PSP

A GPSC Initiative

An Incomplete Guide to Engaging Physicians into Quality Improvement

尊敬

RESPECT

I won't waste your time • I won't tell you what to do

BRITISH COLUMBIA
The Best Place on Earth

BRITISH COLUMBIA MEDICAL ASSOCIATION

Preface

Our Vision is to improve patient care and provider experience by supporting family practice physicians and specialists through our innovative programs.

This incomplete guide offers a framework for preparing to engage meaningfully with physicians. It is intended for those individuals who work with physicians in quality improvement initiatives, and who have an intermediate level of knowledge in quality improvement methods. Included is a resource section that contains pearls of wisdom from others, offered in a semi-organized fashion as a buffet of ideas rather than structured reading. We hope you can help complete this material by adding from your own knowledge and experiences.

Physician engagement is not a step-by-step process but rather an organic process requiring empathy, thought, respect, flexibility and courage to initiate action to meet the needs of physicians.

Over the last three years in British Columbia, we have engaged the ready and willing into our programs. Now we embark on the greater challenge of engaging specialists and a broader population of family physicians, and potentially transforming health care in British Columbia.

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1. A Day in the Life of a Physician

A Day in the Life – Family Physician

0715	Leave for Hospital, get coffee on the way, and have trouble finding parking
0815	Hospital Rounds, 1 new patient in ER for assessment
0900	Office starts, Dr still at hospital
0930	Dr arrives at office, five patients in waiting room; informed that specialist is on the phone
	Six patients scheduled per hour but first patient who was scheduled to review test results informs Dr that her husband has left her, so 10 minute appointment is now 30. Two calls from nursing homes, two calls from home care nurses, a fax from a nursing home wanting reply ASAP. Call from hospital pharmacist asking for a change in antibiotic dosing. Courier arrives with 200+ documents. Falling further behind — almost every patient has a list of six problems
1230	MOA wanting lunch break but not done with patients until 1300
1300	MOA takes lunch and Dr starts paperwork and phone calls, eats muffin and has coffee
1330	First patient for afternoon arrives. Pace of afternoon similar to morning
1700	Last scheduled patient but still behind, MOA has fit in three more urgent patients
1750	Start writing referral letters and reviewing the day's lab results
1900	Home late for dinner

Obviously family physicians are busy.

How do you see your meeting fitting in?

When engaging physicians is at the top of your priority list, the time you spend with them must be quick and meaningful.

A Day in the Life at the Office – Orthopaedic Surgeon

0715	Hospital rounds, collect diagnostics, discharge patients, dictate discharges, paperwork, see new patients admitted overnight
0800	Office starts. Review new referrals and categorize into urgent, semi-urgent and not urgent
0820	First patient is a fit-in from a family practice who referred a patient due to pain following a surgery 18 months ago, patient arrives late. Schedule new referrals for 20 minutes and follow-up visits for 10 minutes. Often disrupted by phone calls from hospital or physiotherapists from home and community care regarding patient concerns. Also called by family practice physicians regarding advice or direction for patients care
1130	Morning Office ends but running late
1200-1300	Finish morning appointments, start dictation and then go to hospital for rounds and a 10 minute lunch
1300-1600	Afternoon patients at similar pace as morning, followed by paperwork. Additional paperwork required for independent medical assessment

A Day in the Life in the OR – Orthopaedic Surgeon

0715	Hospital rounds, collect diagnostics, discharge patients, dictate discharges, paperwork, see new patients admitted overnight
0730- ?	Site mark patient, discuss with Anesthetist, perform surgery, dictate. Two total joints scheduled for morning. Second surgery delayed due to defect in sterilization
Lunch	Sometime between cases eat lunch and do quick rounds, return phone calls and pages
1530-1700	End cases and see post operative patients one more time. Round wards, return phone calls and pages, hallway consults with other physicians
1700-2200	On Call: 1 in 4 weekdays, 0-4 new cases. Weekend call 1 in 5 weeks for 3 days

1. A Day in the Life of a Physician...

A Bit of the Biz

In a family practice office, documentation for a day may look like this:

- 6 x complete physicals, 2 x counseling visits, Rx'd 40–50 individual medicines, 2–3 x insurance forms, 2 passports, 2 WCB forms, 10 diagnostic forms, 5–6 referral forms, 1–2 SA forms, 30 x 0100 billings

In a Orthopaedic Surgeons office, documentation for a day may look like this:

- 8–10 x new referrals, 10–15 follow-up appointments,1 WCB forms, 1 independent medical assessment, 3 x prescription changes

Majority of physicians work in a fee for service system where they can bill for services as described within their agreement.

