Physician Actions

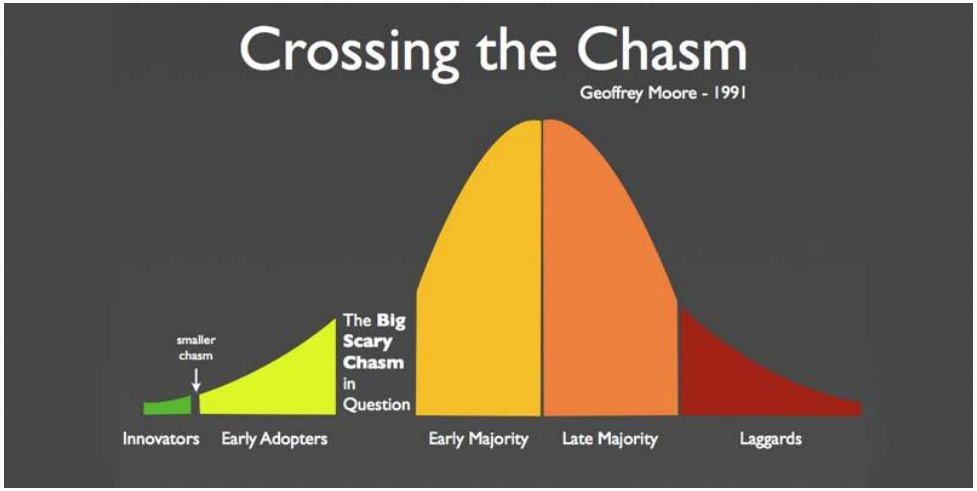
Can we change them?

The Challenge:

- Five Best Practices:
  - 24/7 availability and on-site attendance when required
  - Proactive visits to residents
  - Meaningful medication reviews
  - Completed documentation
  - Attendance at case conferences
- Three system level outcomes:
  - Reduced unnecessary or inappropriate hospital transfers
  - Improved patient/provider experience
  - Reduced cost/patient as a result of a higher quality of care

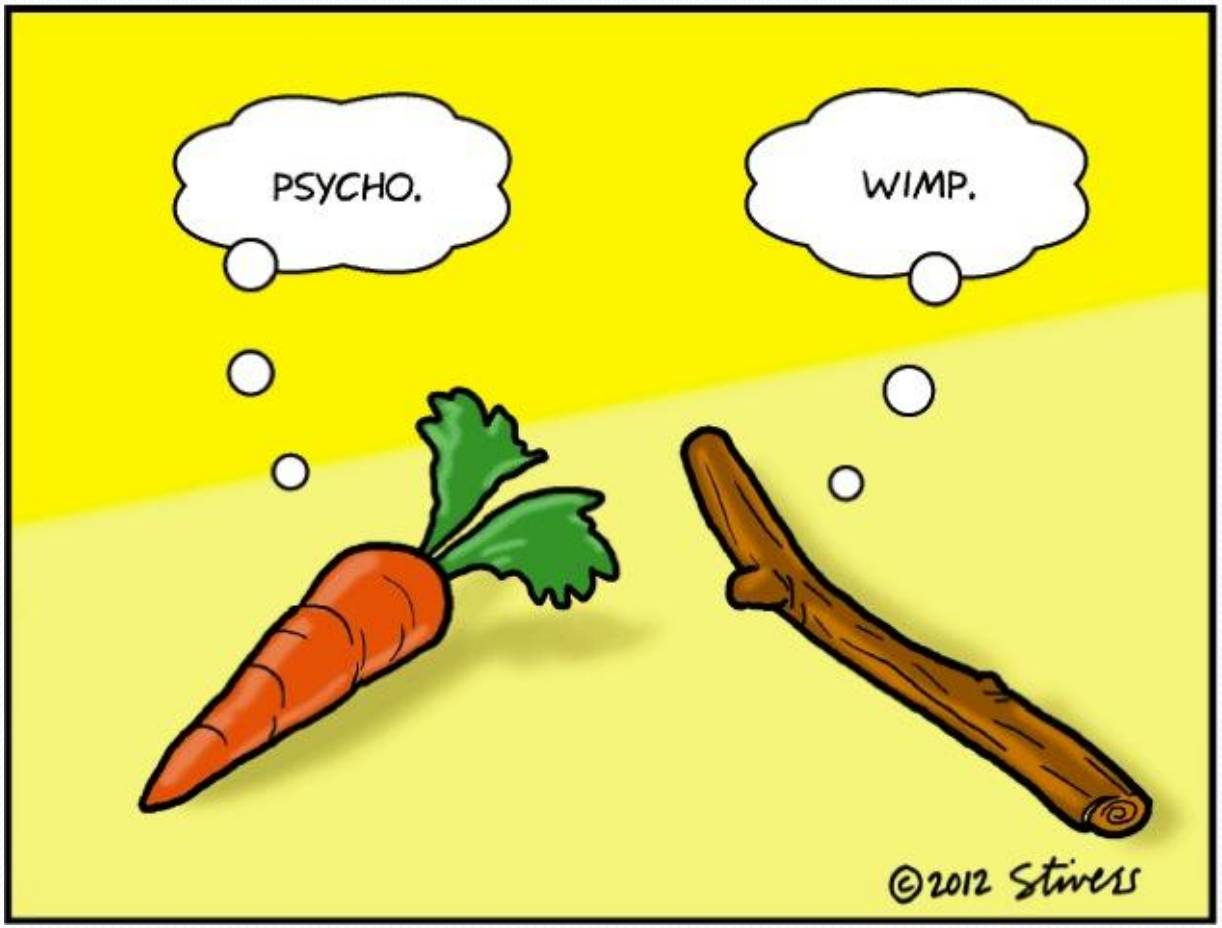
Things I said at the last provincial divisions event

