Enhancing clinician communication skills in a large healthcare organization: A longitudinal case study

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Abstract

Objective: This article describes the approach taken over the past 16 years by one large healthcare organization, Kaiser Permanente (KP), to enhance the clinical communication and relationship skills of their clinicians.

Methods: The centerpiece of KP’s approach has been the creation and dissemination of a unifying clinician-patient communication (CPC) framework for teaching and research called the Four Habits Model.

Results: The Model has served as the foundation for a diverse array of KP programs. Sustained improvement in patient satisfaction scores has been demonstrated. Clinician-patient communication training has become a well-established component of professional development in KP.

Discussion: Enhancing clinicians’ communication with patients is a complex task requiring planning and organizational commitment. Factors that have contributed to the success and lessons learned from incorporating clinician communication skills across the organization are described.

Conclusion: The KP experience attests to the feasibility of bringing the vital skills of effective communication to large numbers of busy clinicians.

Practice implications: Healthcare practices wishing to enhance clinician-patient communication skills should consider using a consistent teaching model, ensuring strong sponsorship from leaders, and emphasizing clinician satisfaction in the design of programs.

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1. Introduction

Physicians in the US conduct 140,000–160,000 medical interviews during an average practice lifetime [1]. Recognizing that poor communication between clinicians and patients decreases quality and increases human and economic costs of care [2], organizations such as the Institute of Medicine, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Internal Medicine have identified communication as one of the core competencies required for good medical practice [3]. As a consequence, as of June 2004, graduates of American medical colleges are required to demonstrate competency in communication in order to receive certification from the National Board of Medical Examiners.

The importance of clinician-patient communication (CPC) is also drawing attention within organizations delivering healthcare. Consumers increasingly demand “doctors who listen” [4]. Likewise, medical educators have called for a shift in emphasis from biomedical to biopsychosocial and more recently from patient-centered to relationship-centered care [5,6]. Research studies demonstrate the links between communication behaviors in the exam room and clinical outcomes [7–13]. Gaps in communication and relationship between patients and
clinicians have been associated with switching doctors or disenrollment from health plans, poor adherence with recommended treatments, and propensity to sue for medical malpractice in the face of an adverse outcome [14–16]. Healthcare organizations wishing to address these gaps face the daunting challenge of assessing, enhancing, and supporting the communication skills of their clinicians.

The purpose of this article is to describe as a case study the approach taken over the past 16 years by one healthcare organization, Kaiser Permanente (KP), to optimize the clinical communication skills of their clinicians. Kaiser Permanente, with more than 11,000 physicians providing care to over 8 million members across eight regions (Northern California, Southern California, Northwest, Hawaii, Colorado, Ohio, Georgia, mid-Atlantic), is one of the largest health maintenance organizations (HMOs) in the US. This case study focuses mainly on CPC efforts within the Northern California region of KP, with over three million members served by the 5300 physicians of The Permanente Medical Group (TPMG). The centerpiece of this effort has been the creation and organization-wide dissemination of an integrated framework for teaching clinical communication and relationship skills called the Four Habits Model [17,18].

2. Early stages of development

TPMG’s focus on clinician-patient communication began not with an elaborate organizational strategy from senior leadership, but with a series of actions by a few people who thought the topic was important. In 1988, the Director of Staff Education for the Northern California region began a series of informal lunch hour conversations with physicians at several medical centers about research showing that the way doctors communicate makes a difference to patients. He found that audiences were interested in learning new skills to improve their interactions with patients.

In order to better understand the interest generated by these lectures, the primary author (TS) conducted informal discussions with groups of clinicians followed by a formal needs assessment of 800 physicians based on the question, “thinking about your communication with your patients, what would you like to be able to do better in order to improve your day?” Response to the survey was high (70%) with the majority indicating that they most wanted to improve their skills in communicating with “difficult” patients (angry, demanding, drug-seeking).