Regardless of how many patients a physician sees per day, all physicians have overhead costs that remain constant which could range from $400-900 per work day (based on 2009 estimates).

Obviously physicians have many expenses.

How do you see your program affecting their business?

Physicians are likely very interested in quality care and making their practice efficient; it is important to understand the financial and business implications of your proposed program before engaging with physicians.

"Making changes in the midst of a busy practice life is like trying to repair a bicycle while riding it."
— unknown

2. Engagement Framework

1. **Program Overview**
   Vision, Purpose, Aims + Measures

2. **Pre Meeting Preparation**
   Discovery Part 1: How can I be prepared?

3. **First Meeting**
   Discovery Part 2: How can I connect with the physician?

4. **Post Meeting Analysis**
   What did I learn?

5. **Post Meeting Follow-up**
   What are my next steps?

6. **Next Meeting and Ongoing Follow-up**
   How do I personalize my program for this physician?

2. Engagement Framework...

1. Program Overview

If asked by a physician, how would you answer the following questions:

What is the purpose of your program?

What are the Aims and Measures of your program?

Goal Setting

What is your stretch goal for engagement?

How many physicians work in your area?

Engagement Summary

Champion List: Schedule of contacts

Adopter List: Schedule of contacts

New Adopter List (unengaged): Schedule of contacts

2. Pre Meeting Preparation

Discovery Part I

What do I know about this physician/practice?

What is the history and culture between physicians in this community and the health authorities?

What is my "hook" into this relationship?

Can I answer questions relating to how my program affects:

- patient care
- quality of life for physicians and staff
- business of this practice?

What can I send in advance and/or take with me?

3. First Meeting

Discovery Part II

Part A – Program Disclosure/Develop Trust

Why is this important to the physician? With full transparency describe the intended outcomes of your program.

Why are you there? Share your story.

What is your value proposition? How is it different from other programs? Believe and see the value in what you have to offer.

What evidence do you have of this value? Share a story of success i.e. stories from other offices, numbers of physicians engaged in your program, locally and provincially.

"Culture eats strategy for lunch"
— unknown

2. Engagement Framework...

Part B – Inquiry

What is the situation in your office regarding _____?

How do you feel about _____?

What is working well?

What do you think would improve things?

What would make it better?

- For your patients
- For your staff
- For you personally.

Did I miss anything in their story?

If I "get it", there's a good chance I can help.

Part C – Common agenda

How can I help this physician/practice with what I have to offer?

If not, can I keep in contact with this physician/office in the future? If so, how?

If I can help: How can I make this easy to achieve?
What is this physician's situation and commitment?
What have other physicians achieved?

Are you offering something by this stage of the discovery?

Try to always stay interested and in an inquisitive mode, avoiding roadblocks to effective communication.

(See *Discovery Phase Questioning Framework and Building Relationships* in the resource section.)

However do not stay in a pure enquiry mode for too long as this might be disengaging. Physicians need to know you've got something to put on the table. Once a commom agenda is established, move quickly into action, lets do something and make it easy.

4. Post Meeting Analysis

What worked well? What did not?

What personality traits did I portray? Was I confident? Did I try to answer questions I didn't have answers for? Was I defensive when being asked questions?

What personality traits did I observe and did I respond appropriately?

How can I reinforce the positive feedback and neutralize the negative feedback?

What is the physician's main concern, worry, need?

What are the MOAs main concerns, worries, needs?

What barriers are there to moving forward – real or perceived?

5. Post Meeting Follow-up

What is my "I heard you" follow-up summary?

What can I offer that is specific for this physician/office?

