Medical Staff Leadership
***
How to Inspire Change & Avoid Madness

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Board of Directors, American College of Emergency Physicians
Medical Director, Studer Group

Caveat #1: What Brought Us to this Dance . . .

Ain’t Going to Get Us to the Next One . . . .
Caveat #2 – The Best Definition of Madness is

To keep doing things the same way and expect different results . . .

Caveat #3 How Most of Us Approach Change
Caveat #4: To Get Quality Anything . . . Double Vision is Required

Systems

People

Process

Outcomes

Staff

Patients

Physicians

Which Means . . .

Efficient Care/Flow

Transitions of Care

Staff Engagement

Patient Engagement

Alignment of Behaviors
Caveat #5: It’s About The Team

While we give care seemingly individually,

- The Patient and Family Experience is dependent upon the coordinated actions of all members of the team . . .

- From the moment they walk in, to the moment they walk out or on . . .

- Success is never achieved alone.

- If it’s not always . . . It’s not great . . .

Caveat #6: No Rest For The . . .

“If the other guy’s getting better, then you’d better be getting better faster than that other guy’s getting better . . . or you’re getting worse.”

-- Tom Peters
The Circle of Innovation
Where We Are
How We Need to Feel . . . What We Need to Do

Why is This Important?

- Declining Reimbursement
- Workforce Shortage
- Malpractice Risk
- Transparency of Data
- Pay for Performance – VBP
- Quality = Service = Quality
“Better Communication Was Associated with Higher Global Ratings of Health Care”

**Background:** Observational cohort study.

**Setting:** 2 managed care organizations.

**Participants:** Vulnerable older patients identified by brief interviews of a random sample of community-dwelling adults 65 years of age or older who received care in 2 managed care organizations during a 12-month period.

**Measurements:** Survey questions from the second stage of the Consumer Assessment of Healthcare Providers and Systems program were used to determine patients’ global rating of health care and provider communication. A set of 236 quality indicators, defined by the Assessing Care of Vulnerable Elders project, were used to measure technical quality of care given to 32 clinical conditions. 227 quality indicators were evaluated by using data from chart abstraction or patient interviews.

**Results:** Data on the global rating item, communication scale, and technical quality of care scores were available for 236 vulnerable older patients. In a multivariate logistic regression model that included patient and clinical factors, better communication was associated with higher global ratings of health care. Technical quality of care was not significantly associated with the global rating of care.

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**Relationship Between Patient Satisfaction, Complaints and Lawsuits**

- Each one point decrement in patient satisfaction scores is associated with a –
  - 6% increase in complaints (RR 1.06, 95% CI 1.03 – 1.08; p<.0001)
  - 5% increase in risk management episodes (RR 1.05, 95% CI 1.01 – 1.09; p<.008)
- Lower performing physicians were at greater risks for lawsuits (RR = 2.10; p 95% CI 1.13 – 3.90; p<.019)
- 75% of complaints were related to communication issues

Pay for Performance for Hospitals is Here . . .

Core Measures (45% Weight)

1.25% Base operating DRG payments

HCAHPS Composites (30% Weight)

Outcomes (25% Weight)

50th percentile or improved over the previous reporting period to “win” the $ back!

Note: Implementation FY 2014
Source: OPPS VBP Final rule 11.1.11

Pay for Performance for Physicians Coming Soon . . .

Quality
- PQRS = Physician Quality Reporting System
- PV = Physician Value-Based Payment Modifier
- Electronic RX and EHR incentives
- Payment is tied to quality and cost metrics
- Cost and quality metrics are transparent via Physician Compare

Patient Experience
- CG CAHPS is the patient experience component for outpatient/office practice
- HCAHPS is the patient experience component for inpatient practice
- ED CAHPS will become the patient experience component for the ED
Patient Experience Measurement: CAHPS

During your hospital stay, how often did doctors/nurses:
- treat you with courtesy and respect?
- listen carefully to you?
- explain things in a way you could understand?

Never/Sometimes/Usually/Always
# Clinician & Group CAHPS

## Composites
- Access to care
  - Getting needed care
  - Getting care quickly
- Provider communication
- Follow up on test results
- Global rating of Provider
- Clerks and Receptionists
- Pediatrics includes Development & Prevention

## The Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. In the last 12 months, how often did this provider explain things in a way that was easy to understand?</td>
<td>1 Never, 2 Sometimes, 3 Usually, 4 Always</td>
</tr>
<tr>
<td>15. In the last 12 months, how often did this provider listen carefully to you?</td>
<td>1 Never, 2 Sometimes, 3 Usually, 4 Always</td>
</tr>
<tr>
<td>19. In the last 12 months, how often did this provider show respect for what you had to say?</td>
<td>1 Never, 2 Sometimes, 3 Usually, 4 Always</td>
</tr>
<tr>
<td>20. In the last 12 months, how often did this provider spend enough time with you?</td>
<td>1 Never, 2 Sometimes, 3 Usually, 4 Always</td>
</tr>
</tbody>
</table>
23. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