2.1. Thriving in a busy practice

Based on the results of the assessment, the first CPC program was launched in 1990, a day-long workshop called Thriving in a Busy Practice (Thriving). During the first half of the day a videotape of an actor playing a patient was used as a trigger for discussion of basic communication skills. Participants were asked to comment on what the patient might be feeling, what they were feeling, and what they would say to the patient. The second half of the day focused on managing difficult interactions. Several volunteers from the audience role-played difficult patients in front of the group with one of the faculty playing the clinician to demonstrate useful communication strategies.

From 1990 to 1995 Thriving was offered 22 times to a total of nearly 1400 clinicians from different specialties. Participants rated the workshop (response rate 77%) as excellent (mean 6.2 on 7-point Likert scale) and stated that they would recommend it to a colleague (mean 6.3). One factor contributing to the large number of clinicians attending this week-day course is the value TPMG’s culture places on continuing education. This value is facilitated and reinforced by offering physicians an allotment of paid time for attending educational programs, many of which are offered without charge by the Department of TPMG Physician Education and Development.

Critical success factors were:

- Emphasizing that the workshop’s purpose was to help clinicians with a tough job.
- Focusing on issues most relevant to the participants (e.g. difficult interactions).
- Using an experiential learning format.
- Holding the program on a weekday in a pleasant setting with good food.
- Starting with highly motivated participants to generate positive “marketing” and give suggestions for improvement.
- Insisting that attendance be voluntary.

A key step in establishing a “foothold” in the organization was demonstrating that clinician education in communication and relationship skills improved clinicians’ confidence and satisfaction. Results of a pre-, and 3 month post-self assessment survey \((n=911)\) showed increased confidence in the skills covered in the workshop, especially those pertaining to the “difficult” patient. Before the workshop, half the respondents said that more than 1 out of every 10 patient visits was “frustrating.” Three months after the workshop only one-third reported the same level of difficulty [19]. A subsequent study performed when Thriving was offered in the Northwest region also indicated that the course had a significant impact on physicians’ self-reported confidence in dealing with difficult patient interactions, a finding that was sustained over three months [20]. Although patient satisfaction among these physicians did not improve compared to a control group, this finding was thought to be due in part to major concurrent organizational changes which may have limited the clinicians’ ability to implement the lessons of Thriving. Publication of this study did not diminish enrollment in Thriving in the Northern California region probably because the course already had a strong reputation within the clinician community.
The positive response of clinicians to Thriving also led to one of the authors (TS) being designated in 1993 as the Director of Clinician-Patient Communication for the Northern California region. Facets of this role have included leadership, advocacy, faculty development, program design, teaching, research, and integration of CPC into major organizational initiatives, such as patient safety and the electronic medical record.

2.2. Patient satisfaction surveys

1994 marked a turning point for clinician-patient communication work in TPMG. Outpatient member/patient satisfaction surveys (MPS) were introduced across the Northern California region. Summary scores were provided as feedback to individual clinicians, departments, and facilities on patients’ perceptions of communication, familiarity, service and on whether the member perceived that they had a personal physician. The results created an unprecedented sense of urgency and interest among clinicians and administrators in ways to improve interpersonal communication skills. In some cases the motivation to improve was heightened by the fact that MPS scores were being used as a basis for salary adjustments. The positive consequence was a dramatic increase in the number of clinicians who enrolled in Thriving.

2.3. Communication Consultants

In order to expand CPC education beyond a 1-day workshop and respond to the demand generated by the MPS survey, a Communication Consultant Program was launched in 1994 [21]. Communication consultants are physicians or psychologists who coordinate facility-based education in CPC. They are selected according to several criteria: outstanding clinical and interpersonal skills, interest in CPC, willingness to take on a new role, and experience with teaching and facilitation (optional). Communication consultant activities have ranged from one-to-one coaching (e.g. listening to audiotapes of visits, problem-solving difficult encounters, observing and debriefing actual patient visits), to departmental presentations and courses, newsletters, and lunchtime discussions about challenging patient encounters. The original group of 8 Communication Consultants has grown to 56 during the 10 years that the program has been operating. Currently, every medical center and office building across the Northern California region is represented by one to four Communication Consultants. The entire group of Communication Consultants meets four times a year and receives ongoing training on CPC content as well as presentation and facilitation skills.