- Evils of the 5 best practices
- Reasons that GP's will change their practice (MAP)
- "People don't buy what you do but *why you do it*"
- Interdisciplinary teams, Attachment to facilities
- Collaboration with partners



But at some point this feels like all talk…

- Everything has to line up just right and energy has to be sustained for so long that 'soft and gentle' lacks some practicality.
- We have some idea what ideal parenting is… but sometimes there is a place for "alternative approaches"
- We have obligation to
  - Have physicians do what they are agreed to do
  - Make good use of public money


PSYCHO.
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20%
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CONTROL
EQUALITY

Accountability

- "…the expectation of account-giving"

- Effort based:
- "The RCI program is about changing the care in residential care, please give account for your actions to bring this about (since you accepted the money)."

Accountability

- Starts with having shared expectations..

- Quantitative based:
- Aggregate results: “Here are facility performance numbers that don’t meet target. We expect you to resolve the gap.”
- Individual results: “Here are the times you missed achieving the 5 BP’s. We expect you to not miss.”

Necessary in High Functioning Teams

Productive conflict generates results.

Do you need consequences?

- “Close the gap or you will not longer get the funding”

- Or slowly raise the Health Authority’s standard of care and have the Health Authority manage creating consequences.

SMART Accountability

- S - specific,
- M - measurable,
- A - agreed upon,
- **R - realistic**,
- T - time-bound

Coaching people toward being accountable

Accountability

- A good partner to the ‘long game’ of changing incentive structures
- A governance responsibility
- Behavior review or Data driven
- Need to be skilled at ‘mining conflict’ and having honest conversations about trust
- Chose consequences (or not)
- Consider coaching them with SMART, small goals.

The evils of the 5 best practices:

- Puts doctors on the defensive
- For those who aren't doing them, they quickly have to justify why not
- For those who are partially doing them, it's not inspirational or motivational. They have been trying and $300 isn't going to move the mountains that are in the way
- They focus the project on implementing solutions before understanding the people and the situation of care
- Ignore relationship and listening

Reasons a GP will change his or her practice

- Skill development
- Community contribution
- Identity building – helper, champion of marginalized
- Teamwork opportunity
- Retirement planning
- Specialization
- Income

Mastery
Autonomy
Purpose

- This is package you can build around the RIC funding model – what does that package look like for your GP's?

