 0.0217) | 0.025*
- Provider spent enough time 90.44% | 91.98% | (0.0013, 0.0295) | 0.032*
- Patient-Provider Communication 91.58% | 93.17% | (0.0105, 0.0213) | 0.000*

* Indicates a statistically significant difference in pre vs. post score

**Figure 6: Pre vs. Post Scores among Low-Utilizers**

Among high-utilizing patients, there was no statistically significant improvement in post-intervention scores. While most of the post-intervention scores increased, the change was not statistically significant ($\alpha = 0.05$).

### Domain Description Pre-Training Score | Post-Training Score | 95% CI for Difference | p-value
--- | --- | --- | ---
**Rating of the Provider**
- Overall Rating of Provider 84.53% | 86.17% | (-0.0011, 0.0340) | 0.067

**Patient-Provider Communication Questions & Composite**
- Provider explanation easy to understand 94.59% | 94.85% | (-0.0084, 0.0136) | 0.641
- Listened carefully 94.03% | 94.92% | (-0.0024, 0.0201) | 0.123
- Provider info about health questions/concerns 93.64% | 94.43% | (-0.0042, 0.0198) | 0.203
- Provider knowledgeable of medical history 93.27% | 92.68% | (-0.0068, 0.0185) | 0.362
- Provider showed respect 96.04% | 95.95% | (-0.0106, 0.0088) | 0.861
- Provider spent enough time 91.95% | 91.98% | (-0.0132, 0.0138) | 0.966
- Patient-Provider Communication 93.83% | 94.23% | (-0.000737303, 0.00887122) | 0.097

**Figure 7: Pre vs. Post Scores among High-Utilizers**
DISCUSSION

The results of this study demonstrate the impact of Power of One Unfreeze™ culture shaping sessions for PCPs on patient perceptions of patient-provider communication. Our findings are consistent with the work on organizational culture and patient experience by Berret & Spiegelman – culture training for providers tends to be positively related to patient’s perception of provider communication and overall quality of care. Among the entire group of patients included in the study, we saw an increase in raw scores in individual questions, the doctor communication composite and overall rating. However, when analyzing by level of patient utilization, we found that there was no statistically significant improvement in pre vs. post intervention scores in high utilizing patient’s scores. There was a statistically significant increase in low-utilizing patient’s scores post-intervention.

The Power of One Unfreeze™ introduced providers to our Power of One Service model called MLH - Make a Connection, Listen to Understand Needs, and Honor Commitments. The results of this study confirm that the Power of One Unfreeze™ for PCPs improved the patient perception of the provider’s ability to “listen for understanding” and “making a connection.” That is, post-training, providers listened to patients (e.g., listened carefully) and then demonstrated this knowledge to the patient (e.g., knowledgeable of medical history, provide information on about health questions or concerns) significantly more so after the Power of One Unfreeze™ than before it.

This is not to say that the Power of One Unfreeze™ does not reinforce the other provider behaviors—explaining in an easy-to-understand manner, showing respect, and spending enough time. All of which improved, just not significantly (α = 0.05), and there was enough improvement within the patient-provider communication domain as a whole that the composite improved significantly (p-value < 0.001). But the results suggest these provider behaviors were not impacted by the Power of One Unfreeze™ to the same extent as listening carefully, demonstrating knowledge of medical history, and providing information on about health questions or concerns.

Analyzing the Clinician & Group Survey responses by level of outpatient utilization indicated important differences between “high” and “low” utilization groups, where there was a statistically significant increase in low-utilizing patient’s scores post-intervention.

