Seven Years of Teaching Communication With the Patient-Centered Observation Form

Patricia Adam, MD, MSPH; Courtney F. Murphy; Mary Dierich, PhD, MSPH; Keri D. Hager, PharmD

BACKGROUND AND OBJECTIVES: For years, family medicine has taught patient-centered communication through observations and observation checklists. We explored the utility of one checklist, the Patient-Centered Observation Form (PCOF), to teach and evaluate patient-centered communication in our family medicine residencies.

METHODS: We conducted a mixed-method study of five University of Minnesota Family Medicine Residencies’ seven years of experience teaching and evaluating residents’ patient-centered communication skills. All programs have a behavioral health (BH) faculty-led observation curriculum that uses the PCOF to assess resident skills and give feedback. We conducted a BH faculty focus group and interviews, generated themes from the BH responses, and then queried family medicine (FM) faculty regarding these themes through an online survey.

RESULTS: Ten BH faculty participated in the focus group/interviews, and 71% (25/35) of FM faculty completed the survey about themes derived from the BH interviews. The residencies complete between 1 to 11 observations per resident per year. Since implementation, four programs have continuously used the PCOF due to its versatility, design as a formative rather than summative feedback tool, and relative ease of use. BH faculty believe longitudinal observations with the PCOF resulted in improved resident patient-centered communication. Most importantly, all faculty described a shift in family medicine culture toward patient-centered communication. Time for observations and feedback is the primary curricular barrier.

CONCLUSIONS: Our findings support the utility of the PCOF for teaching and evaluating patient-centered communication in family medicine training.

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In 2013, the medical specialties defined milestones residents should achieve to demonstrate competency. For the primary care specialties, those milestones include patient-centered communication behaviors. Therefore, the Accreditation Council on Graduate Medical Education (ACGME) strongly recommends faculty conduct observations of resident-patient interactions to assess resident milestone competency.1,2 Research supports the incorporation of direct observation to teach and assess learner competence in meeting patient communication skills.2-5 Family medicine has for many years prioritized resident observation as a tool to help teach patient-provider communication.6,7

Despite limited reliability data, the most commonly used observation tool for teaching patient-centered communication skills in family medicine is the Patient-Centered Observation Form (PCOF).7 The PCOF is a two-page checklist that breaks down the patient visit into well-defined components that are supported by measurable, discrete clinician behaviors.8-10

In 2009, the University of Minnesota Department of Family Medicine and Community Health (UMN-DFMCH) charged its residency programs to implement a patient-centered communication curriculum using the PCOF.8-10 Although the PCOF is one of the most commonly used forms used for assessing patient-centered communication, there is limited published data on how programs have implemented use of the PCOF and its impact on resident communication skills. We conducted a mixed-methods study aimed at characterizing the experiences of five residency programs over 7 years of PCOF implementation and use. Our goal was to explore the utility of the

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PCOF to teach and evaluate patient-centered communication in our family medicine programs.

Methods
The UMN-DFMCH is comprised of eight sponsored or affiliated family medicine residencies. Each residency has one or two behavioral health (BH) faculty.

The PCOF includes 12 skill sets of patient-centered communication behaviors starting with “establishes rapport” and ending with “closure.” Each skill is divided into observable elements and is organized as a checklist. The more boxes the observer checks, the more patient-centered the communication. During the study period, the newest version of the PCOF was utilized as it became available (http://courses.washington.edu/pove/files/PCOF_9_27_2013_clinician.pdf).

Phase 1: Behavioral Health Faculty Focus Group/Interviews
Seven out of 10 behavioral health (BH) psychologist faculty from five of the UMN-DFMCH residencies participated in a 60-minute focus group exploring their experiences using the PCOF to evaluate and teach patient-centered communication. Participants were asked semistructured questions about the original implementation plan, current use of the PCOF, and successes and barriers in teaching patient-centered communication. The three remaining BH faculty had 30-45 minute phone interviews using the same questions. The focus group and phone interviews were audio recorded and transcribed verbatim. A single, trained investigator conducted the focus group and interviews. Phase 1 data analysis was informed by the social constructivist version of grounded theory (used when researchers have some a priori experience/knowledge in the qualitative question being asked). First, each investigator independently reviewed and coded the transcripts. After independent review, investigators then met and reached consensus about emerging themes through an iterative discussion process. Phase 1 BH interview and focus group themes informed development of the Phase 2 family medicine (FM) survey items.

Phase 2: Family Medicine Faculty Survey
Family medicine physician faculty from the five residency programs (n=35) subsequently completed a 21-item anonymous online survey (5-point Likert scale; strongly agree to strongly disagree) regarding experiences with the PCOF as a training tool. Items included FM faculty training on the PCOF, frequency of use, comfort using the PCOF, perceptions of utility/impact of the PCOF, and questions specific to the PCOF as a tool.

The University of Minnesota Institutional Review Board deemed this study exempt from review.

Results
Table 1 describes the family medicine residency programs’ demographics and their use of the PCOF.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Family Medicine Residency Culture Shift</td>
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<tr>
<td>2</td>
<td>PCOF Functionality</td>
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</tbody>
</table>

In terms of physician communication, I feel like, just observationally, they're so much better than they used to be... I feel like the quality of the communication that I see in our resident physicians has improved over that time. (BH Focus Group)

Theme 2: PCOF Functionality
BH and FM faculty agreed the PCOF is a useful, relatively easy tool to use, although it is lengthy and at times not culturally appropriate. FM and BH faculty opinions differed regarding tool functionality with the EHR, helpfulness for milestone competency assessment, and whether the tool is evidence-based (Table 3). BH faculty reported the PCOF helped learners and faculty identify specific patient communication issues and improve communication techniques while emphasizing growth along a continuum rather than a “grade.” By anchoring feedback to behaviors, BH faculty noted feedback is more specific and improvement becomes measurable.