6. Next Meeting and On Going Support

What is my action plan for this physician/office:

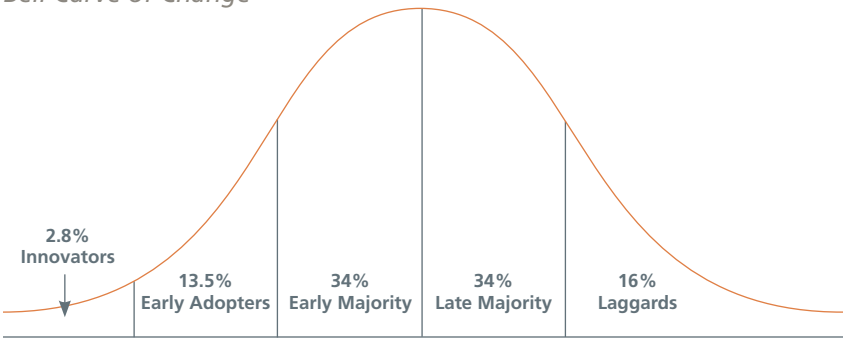
- Invite to a meeting
- Provide more information
- Link to a champion
- Link to other primary care programs (Practice Support Program, Integrated Health Networks, PITO, Divisions of Family Practice)
- Document their issues and re-connect with office if future program materials meet their needs?

3. Resources for Engagement

This section contains pearls of wisdom from others offered in a semi-organized fashion, and is intended to be a buffet of ideas rather than structured reading. We hope you can help complete this material by adding from your own knowledge and experiences.

Resources – Program Overview

Bell Curve of Change[i]



Innovators – adventurous, have financial resources and like to play with new tools

Early Adopters – see strategic advantage in adopting an innovation

Early Majority – followers who make a deliberate choice to adopt

Late Majority – those who are skeptical and who adopt when it is less risky

Laggards/Traditionalists – those who adopt a "not over my dead body" attitude

Spread[ii]

- Two Aspects:
  - Technical: the nature of the change itself
  - Social: how people feel about doing it
- Two Activities:
  - Disseminating information: people need to find out about it
  - Overcoming thresholds for change: people need to get beyond emotional, structural and resource thresholds
- Spread is the result of the process of adoption and not the other way round — the ultimate success is not from someone doing the spread but by others 'adopting' the ideas
- The process of adoption involves:
  - having an awareness of need
  - seeking ideas that generate interest and seem to meet the need
  - evaluating the ideas and coming to some conviction that they will meet the need
  - taking action to change
- The successful improvement leader is more of a matchmaker than a commander
- Adoption and spread processes have a large social component
- Ideas that spread more rapidly than others have attractive qualities
  - Clear advantage compared to current ways
  - Compatibility with current systems and values
  - Simplicity of steps, processes and tools
  - Can be easily tested
  - Visible results.

3. Resources for Engagement...

QI Concepts

How Much We Remember

- 10% of what we read
- 20% of what we hear
- 30% of what we see graphically
- 50% of what we see and hear
- 70% of what we discuss with others
- 80% of what we experience personally
- 90% of what we say and do.

Quality Improvement Culture

- Not knowing is the window into learning and change
- All Teach, All Learn
- There are no "experts" – all have expertise
- Share Generously, Steal Shamelessly
- Celebrate Success, Celebrate Failure.

Adult Learning Principles[iii]

- Self Direction
- Active Learning
- Relevant, immediate practical application
- Skill Based
- Keep it simple, in doable chunks
- Feedback.

Quality Chasm – Institute of Medicine, 2001[iv, v]

- "Trying harder will not work"
- "The Current care systems cannot do the job"
- "Changing the care systems will".

Resources – Pre Meeting Preparation

Cialdini defines six "weapons of influence":

- **Reciprocation** – People tend to return a favor
- **Commitment and Consistency** – If people commit orally or in writing, to an idea or goal, they are more likely to honour that commitment
- **Social Proof** – People will do things that they see other people do
- **Authority** – People will tend to obey authority figures
- **Liking** – People are easily persuaded by people that they like
- **Scarcity** – Perceived scarcity will generate demand.

Physician Engagement View of "Influence"

Reciprocation: Bring something to the office — knowledge, resources, coffee, billing guide, list of ways to increase office efficiency

Commitment and Consistency: Establish a common purpose and develop an action plan, then commit to a time for review (learning session and office support)

Social Proof: Stories of successful engagement in program. BC statistics of engagement into primary care programs

Authority: Traditional authority figures may not apply to the physician community, however credible physician champions and physicians leads within the community may best have this influence. Qualities of physician leads may include: practice in the "Trenches", good communicators, willingness to learn and teach others. Their MOA may have earned stripes here as well.

Liking: Build a good rapport, be a good listener (to both physician & MOA)

Scarcity: Offer special events with guest speakers.