The model of regional leadership and educational programs devoted to CPC plus facility-based Communication Consultants enhanced the visibility of communication skills training in the organization. This infrastructure allowed for centralized coordination and advocacy while encouraging local autonomy and creativity.

3. The Four Habits Model

Growing recognition of the importance of CPC skills and increasing requests for training highlighted the need for a simple cohesive structure or model that would enable clinicians to learn to communicate effectively and efficiently. In 1996, two of the authors (RMF and TS) addressed this need by designing the Four Habits Model (Table 1). The model is an evidence-based framework that connects and integrates skills to fit the real-time running organization of the clinical interview. A monograph describing the components of the model and its research base was published internally by these two authors for distribution at CPC programs [17]. In 2003, the monograph was revised and updated in partnership with the third author (EK) [18]. To date over 32,000 monographs have been printed and distributed across KP. Two peer reviewed journal articles describing the model have also been published [22,23].

The term Habit denotes organized and integrated ways of thinking and acting during clinical encounters. The Four Habits are: Invest in the Beginning, Elicit the Patient’s Perspective, Demonstrate Empathy, and Invest in the End. The purpose of the Four Habits is to establish rapport and build trust rapidly, to facilitate the effective exchange of information, to demonstrate caring and concern, and to increase the likelihood of adherence and positive health outcomes.

Several conceptual models of the medical interview informed the development of the Four Habits Model [6,24,25]. Expert opinion as found in the Toronto and Kalamazoo Consensus Statements helped define specific communication competencies associated with desired outcomes of care [26,27]. A unique feature of the Four Habits Model is the linkage of skills to the temporal flow of events that make up a medical encounter. For example, interruption of the patient’s concerns at the beginning of the encounter may lead to so-called “hidden concerns” at the end of the encounter [28,29]. Understanding the relationship between early interruption (Habit 1) and the increased potential for “hidden concerns” at the end of the encounter (Habit 4) allows a clinician to use the skill of eliciting the full spectrum of patient concerns at the beginning of the visit to reduce patient frustration with unspoken or poorly addressed concerns at the end.

Framing the Four Habits in terms of the association of clinician communication behaviors to health outcomes, clinician and patient satisfaction, and the impact on medical legal risk began to establish the science accompanying the art of medicine. Tying the emerging literature on CPC to research was essential since many participants in the courses considered communication as “touchy-feely” or “merely” bedside manner.
A new course, provider–patient interaction (PPI), was designed and tested in 1995 to help the fledgling Communication Consultants teach the Four Habits and its associated skills to their colleagues at their medical centers. PPI began as four 2 h sessions, each focusing on a single habit. Between sessions, participants were asked to perform
tasks related to that habit, such as making empathic statements or testing for patient comprehension. Scenarios were written for multiple specialties so that participants could practice the skills using relevant role plays. PPI was the first communication skills course in TPMG in which onsite trainers were given a set of pre-packaged materials and were trained to deliver the program. For the first few years, each PPI course was co-taught by a professional trainer and a Communication Consultant. The professional trainers served as the primary presenters; the Communication Consultants supplemented the content with stories and examples from their own practices, a role which required minimal preparation.

Between 1996 and 1998, 135 PPI courses were offered in 27 medical centers. One of the most important lessons learned was that departments with the greatest success in participation and enthusiasm were those in which the chief promoted and attended the program. Since 1998, PPI has continued to be taught almost entirely by Communication Consultants, usually two to three times per year at each facility and primarily for newly hired clinicians. In some medical centers, attendance is a required part of orientation.