0 Worst provider possible

1

2

3

4

5

6

7

8

9

10 Best provider possible

The Global Rating Question

Physician Compare

Physician Compare

Physician Quality Reporting System (PQRS)

Physician Quality Reporting System (PQRS)

Physician Quality Reporting System (PQRS) is a pay-for-reporting program that gives eligible professionals incentives and payment adjustments for improving the quality of care. All eligible PQRS is a standalone program that leverages reporting such as the PQRS Incentive Program, the Medicare Shared Savings Program, and the value-based Payment Modifier. To learn more about the program, visit:


PQRS Group Practice Reporting Option (GPRO)

Public Reporting of PQRS and CGCAHPS beginning Calendar Year 2014
Physician Quality Reporting System (PQRS):

- For 2014, add 47 new individual measures and 4 measures groups to fill existing measure gaps and retire a number of claims-based measures to encourage reporting via the registry and EHR-based reporting mechanisms
- Proposed deletion of 46 measures
- Proposed addition of recommended core measures that align with the EHR Incentive Program recommended core measures
- 4 new measures groups: Total Knee Replacement, Optimizing Patient Exposure to Ionizing Radiation, General Surgery, and Gastrointestinal Surgery

Physician Value-Based Payment Modifier (VBPM)

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Value-Modified Payment Adjustment</th>
<th>Eligible Professionals Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015 payments</td>
<td>Groups ≥ 100</td>
</tr>
<tr>
<td>2014</td>
<td>2016 payments</td>
<td>Groups 10-99</td>
</tr>
<tr>
<td>2015</td>
<td>2017 payments</td>
<td>ALL ELIGIBLE PROFESSIONALS</td>
</tr>
</tbody>
</table>
Value Modifier and PQRS 2016

Data collected 2014 will affect 2016 payment

- For 2010 Groups of physicians with 10+ eligible professionals (EPs)
  - PQRS Reporters: Avoid the 2016 payment adjustment under PQRS by using GPRO web interface, registries, EHR or the individual 70% option
  - Groups of physicians with 10+ EPs: Upward, or no adjustment based on quality scoring
  - Groups of physicians with 100+ EPs: Upward, neutral, or downward adjustment based on quality scoring

- Non PQRS Reporters: Fail to avoid the 2016 payment adjustment under PQRS by not using GPRO web interface, EHR or the individual 70% option
  - 2.0% (downward adjustment)

Quality Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite

- Clinical care
- Patient experience
- Population/Community Health
- Patient safety
- Care Coordination
- Efficiency
- Total overall costs Medicare Spending Per Beneficiary
- Total costs for beneficiaries with specific conditions

Quality of Care Composite Score

Cost Composite Score

VALUE MODIFIER AMOUNT
Quality Tiering Approach

- Each group receives two composite scores (quality of care; cost of care), based on the group's standardized performance (e.g., how far away from the national mean).

- This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.

<table>
<thead>
<tr>
<th>Quality/cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality</td>
<td>+2.0%*</td>
<td>+1.0%*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Medium quality</td>
<td>+1.0%*</td>
<td>+0.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-1.0%</td>
<td>-2.0%</td>
</tr>
</tbody>
</table>

*Eligible for an additional +1.0% if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

The Old Paradigm

Care = Income
The New Paradigm

Outcome = Income

Exceptional Clinical Quality & Extraordinary Patient Experience = $$$

Service vs. Quality . . . or Service = Quality

Some would say . . .

▼ Clinical quality is the real deal, the “hard stuff.”

▼ Service excellence is the “fluff stuff.”
Physician communication correlates STRONGLY with adherence rates by patients in acute and chronic disease. There are now over 100 observational and 20+ experimental studies published demonstrating the correlation of communication (patient satisfaction) with compliance. **Compliance with treatment regimens has significant influence on quality measures in chronic disease and outcomes.**

*Medical Care*: August 2009 - Volume 47 - Issue 8 - pp 826

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**Higher Patient Satisfaction = Communication = Compliance = Quality**

Patient experience is positively associated with clinical effectiveness and patient safety.

Associations appear consistent across a range of disease areas, study designs, settings, population groups and outcome measures

- **Positive associations** 429 studies (77.8%)
- **No association** 127 studies (22%)
- **Negative association** 1 study (0.2%)

*British Medical Journal 2013*  
[http://dx.doi.org/10.1136/bmjopen-2012-00157](http://dx.doi.org/10.1136/bmjopen-2012-00157)
Does a physician’s empathy impact a diabetic patient’s treatment?