BH faculty described the PCOF as adaptable to different curricular venues (live observations, video reviews, group reviews, self reviews)
Table 1: Residency Demographics Number and Type of Observations* by Site

<table>
<thead>
<tr>
<th>Program</th>
<th>PGY</th>
<th>Total Video Reviews per Resident per Year</th>
<th>Total Direct Observation per Resident per Year</th>
<th>Mean (Range) Total PCOFs Completed per Resident per Year</th>
<th>Location of Observations</th>
<th>Program BH FTEs</th>
<th>Number of Residents (G1/G2/G3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>12 (8 – 15)</td>
<td>outpatient &amp; inpatient</td>
<td>1.9</td>
<td>18 (6/6/6)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>14 (8-19)</td>
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<td></td>
<td>3</td>
<td>4</td>
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<td>11 (7-15)</td>
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<tr>
<td>B</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>8 (3-12)</td>
<td>outpatient &amp; inpatient</td>
<td>1.3</td>
<td>30 (10/10/10)</td>
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<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>6 (2-8)</td>
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<td>1</td>
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<td>outpatient &amp; inpatient</td>
<td>0.8</td>
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<td>D</td>
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<td>1</td>
<td>5</td>
<td>6 (5-10)</td>
<td>outpatient</td>
<td>1.8</td>
<td>24 (8/8/8)</td>
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<td>6 (4-6)</td>
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<td>6 (6-7)</td>
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<td>outpatient</td>
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</table>

Abbreviations: PGY–Postgraduate year, PCOF–Patient Centered Observation form, BH–Behavioral health

*Note–One direct observation or video review may include multiple patient encounters. Faculty complete one PCOF per patient encounter. Hence the number of PCOFs may be greater than the number of direct observations or video reviews.

Table 2: Family Medicine Culture Shift

<table>
<thead>
<tr>
<th>Behavioral Health Focus Group Findings</th>
<th>Family Medicine Faculty Survey Findings</th>
<th>Responses (N=23) Agree/Strongly Agree N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quotes “And the focus across the family medicine faculty on this being important.” “The whole patient-centered conversation when the PCOF came, just shot up across our [family medicine] faculty… I think that is a huge success.”</td>
<td>Questions It is important that family medicine faculty incorporate the patient-centered communication behaviors in their patient interactions.</td>
<td>21 (91)</td>
</tr>
<tr>
<td>“We had a structured tool we were using.” “I’m a very powerful advocate for this tool.”</td>
<td></td>
<td>20 (87)</td>
</tr>
<tr>
<td>“It’s affected my clinical practice just in terms of how I structure my visit… mirrors the PCOF more than it did previously.” “… used the teach-back for sure, … and probably agenda setting.”</td>
<td>Questions I have changed how I communicate with my patients as a result of using the PCOF to teach residents patient-centered communication skills.</td>
<td>13 (57)</td>
</tr>
</tbody>
</table>
and goals (resident or program-directed). They recommended the PCOF be used longitudinally with incorporation into learner portfolios to track individual feedback and promote skill building over time. One BH participant noted the PCOF lacked advanced patient-centered communication behaviors, did not match milestones well, and was not flexible for all encounters (eg, basic medication recheck vs noncompliant patient with diabetes). Their program stopped using the PCOF and has developed their own checklist.

**Theme 3: Barriers to PCOF Implementation**

Barriers to PCOF implementation are listed in Table 4. Additional barriers noted by BH faculty included inconsistent faculty training and equipment/logistical barriers. They also noted residents earlier in training, whose priority is to “avoid killing their patient,” may not be developmentally ready for communication feedback.

**Discussion**

Our findings support the utility of the PCOF for teaching and evaluating patient-centered communication
in family medicine training. As we discovered, use of an appropriate,\textsuperscript{12,13} established tool consistently over an extended period of time\textsuperscript{2,14} is important. Since implementation in 2009, four of the five programs have continuously used the PCOF due to its versatility, design as a formative rather than summative feedback tool, and relative ease of use. Despite inconsistent training on the PCOF form, BH faculty believe longitudinal observations resulted in improved resident patient-centered communication, and FM faculty believe they are more effective teaching and comfortable evaluating patient-centered communication behaviors. Most importantly, faculty described a shift in family medicine residency culture toward patient-centered communication. As cited frequently in the literature, the primary barrier for PCOF implementation was time.\textsuperscript{7,8,9,12,15}

The literature supports our findings of learner anxiety and grade focus over skill focus,\textsuperscript{3,9,16,17} along with the need for consistent faculty training.\textsuperscript{2,8,9,16} as ongoing barriers.

Study strengths include the mixed-methods design and incorporation of both BH and FM faculty perspectives, perspectives that often concurred, thus reinforcing the findings.

This study was limited to five programs in one family medicine department, thus findings may not be generalizable.

Future research is needed to assess the long-term effect of patient-centered communication training on patient satisfaction and health outcomes.\textsuperscript{1,18}

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**References**


