An Incomplete Guide to Engaging Physicians into Quality Improvement

RESPECT

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

In British Columbia, since 2007, 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 an 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

A. Working with Individual Physicians

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?

B. Working with Physicians within Your Organization

Adapted from Dr Jim Reinertsen and Alice Gosfield, Institute for Healthcare Improvement.

1. Assess the Current Situation in Your Organization

2. Discover a Common Purpose

3. Reframe Values and Beliefs: Culture Change

4. Segment the Engagement Plan

5. Use “Engaging” Improvement Methods

6. Show Courage

7. Adopt an Engaging Style
2. Engagement Framework...

A. Working with Individual Physicians

1. Program Overview

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

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 common agenda is established, move quickly into action, 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?
2. Engagement Framework...

B. Working with Physicians within Your Organization

1. Assess the Current Situation in Your Organization

Historical Context:
Does this sound familiar in your organization?
- Poor turnout at physicians meetings
- Roll out a new program and physicians say “no one ever talked to me about it”

First Step: How would you reflect on the current relationships and engagement of physicians in your organization?

What are your findings?

It is possible that upwards of 70% of decisions in healthcare are directed by physicians’ orders.
- If making improvements to the healthcare system are on the top of your agenda, how does your current reflection on physician engagement compare to this?

Although it’s difficult to achieve, physicians can be engaged and supportive of quality improvement efforts if the activity is presented and managed effectively.
2. Discover a Common Purpose

In fact, quality improvement is a good “sweet spot” for physician engagement as physicians care about and can strongly relate to issues such as:

- Reducing hassles, bottlenecks and delays
- Improving care for their patients

While reviewing your initiative(s) reflect on the following questions:

- Is this initiative framed and communicated to physicians so that it is clear we are aiming to improve patient outcomes?
- How will specific aspects of this initiative reduce hassles and wasted time for physicians?
- How will you measure that improvement?

“Time is currency, work-life balance is important and money isn’t everything”
— Unknown physician

3. Reframe Values and Beliefs: Culture Change

A recent Academic Medicine article\textsuperscript{ii} states that the physician of the 21st century will face a very different set of challenges with an emphasis on coordinating the care of patients and the application of an array of technologies that will require teams of experts and support staff for their successful implementation.

Having physicians more involved in your team will require flexibility on both sides. When doing so, keeping the patient needs in focus will make it easier to create a common agenda.

Assessing your readiness:

- How will you get physicians to see the “balcony” or “big picture” view of your initiative?
- How do you envision physicians sharing decision-making within your team?
2. Engagement Framework...

4. Segment the Engagement Plan

Engaging all physicians at once is difficult and it is likely your initiative only affects certain groups. By segmenting your plan, you will be able to provide specific communications and support by identifying:

- Which physicians have to be involved for your initiative to succeed
- Clearly identify the role of the physician: Project lead, Champion, Advisor
- Length of their involvement in the initiative

Assessing your readiness:

- Are you able to identify those physicians you need involved for success?
- Within that subgroup, are there natural physician leaders or champions? If so, how would you approach them with your ideas? How will you support them?

5. Use “Engaging” Improvement Methods

This topic identifies the pursuit of Standardization. Can you relate to:

- Months of meetings designing care pathways, standing order sheets and protocols → Focus is on the WHAT should be done (not the How) → 10,000 copies and mass email of final version, edits to final version are discouraged → Physicians are asked to “opt in” to new way

A new approach to standardization?

- Spend no more time than one meeting on the “what”
- Start testing one way to do the new “what” in the field, on a small scale
- Encourage small tests of change in how, where, who and in the “what” if necessary, until the new way is working well for the majority of care providers and patients
- Once it is working well for the majority, consider making the change more official

“Move the work from the conference room to the exam room”
— Dr Jim Reinertsen
Physicians and Data:

How do you currently share data with physicians?

Physicians are generally suspicious of interpreted data; it could be misleading or hiding something.