- Hemoglobin A1c test results to measure the adequacy of blood glucose control according to national standards → lower = better control
- LDL cholesterol level → lower = better control

“Empathic engagement in patient care can contribute to patient satisfaction, trust, and compliance which lead to more desirable clinical outcomes.”

What Does All This Mean For Us?

- There’s a lot of work to do.
- We have to assure engagement before we can expect alignment.
- You can’t get quality as a group if everyone is not on board, which means . . .
- We all need to recommit and understand “No more reserved seats on the bus.”
- With the measurement feedback you get (ask for it!!), if you personally are not at the mean or above, ask for help/skills training/shadow rounding.
The Big Question

How can you, as an organization, create a consistent high quality compassionate experience for your patients, despite:
- Staff Diversity
- Different approaches/training
- Different years of experience
- Different and rotating personnel
- The pressures for doing more with less
- Time – Time – Time

What Makes a Highly Reliable Organization?

- **Consistency** of Practice
- **Dependability** of Performance
- **Uniformity** of Behavior
Variation in Clinical Practice

Variation in Use of Head Computed Tomography by Emergency Physicians

Luciano M. Pravedello, MD, MPH, Ali S. Raja, MD, MBA, MPH, Richard D. Zane, MD, MPH
Aaron Sodickson, MD, PhD, Stuart Lipsitz, ScD, Louise Schneidler, MD, MPH, Richard Hanson, MD
Srinivasan Mukundan, PhD, MD, Kamin Khorasani, MD, MPH

*Center for Evidence-Based Imaging and †Departments of Radiology, Emergency Medicine, and ‡Center for Surgery and Public Health, Brigham and Women’s Hospital, Boston, Mass. ‡Harvard Medical School, Boston, Mass.

The American Journal of Medicine

Variation in Clinical Practice

The researchers found that, overall, head CT examinations were ordered for 4,919 emergency department visits (8.9 percent). There was significant variation between physicians, with the unadjusted rate of head CT ordering ranging from 4.4–16.9% overall, per physician, and from 15.2–61.7% for patients diagnosed with atraumatic headaches. Overall, there was a two-fold variation in head CT ordering (6.5–13.5%), and for atraumatic headaches there was an approximately three-fold variation in head CT ordering (21.2–60.1%). This variation persisted after adjustment for confounding variables.
### A Few Lessons Learned

- **Blame Nobody, Expect Nothing, Do Something** (Bill Parcells, NY Post 1999)
- **Change starts at home – first me, then thee** *(Leadership)*
- **It’s not the ideas, it’s the implementation** *(Accountability)*
- **Perception is all there is** *(Almost)*

### How To Lead: Steps In The Process

- Define your vision
- Engage your people (Leader Rounding/Stoplight Report)
- Clarify your expectations (Standards)
- Teach them the skills (Skills Sessions)
- Verify their compliance (Rounding on Patients/Shadow Rounding with Providers)
- Reward or Replace (There Must Be Consequences)
Where To Start: Define a Common Destination

“If you don’t know where you are going, you might wind up someplace else.”

Ask Yourself and Then Your Staff: What Do You Want to Be Known For?

1. I am known for (1-2 items); by next year at this time, I plan also to be known for (1 additional item):

2. We (My practice) is known for (1-2 items); by next year at this time, we plan also to be known for (1 additional item):

3. The first step I (we) need to take in order to make that happen is . . .

4. The single biggest obstacle we have to overcome is . . .
Have the Conversation: What Do We Want To Be Known For?

Engaging and Aligning People: Leader Rounding on Staff

- Harvest Wins:
  “Are there any individuals or physicians you would like me to compliment or recognize?”

- Focus on the Positive:
  “What is going well today?”

- Identify Process Improvement Areas:
  “What systems can be working better?”

- Repair and Monitor Systems
  “Do you have the tools and equipment to do your job?”

- Coach on Behavior/Performance Standards
  “Our focus for the day is__. Can you do that?”
Fix the Systems -
Create a Working List

- What is working . . .
- What is not working . . .
- Are there tools/equipment you need?
- Are there personnel you need?
- Is everyone on board?

Key Tactic: Document What You Are Doing - Stoplight Report

Green: Here is what we have already done.
Yellow: Here is what is in process.
Red: We can't do now and here is why.
Focus/Fix/Follow-Up (Communicate It)

You may be asking: What have we done for you lately?

As you will hopefully remember, this past July you and your colleagues were asked to complete our physician survey. We had an excellent response and have been working diligently to address the items you brought to our attention.

As we prioritized the issues, a few quickly came to the top. Below is a brief summary of our efforts to make improvements in these areas.

Physician Engagement Team
- This team was implemented to identify and remove barriers that prohibit our physicians from practicing effectively. The team's goal is to make ANP the best possible place for a physician to practice. Current physician members include Dr. Chris Stover, Dr. Laura Hill, Dr. Salvatore Luffianic, Dr. David Fligel, and Dr. Roger Hawkins.