3.2. Communication skills intensive

Another turning point occurred in 1996 with the introduction of a 5-day residential course called the Communication Skills Intensive. The concept of a residential program for clinicians who receive lower patient satisfaction scores originated with the Bayer Institute for Healthcare Communication (a non-profit organization dedicated to improving communication between clinicians and patients), and evolved as a collaboration between TPMG and the Bayer Institute. The Intensive is held off site allowing participants to focus their full attention on learning and practicing the Four Habits skills. It consists of three 4-h sessions in which groups of four participants work with one or two faculty, professional actors, and a video camera to practice and receive feedback on their communication skills. These practice sessions are nested within other activities such as small group exercises and large group interactive presentations. Several hours are spent sharing genograms within the small groups as a means of exploring connections between family history and communication difficulties with patients.

One of the challenges of launching the Intensive was the high percentage of participants who began the course feeling skeptical, angry, and hostile as a result of having low patient satisfaction scores and being urged to attend by their department leaders. The keys to transforming this initial resistance were empathy and an emphasis on the personal benefits of strong communication skills rather than a primary concern with improving scores. Workshop evaluations indicate that nearly all of the participants strongly endorsed the value of the course by the end of the 5 days.

The introduction of the Intensive accomplished several goals. First, it addressed a longstanding need to help clinicians who are technically competent but less adept at relating to patients. Second, the credibility and visibility of CPC education was enhanced when colleagues and chiefs observed the dramatic transformation of some of the participants’ skills and attitudes after the course. Third, and perhaps most importantly, patient satisfaction scores of the cohort of physicians attending the course each year showed significant improvement. For each of the years 1998–2003 (the MPS survey changed content and format at the end of 1997 so the data collection began in 1998), aggregated MPS scores of course participants show statistically significant improvement in the 6 months following the course compared to the 6 months before the course on the five items pertaining to the interaction with the physician/healthcare professional: skills and abilities, confidence in care, listened and explained, involvement in decisions about care, familiar with medical history (Fig. 1). The gains for each cohort have been sustained or continued to improve through the first half of 2004. These results have demonstrated to organizational leadership the value of the ongoing investment in this resource. The program has now been offered 23 times since 1996 to 483 clinicians. A small number of participants from other KP regions and from outside KP have attended. The course is currently offered twice a year and is over-subscribed.

4. Expansion of the Four Habits Model within KP

Although the Four Habits Model was initially developed within the context of primary care practice, it has been adapted and used as the basis for teaching programs covering a wide variety of settings and specialties since 1996. These include:

- Strangers in crisis, a 1-day program for emergency department physicians and nurses (developed as a result of requests from ED physicians who attended Thriving and wanted a program addressing their unique challenges).
- Meeting point: hospitalists at work, a 1-day communication course for hospital-based specialists and teams (developed soon after the introduction of Hospital Based Specialists and inspired by opportunities to improve patient satisfaction in the in-patient setting).
- Brief negotiation, a department-based course, and Thriving 3: communicating for health behavior change, a regional course, focused on communicating with patients about behavior change, incorporating motivational interviewing [30] and stages of change [31,32] (implemented because the content addressed a frustrating and often poorly handled aspect of care and because the Bayer Institute was offering training on the topic).
- Thriving 2, introduced in 1995 as the “second generation” version of Thriving in a Busy Practice and typically
offered as the second day of the regional New Physician Orientation.

- Conversations at the end of life, initially geared toward oncologists and other professionals caring for patients with cancer and later offered to primary care clinicians (identified as an area of weakness in the medical literature and within KP).
- Connected, a 3–4 h module on using computers during interactions with patients in the exam room (developed as a few KP regions began using a computerized medical record).
- Communicating after unexpected adverse outcomes, a workshop on discussing medical errors and adverse outcomes with patients and families (implemented as part of an organizational emphasis on patient safety and as a result of the requirement that hospital personnel inform patients and families after errors).

Many of these programs were developed in collaboration with the Bayer Institute for Healthcare Communication.