3. Resources for Engagement...

Three "currencies of influence" in the medical office, know how your program can improve:

- Care for patients
- Quality of life for physicians and staff
- Compensation (neutral or better business case)

Institute for Healthcare Improvement: Triple Aim

- Improve the health of the population
- Enhance the both patient and provider experience of care
- Reduce, or at least control, the per capita cost of care.

Jack Silversin[vi]

Leaders get physicians ready to change by helping them understand the price of not changing and by creating a picture of a desired future state that is attractive enough to overcome the pull toward the status quo.

- How to understand where physicians are at:
  - Build relationships, ask open ended questions, use reflective listening. Goal is to explore what concerns or problems they have that can be helped by what you are offering.
- Create a shared vision
  - Picture how things will be in the future where the issues of concern are resolved by applying what you offer. This vision will help them understand and believe that what you have can benefit them.

Resources – First Meeting

Engaging with Physicians with a Shared Quality Agenda[vii]

Discover a Common Purpose

- "Fix what affects me" – understand their mindset
- If taking measures, take meaningful measures AND don't mess with them
- "What could be more meaningful for physicians than to eliminate those things that waste everyone's time, so you and the team can concentrate on important things that really determine patient outcomes?"

Reframe Values and Beliefs

- Partnering with physicians requires flexibility on both sides
- "Make the patient the only customer"

Segment the Engagement Plan

- Identify and activate Physician Champions
- Start Small (Model for Improvement – Plan Do Study Act cycle)

Use "Engaging" Improvement Methods

- Do not use quality improvement language
- Have data and stories to share that connect with issues

Show Courage

- Value and support physicians already involved
- Provide "back up all the way to the board" (British Columbia Medical Association, General Practice Services Committee, BC Ministry of Health Services, Health Authorities)

Our Primary Care system is expected to care for all British Columbians: full stop.

3. Resources for Engagement...

Adopt an Engaging Style

- Some think being asked to change means "I am doing something wrong"
- Communicate candidly and often
- Make physician involvement VISIBLE
- Value the physicians time (to note, once rapport is established a physician may voluntarily spend more time with you than expected – be ready for this)

Discovery Phase Questioning Framework

The Meeting	Discovery Questioning Framework	
	Staying Inquisitive	
Pure Inquiry →	Exploratory Diagnostic Inquiry →	Consultant Suggestion Inquiry
• What's the situation? • Can you tell me what's going on? • What's working well? • What are you proud of? • What have you achieved? • What would make it better – For your patients – For your staff – For you personally? • Give me examples • What's the impact? • How often does this happen? • How important is it on a scale of 1 – 10? • What's causing this? • Are there other potential causes?	Exploring emotional responses: • How do you feel about the situation? • How did/do others feel about the situation? Exploring reasons for actions and events: • Is this something you implemented? • Why did you do that? • What's been the reaction to it? • Have you made any subsequent changes? • Do you plan to? • Why do you think that will improve things? • Are there other options you've thought about? • What do you think will be the response by others. (patients, staff, colleagues etc.)? • What's the *right thing* to do in this situation?	• Process ideas • Could you have done the following? • Would this have worked? • Have you thought about doing...? • Whay haven't you tried...? • Have you considered these other options?

3. Resources for Engagement...

Physician Self Management Support

Definition: Self-management support is defined as the systematic provision of education and supportive interventions by support staff to increase physicians' skills and confidence in managing their office and patient populations including regular assessment of progress and problems, goal setting, and problem-solving support. It gets at the heart of day to day management.

What doesn't work: Giving information and advice without establishing level of interest, level of concern and knowledge; warning of consequences of bad outcomes associated with behaviors; inducing fear; lecturing; waiting for physician to ask for help.

Basic Principles

Establish rapport

Establish a common agenda

Assess readiness for change

Ask-Tell-Ask

Action plan

Problem solve barriers

Support and follow-up

"People are often persuaded by what they themselves say than by what other people tell them."

Building Rapport

- **Be Inquisitive** – use "Tell me…", "What…" "How…" as lead-ins; avoid using "Why…"
- **Reflective listening** – listen, express interest and understand meaning of what physician is trying to say. Use (but don't overuse) "So, you are saying..." "It sounds like..." "What I'm hearing you say is..."
- **Affirmations** – identify and acknowledge strengths. Believe in their ability to change and promote self-confidence. Be genuine. Attitudes are shaped by our words.