Other Divisions

- Okanogan
  - Collaboration with health authority
  - Common cause
- Vancouver
  - Young physicians want to be part of interdisciplinary teams
  - Attachment to facilities can be generated and attractive

Thoughts from previous webinar

Jen

- Collaboration?
- Common Cause?
- Streamline Care?

But what if RCI was first and foremost about this?

Jamie

- Mentoring?
- Strong physician attachment to the facility?
- Physician integral part of an interdisciplinary care?
- Young physicians?

- New practice of care?
- Res care is a valuable opportunity?
- Supportive team model attracting young physicians
- We get caught up with the framework of money and 5 best practices
- Maybe we should think about things 'in our community' first.

“People don’t buy what you do, they buy why you do it.”

Simon Sinek

"Why statement" for the RCI leadership team in your community?

- Jen's might be, "We are passionate about improving patient care in our community. We believe that the the best improvement happens when people who care for patients and people who operate the care system, collaborate on a common cause. Will you help us improve the care of frail elderly living in facilities ?"

"Why statement" for the RCI leadership team in your community?

- Jamie's might be, "We believe in challenging the common notions of how patient care is provided by GP's. In residential care we are implementing a model of care that puts the GP as an integral part of an integrated care team and builds a strong attachment between physician, staff and patients. Would you be a part of this innovation in patient care delivery?"

IS RCI *Status Quo* or *Change?*

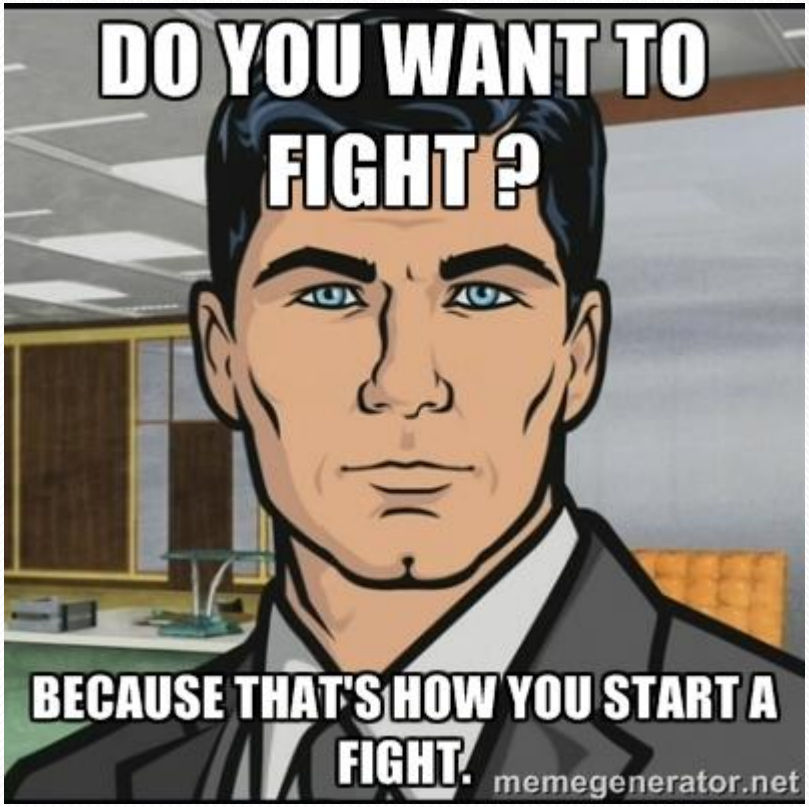
- RCI is about *change* but
  - We have limited supply of doctors
  - Change is needed with staff, patients and admin
  - Change theory says you can't change everything all at once
  -
  - Therefore… RCI is about *staus quo* too

Before MOU signing

- "Here is a funding model – we have to do X to get Y. Do you want to do this? If so how?"
  - Need reasonable amount of buy-in to a rough plan

- How is your community of doctors going to meet the 5 best practices?
  - 24/7 availability and on-site attendance when required
  - Proactive visits to residents
  - Meaningful medication reviews
  - Completed documentation
  - Attendance at case conferences

Are you saying, my care is not good enough?



Change Model