In addition to serving as the basis for many CPC programs, the Four Habits Model has been adapted for use in several other topic areas including: cultural issues in the clinical setting, staff-to-staff communication, depression management, and leadership communication. For instance, in materials to teach culturally competent care, Habit 2—eliciting the patient’s perspective—involves an anthropologist Arthur Kleinman’s approach to understanding patients’ explanatory models [33]. When the Four Habits Model is used to practice staff-to-staff communication, Habit 1—invest in the beginning—shifts the initial emphasis in conversations between staff members from merely “doing business” with one another to establishing a good relationship. Included in guidelines for depression management, Habit 4—invest in the end—focuses the conversation on potential barriers to the treatment plan in order to increase adherence.

A 3-day residential course on leadership communication for department chiefs was developed in 2000 using a version of the Four Habits Model as the construct for teaching leaders about interpersonal communication. This course was later condensed to a one day program as part of a modular series for chiefs and was presented to more than 600 physician leaders in 2002–2003. The Four Habits Model provided a framework for chiefs to conduct challenging conversations, such as performance reviews, using more collaboration and empathy.

4.1. Interregional collaboration

By the mid 1990s groups in every KP region had begun to develop CPC training. Some regions chose to offer Thriving in a Busy Practice, while others explored courses from outside KP or developed their own. The Southern California region, for example, designed appointment with success, a 1-day course which uses a group of actors who have continued to participate in their CPC trainings.

Collaboration on CPC education across all regions of KP began formally in 1996 with the creation of the Interregional Clinician-Patient Communication Leadership Group (IRCPC). Since its inception, the IRCPC has had monthly conference calls and hosted a yearly gathering to
showcase and develop new CPC programs, discuss marketing of CPC programs to clinicians, and hear about evaluation and research opportunities. Two of the programs described in the previous section, connected and communicating after unexpected adverse outcomes, were created by IRCPC design groups. Trigger videos on cultural issues in the clinical setting were developed in one region and shared with all IRCPC members. The IRCPC has recently completed materials and training for discussing out-of-pocket costs with patients and using a new system-wide computerized medical record to enhance the clinician-patient relationship.

5. Expansion of the Four Habits Model beyond KP

After being used widely for many years within Kaiser Permanente, the Model has now begun to be utilized outside the KP system. At the national level, the American Board of Medical Specialties is developing an instrument to assess physician communication from the patient’s perspective. The items have been drawn from the SEGUE coding scheme [34], the Four Habits Model, and others. The instrument is currently undergoing preliminary field trials and appears to have acceptable psychometric characteristics.

Indiana University School of Medicine has adopted the Four Habits Model and coding scheme in its four year competency-based communication curriculum. Residents in Internal Medicine also receive Four Habits training during their ambulatory rotations. The Model is being used in a state-wide geriatrics education initiative funded by the Reynolds Foundation and will be used to train over 1200 practicing geriatricians, residents, and students. Finally, the admissions committee uses the Model to train faculty interviewers to recognize and explore applicants’ competencies in four key areas (communication skills, moral and ethical reasoning, professionalism and personal awareness) as a basis for admission to the school.

6. Shifting the focus toward research

6.1. The Garfield Memorial Fund (GMF) research initiative

Developed initially for the purpose of teaching communication skills within KP, the Four Habits Model has more recently begun to serve as the springboard for empirical research. In 2000 the Board of the Garfield Memorial Fund, a grants giving unit within Kaiser Permanente, offered to sponsor a CPC research initiative. Following a needs assessment, a request for proposals focusing on five priority communication areas (technology, end of life care, physician satisfaction, best practices, and patient safety) was sent to KP researchers. After external peer review 5 out of 35 projects were funded including: an observational study of physicians with differing patient satisfaction scores; evaluation of the effectiveness of end of life communication skills training for physicians; a video study of the effects computers in the exam room; the impact of online discussion groups for patients with diabetes; and use of a reinforcement model to help clinicians remember and practice lessons learned from communication skills training.