Roadblocks to Reflective Listening & Building Rapport

Order, direct or command; warn, caution; threaten, persuade, argue, lecture; disagree, judge, criticize or blame; unwanted advice.

Motivational Interviewing (MI) Techniques may include:

Ask: to understand the problem(s)

Listen: to understand the meaning of their problem correctly

Inform: educating

(Must balance these skills; be flexible)

Or

Ask: what do you feel needs to be improved in your practice? Or
How would you feel if that happened?

Tell: provide information on how your program can help them

Ask: how would you feel if we made these changes?

"The leader of the past was a person who knew how to tell.
The leader of the future will be a person who knows how to ask."

3. Resources for Engagement...

Resources – Post Meeting Analysis[viii]

Introvert Sensing Thinking Judging – *ISTJ*
Type and Communication: *Myers – Briggs*

Physicians likely distribute along the entire Myers Briggs spectrum, however when preparing or reflecting on communication with physicians, the ISTJ subtype may help.

Communication highlights: straightforward, practical, logical, efficient, independent, self sufficient and reliant, focused on facts, details and results, trust and information gained from experience, depth of knowledge and wealth of specialized information.

At first glance: task orientated, independent, "matter of fact", hold firmly their choice, loyal, reliable and determined, implement decisions and follow through.

What they want to hear: exactly what is expected of them, clear feedback and step by step procedures, detailed facts and information relevant to their situation, logical and factual evidence, accurate and organized.

When expressing themselves: no-nonsense, practical, logical, focused on task at hand, straightforward, centered on conclusions, results and offering direction, give and expect others to follow exact directions, break complex information into small and detailed pieces.

Interpersonal focus: not tuned into emotional undertones, can seem abrupt or detached, dislike small talk and may not work towards developing rapport.

"Brevity is wit"
— Mark Twain

Communicating Effectively with ISTJ

Do:

- be calm, reasonable, competent, frank, honest, direct and focused on results, present information in a logical, and objective manner
- share: clear directions, expectations, measurable objectives
- provide comprehensive detailed information ahead of time
- present accurate, precise data – expect analysis & questions
- allow uninterrupted time for analysis before expecting a response or decision
- provide practical information with immediate applications, focus on one thing at a time in a concrete and realistic manner
- link new information to what is already known and trusted from experience.

Don't:

- focus on emotional or personal issues
- expect them to change their mind quickly or give an immediate response
- surprise them or introduce change without providing practical and logical rationale
- expect them to do something unless it makes sense
- come across as overly excited about or enamored of an idea
- be wordy, theoretical, abstract, or introduce ideas without supporting details
- focus extensively on long-term consequences or advantages
- give vague directions or share only part of the information
- expect them to take a quick look at or overview something
- personalize their need to question and critique.

Understanding your personality type (as accurate as this may be) may help you better communicate with physicians.

3. Resources for Engagement...

Resources – Post Meeting Follow-up

Importance Confidence Table

High Importance/ Low Confidence Want to change and are willing but not sure if they will succeed	High Importance/ High Confidence See change as important and are convinced they can succeed
Low Importance/ Low Confidence Not as important and do not believe they could succeed with change	Low Importance/ High Confidence Could make the change if it were important, but not convinced it is important

Low Importance and Low Confidence

- Provide information that is new: materials from your program, supporting evidence, successes from others with your program
- Offer to help when and if they want to consider the issue: "I understand improving access to your office is not a high priority to you just now. If that changes, I would like to help in any way I can"
- Accept the situation without making a judgment.

High Importance and Low Confidence

- Emphasize the importance of the physician making choices about the issue, rather than treating it as something beyond volition: This is not the Health Authority or Government imposing change
- Work to develop a plan consisting of small steps that the physician believes are likely to be accomplished:

  "You are the expert on your schedule and what is possible. Let's focus on one or two things that you could do that seem realistic to you."

Low Importance and High Confidence

- Build on the natural ambivalence that is present. Increase awareness of the ambivalence so that it can be discussed:

  "You mentioned that at times you thought about the benefits of reducing the stress in your office, but you are afraid that giving up or changing would be too much of a hardship for you and your staff. Let's consider both sides of the situation."

- Help to identify and discuss discrepancies between what he or she wants and what may exist, or discrepancies in the information.