Not surprisingly, encounters among “high” utilizers of outpatient healthcare services were predominately associated with higher rates of the above-mentioned behaviors being performed, as compared to “low” utilizers. A likely and simple explanation for this is that these patients are satisfied enough with their provider’s ability to communicate to keep coming back, which creates a potential bias. Even still, six out of eight metrics, including the patient-provider communication composite and the overall rating of the provider, improved, but not significantly (α = 0.05). The two behaviors that did not improve are demonstrating knowledge of the patient’s medical history and showing courtesy and respect for what the patient had to say. The lack of statistically significant improvement, though, should not necessarily be cause for concern, particularly because of the relatively high pre-intervention scores. That being said, communication between providers and high-utilizers is something that should be monitored going forward. “Unfreezing” old behaviors is inferably much more difficult to do in regards to patients with which a provider already has a relationship. For instance, a provider might be less likely to demonstrate knowledge of a patient’s medical history if he or she sees this patient often; or maybe this provider’s behavior is more casual, and thus perceived as being less courteous.

Conversely, scores among “low” utilizers of outpatient services had lower scores in general, but all which, with the exception of the provider’s ability to provide easy-to-understand explanations (p-value = 0.096), improved significantly following the Power of One Unfreeze™. This underscores the ability of the Power of One Unfreeze™ to help providers make a connection, in this case, with patients with whom they might be less familiar. Additionally, unlike “high” utilizing respondents and overall respondents, there was significant improvement in scores across all MLH concepts. This, of course, is important in terms of patient experience and quality, but also, practically speaking, for growing provider panels.
After conducting several Power of One Unfreeze™ sessions, several lessons were learned, particularly in terms of creating an environment that fostered participation. The success of the intervention was dependent upon active provider participation, and this was a direct result of steps taken before, during, and after the intervention.

Some examples of steps taken before the Power of One Unfreeze™ include, among other things, showing a promotional video where other providers discussed the personal value of culture-shaping in an attempt to minimize resistance; randomly assigning providers to a training cohort so that each cohort had a balanced mix of enthusiasm, rather than training mostly innovators and early adopters upfront; compensating providers for their time and tailoring the curriculum so that continuing medical education credit could be offered; and, probably most importantly, ensuring participation of leadership to bring credibility to the initiative. It became increasingly apparent that it is vital for system leaders to not only attend but be very engaged participants—sharing stories, showing appreciation, providing feedback, and addressing unhelpful remarks.

After the Power of One Unfreeze™, it’s helpful for providers to return to a setting where Associates from top down, have been exposed to the same organizational culture. Leaders in particular should be well versed so that they can reinforce concepts after the Unfreeze™. For this reason, leaders often went through a Power of One Unfreeze™ multiple times, including with providers.

Further, to help clarify what these concepts look like in practice, a Methodist Healthcare/Physician Compact was drafted by aligned doctors. The draft was finalized by a physician/leader work group, and methods of accountability are under discussion. A modified version of this compact will be written to guide all physicians who practice at Methodist.

This study design is not without limitations. The nature of the “Visit” Clinician & Group Survey is such that patients are eligible to be surveyed more than once but no more than twice per twelve-month period, and unique patient identifiers were not available to exclude those with multiple survey completes. Therefore, samples cannot be considered completely independent. External benchmarks, such as database percentile rankings, were also not available. Further, a more reliable case-control study design was preferred, but the fact that almost all primary care providers were trained resulted in a simpler pre-post study design being used.

Nevertheless, the results suggest the Power of One Unfreeze™ seems to be an effective means to improve patient-provider communication in the primary care setting, particularly among low-utilizing patients; however, this cannot solely be attributed to the intervention itself, rather any success is the product of a very deliberate, multi-year journey to shape Methodist Le Bonheur Healthcare’s organizational culture from the top down.

As for next steps, a baseline has been established and progress will be monitored, at the provider-, group- and cohort-levels, on a quarterly basis. At this point, the results do not indicate a change to the curriculum is necessary; however, more work on this project will be done to assess provider behaviors toward high-utilizing patients, with whom they may be more accustomed to seeing regularly. Future work might also incorporate Associate Feedback Survey results into the analysis to provide a broader view of organizational culture. Additionally, external benchmarks, most likely derived from a vendor database, will be included in the analysis once available. This benchmark data will help to provide context in determining which behaviors need more focus.
REFERENCES