When sharing data with physicians, here are some important guidelines to consider:

- Share the raw data. They might not want to review it all but they want to know you aren’t hiding anything from them
- Start with telling them everything you know that is wrong with the data
- Partner with your physicians when interpreting the data; include them from the beginning
- Be careful in the first or second meetings when sharing data that profiles individual physicians, otherwise that physician will likely attack the quality of the data rather than the gaps in care
- Don’t use QI language; it may seem “clubby”. Use plain language, data and stories.

The idea is working towards using data to shed light not heat. There can be two sides to data: Judgment/Fear and Learning/Curiosity

- Judgment and Fear can lead to defensiveness which can disengage interest in data
- Learning and Curiosity can lead to research and improvement which can increase desire to review data

By using engaging methods one can make the right thing easy to try and make the right thing easy to do while providing data to support your changes.

Assessing your readiness:

- Is there a plan in place to develop the new way of standardization?
- Can the data you collect be easily shared with physicians?
2. Engagement Framework...

6. Show Courage

Can you relate to this scenario?

We had a great plan, enthusiastic champions and excellent use of methods, but when it came time for us to pass the test with the diehard resisters

- The physician council looked the other way; Administration waffled; The Board blinked

When engaging with physicians, ensuring your initiative has the right supports to make the changes necessary and possibly change the “structure” to better suit the “function” is critical for success.

Assessing your readiness:

- When starting your initiative, do you have support from those who can make the changes?

7. Adopt an Engaging Style

When engaging with physicians in quality improvement, making an effort to develop and maintain trust is essential.

- Physician’s world:
  - Approach is “one patient at a time,” therefore asking them to step back and see the aggregate is new, and possibly difficult.
  - Accountable for life and death- every last physician, young and old, can tell you by name who they harmed or killed by virtue of an innocent mistake based on imperfect information on the fly and they know how vulnerable they are to doing this again. This fear may affect how a physician approaches changes to decision making.
  - Believe they are what they do. If being asked to change, it may be personalized as “I am doing something wrong”
  - At times, may have concerns about being audited by their regulatory body. At minimum, if audited, this process requires a good deal of time for physicians. Time is Currency.
Engaging Styles that may help:

• Include physicians at the beginning of a project. If invited too late, may believe they are getting influenced
• Identify your real leaders – not always the ones with fancy titles
• Make physician inclusion of your project visible to other physicians
• Build and rebuild trust: How? Do what you say and say what you do, consistently over time.
  This isn’t easy, as you must be able to describe what you want to do and then be able to point back to this fact after it is done.
• Use open, frequent and candid communication
• Respect their time- refrain from showing up at meetings late or working on your smart phone during a meeting
• Maintain confidentiality of sensitive information
• Value the process and support the process more than the structure. If the structure is impeding progress, with the support of your leaders, change the structure.

What additional strategies would you use?
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

- **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**

- **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\textsuperscript{v}
- Self Direction
- Active Learning
- Relevant, immediate practical application
- Skill Based
- Keep it simple, in doable chunks
- Feedback.

Quality Chasm – Institute of Medicine, 2001\textsuperscript{vi, vii}
- “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.
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 both the patient and provider experience of care
- Reduce, or at least control, the per capita cost of care.

Jack Silversin

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.
Discovery Phase Questioning Framework

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

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 with 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**

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<thead>
<tr>
<th>High Importance/ Low Confidence</th>
<th>High Importance/ High Confidence</th>
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<tbody>
<tr>
<td>Want to change and are willing but not sure if they will succeed</td>
<td>See change as important and are convinced they can succeed</td>
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<table>
<thead>
<tr>
<th>Low Importance/ Low Confidence</th>
<th>Low Importance/ High Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not as important and do not believe they could succeed with change</td>
<td>Could make the change if it were important, but not convinced it is important</td>
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**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\textsuperscript{xii}

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.

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<th>Physicians Initials</th>
<th>Area of Expertise</th>
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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
- Three Questions of patient self management
  - What worries you most about your condition?
  - How do you feel about this?
  - What would you like to change and how do you think you might do that?

For more information on practice efficiency please see the Practice Support Program website www.pspbc.ca
5. References


v Plesk, P. “Spreading Good Ideas for Better Health Care: A Practical Tool Kit” Irving.TX: VHA Inc.