A sixth Garfield funded study is aimed at validating an instrument to code CPC based on the Four Habits Model. The construct validity of the Four Habits Coding Scheme was tested by investigating associations between it and other well-validated instruments such as the Roter Interaction Analysis System [35,36]. The results of this analysis (“submitted”) indicate that The Four Habits Coding Scheme is both reliable and valid as a measure of communication between clinicians and patients.

7. Current and future CPC efforts in TPMG

Personalization of care: toward the end of 2003, the CEO and Executive Director of The Permanente Medical Group asked the Department of Physician Education and Development to train all 5300 TPMG physicians in skills to deepen personalization of care to members and patients. The purpose of this regional initiative was to ensure that members of KP in Northern California—even those who seldom or never come in for visits—would feel connected to a personal physician who knows their medical history, encourages prevention and healthy lifestyles, and seamlessly coordinates their care with appropriate specialists. The skill set for personalization of care included: outreach phone calls and letters, use of physician web pages, and direct booking for specialty referrals during primary care visits. Also included has been an emphasis on exemplary interpersonal communication, especially when integrating technology into patient care and in reinforcing relationships with patients’ personal physicians.

In fall 2004 a 2.5 h workshop called Personalizing our Care: Deepening our Patients’ Trust was delivered to all TPMG physicians, with 40 participants attending each workshop. The 150 workshops were facilitated by 74 physicians selected from each medical center for their excellent interpersonal skills and leadership potential and then trained at a 3-day offsite to deliver the workshop in pairs. The workshops have been well-received and will be offered to additional clinicians and staff in 2005. This unprecedented educational sweep across the organization has been possible because of the sponsorship and support of the CEO and because a solid educational and research foundation for CPC has been in place for over a decade.
8. Summary

This case study describes the history of clinician-patient communication education and research in KP. The KP experience and the Four Habits Model are examples of pedagogy and research informing each other in a cycle of continuous improvement. The story of the Model and its dissemination illustrates how organizational and scientific needs interact in practice to improve clinician satisfaction and ultimately the care delivered to patients.

Three major factors may help explain the steady growth of clinician-patient communication skills programs and the use of the Four Habits Model in this large healthcare organization. First, KP is a physician-led organization with a strong commitment to providing high quality technical and interpersonal care for its members. Excellence in CPC is consistent with the organization’s mission and values. Second, the organization in which these programs were instituted was “ready” for them. Leaders recognized the importance of skill-building in CPC and were willing to invest resources. Clinicians had already identified difficult interactions as a major source of frustration in their day-to-day practices. Satisfaction surveys provided feedback on patient perceptions so that the need for and the impact of improvement efforts could be measured. Third, programs were developed around a practical, evidence-based teaching framework, the Four Habits Model. Numerous clinicians have reported that the model has “transformed” the ways they think about and practice medicine.

The KP experience implementing programs and services to optimize clinicians’ interpersonal skills in the exam room attests to the feasibility of bringing this vital dimension of medicine to large numbers of busy clinicians. As medical training programs and healthcare delivery systems are increasingly recognizing, good communication is important not only because it relates to specific outcomes of care, but because it is the core of what makes medicine a human endeavor.

8.1. Practice implications

Educational interventions to enhance clinicians’ communication skills can be offered on a broad scale for diverse specialties within a large healthcare organization. Participation in in-depth learning experiences with skills practice can result in improvement in patient satisfaction scores. The success of clinician-patient communication programs in the Northern California region of Kaiser Permanente has been manifested by high voluntary enrollment, active participant involvement, positive evaluations, and strong word-of-mouth recommendations among colleagues. Some of the factors accounting for this success are: the use of a unifying, pragmatic teaching model; an emphasis on practical and tangible skills to improve the work-life of clinicians; practice with actors; integration of relevant research; the availability of local coaches for ongoing learning and reinforcement; and enduring sponsorship from leaders.

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