High Importance and High Confidence

- Work with the physician and staff to anticipate difficult times and plan ways to handle them
- Identify and remove obstacles to maintaining the desired course of action
- Attend to progress by noting and affirming it. Refer to measures agreed upon and review and reflect.

"Start with what they know, build with what they have. The best leaders when the job is done, task is accomplished, the person will say I have done it myself."
— Lao Tzu

3. Resources for Engagement...

Resources – Next Meeting and Ongoing Support

The ongoing success and spread of primary care quality improvement relies on the continued and ongoing support from Regional Support Teams to identify and support Physician Leaders, to be flexible with program delivery, to provide positive and non-judgmental feedback on any data collected and to share stories of successes and challenges in and among the community. The following excerpt from a business journal adds further evidence to encourage frequent and meaningful contact with physicians and their staff.

Leadership is a contact Sport[ix]

by Marshall Goldsmith and Howard Morgan

Given the increasingly competitive economic environment and the significant human and financial capital expended on leadership development, it is not only fair but necessary for those charged with running companies to ask, "Does any of this work? And if so, how?"

What type of developmental activities will have the greatest impact on increasing executives' effectiveness?

How can leaders achieve positive long-term changes in behavior? With admitted self-interest — our work was described in the Crainer–Dearlove article, and is frequently cited in reviews of and articles about leadership coaching — we wanted to see if there were consistent principles of success underlying these different approaches to leadership development.

We reviewed leadership development programs in eight major corporations. Although all eight companies had the same overarching goals — to determine the desired behaviors for leaders in their organizations and to help leaders increase their effectiveness by better aligning actual practices with these desired behaviors — they used different leadership development methodologies: offsite training versus onsite coaching, short duration versus long duration, internal coaches versus external coaches, and traditional classroom-based training versus on-the-job interaction.

Rather than just evaluating "participant happiness" at the end of a program, each of the eight companies measured the participants' perceived increase in leadership effectiveness over time. "Increased effectiveness" was not determined by the participants in the development effort; it was assessed by preselected co-workers and stakeholders.

Time and again, one variable emerged as central to the achievement of positive long-term change: the participants' ongoing interaction and follow-up with colleagues.

Leaders who discussed their own improvement priorities with their co-workers, and then regularly followed up with these co-workers, showed striking improvement.

Leaders who did not have ongoing dialogue with colleagues showed improvement that barely exceeded random chance. This was true whether the leader had an external coach, an internal coach, or no coach. It was also true whether the participants went to a training program for five days, went for one day, or did not attend a training program at all.

Leadership, it's clear from this research, is a *relationship*.

The development of leaders, we have concluded, is a contact sport.

4. Measures of Success

Physician Engagement

- Physicians give you the "back door" office number
- Physicians return your call
- During conversation,
  - the "real issues" are disclosed
  - physician/MOA doing the majority of talking
- Physician and/or MOA asking for your information and advice
- Share stories and data from the office

Coach/Facilitator/Coordinator Engagement Skills

- Calmer during visits, conversations
- Less defensive when being asked questions
- Comfortable maintaining contact with offices
- Know just how many questions to ask before dropping a 'pearl' of information to further engage them.

Measures of Success

(add your own)

Physician Engagement

Coach/Facilitator/Coordinator Engagement Skills

Schedule of Contacts – Champion List

Traits of a Physician Leader: street sense, respect of others, integrity, avoids personal or specialty goals, communicates effectively and has a willingness to learn.

Traits of a Physician Champion: a person with social skills who speaks with courage at critical moments. Others may see them as being "like me". This person may or may not have skills needed for facilitation or public speaking.

Physicians Initials	Area of Expertise	Date last Contacted

Capacity Building

List of Some Practice Efficiency Techniques

- Working as a team in the office
- Expanding the scope of Care Team members
- Flow Mapping
- Plan Do Study Act cycles
- Advanced Access and Continuity (attachment of a patient to a physician)
- Measurements
- Know your Panel
- Patient Self Management

List of Some Practice Efficiency Tools

- Daily Huddle Sheet
- Primary Care Practice Know your Processes
- Access your practice-patient panel, professional (staff), processes and patterns
- "Help Us Help You" waiting room poster
- "Why I left the examining room" tally sheet
- "Do I need to be a MD to do this task" tally sheet
- PSP Three Questions of patient self management

For more information on practice efficiency please see the Practice Support Program website **www.practicesupport.bc.ca**

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