Emergency Department
- A team of two separate teams of physicians to identify concerns related to the ED.
- Assembled a hospital team and brought in outside council to help us review the bylaws while addressing some issues specific to the ED.
- Engaged Dr. Jan Kaplan, board member of the American College of Emergency Physicians, to provide an outside perspective.
- Maintained all hospital managers responsible for the success of the ED in 2010.
- Developed an action plan for addressing specific pediatric concerns.
- Implemented a Pediatric Nurse Coordinator to work with the ED physicians to make sure that they have multiple opportunities for pediatric CME specific to our patient population.

Operating Room
- Invited all of the nurses who utilize the OR along with their office staff, to a meeting to discuss difficulties in scheduling and utilization of block time.
- Invited attending surgeons who are interested in the OR to a meeting to discuss their needs.
- Invited all operating room staff, including nurses, to a meeting to discuss our needs.
- In the process of forming a physician team who will review block time usage, equipment requests, and other OR-related issues and make recommendations to the administration team. Dr. Robisky and Tadros.

Where To Go Next - Accountability
Get Everyone On Board

Once you’re on the road, being on the bus becomes an active decision . . .
Getting People On Board . . . With What? Standards

The Straub Physician Promise

As a Straub Physician I will strive to be:

A champion for my patients:
- My highest priority will be my patients’ well being.
- I will provide the best care and service to every patient with every encounter.
- I will help my patients get the health care services they need.

A trusted resource for my patients:
- I will continuously work to improve my technical skills and scientific knowledge.
- I will be an expert in what I do.
- My compliance will command respect from my peers and community.

A true friend to my patients:
- I will know my patients as well as I know their health conditions.
- I will be approachable, accessible, and attentive.
- I will be respectful of my patients’ time, feelings, and personal philosophies.
- I will speak in a way my patients understand.
- I will give my patients the time they need.
- I will make my patients feel better at every encounter.

A master of the health care system:
- I will lead my fellow physicians and staff to help me serve my patients.
- I will improve my clinic so that it can more effectively serve my patients.
- I will nurture relationships to facilitate cooperation in caring for my patients.
- I will help my patients navigate the health care system to get needed services.

A leader in my community:
- I will inspire others by my example.
- I will represent my clinic and my profession with dignity and honor.
- I will advocate on behalf of all patients, everywhere.

Behavior Standards Impact

**High**
- Used for orientation/signed
- Behavioral components used for “Selection”
- Consistent with “Vision”
- Physicians trained in behavioral standards
- Supported and projected by leadership
- High VISIBILITY
- Consequence for violation

**Low**
- No upfront signing/orientation
- No training of physicians
- Low leader visibility
- No consequences for violations of behavioral standards
Physician Code of Conduct

**Mission:** To develop and sustain an integrated primary and specialty health system that is responsive to the comprehensive health needs of the communities we serve.

**Vision:** Provide outstanding, accessible healthcare and wellness to the communities we serve.

**Values:**
- Patient Centered Care
- Service Leadership
- Evidence Based Medical Practice
- Metric Driven Quality and Performance Indicators
- Fiduciary Responsibility
- Genuine Provider Citizenship

As a provider at Cheyenne Regional Medical Center and/or Cheyenne Regional Medical, I will always work to develop positive relationships with administration, staff, patients and my colleagues and support our teams through:

Translating Standards into Behaviors

▼ For the Patient:
  ▼ Sit Down at the bedside
  ▼ Use Key Words
  ▼ Use the 5 Fundamentals of Communication (AIDET®)
  ▼ Collaborative Rounding

▼ For Staff
  ▼ Colleague as customer
  ▼ Say “Thank You” more
Verifying Behaviors: Leader Rounding on Patients

LEADER Rounding Log

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name:</th>
<th>Patient Knows Their Nurse/Doctor.</th>
<th>Patient is Informed.</th>
<th>Pain is being Controlled.</th>
<th>Sensitive to Privacy.</th>
</tr>
</thead>
</table>

Examples of key phrases to use during your visit:

- **Good Morning, I'm NAME, TITLE for the ED. I'm just stopping by to make sure my staff and I are doing everything we can to give you *very good* care.**
- **Do you know who your nurse is today? Doctor?**
- **Do you know what your nurse and doctor are doing for you right now? Have there been any delays? Have you been kept informed?**
- **Has your pain been addressed yet? Is your pain being controlled?**
- **Do you have any questions? Is there anything else I can do for you?**

You may receive a survey in the mail after you go home. We would appreciate if you would fill it out. The survey lets us know how we are doing and if we are providing our goal of *very good* care. We also want to use it to reward and recognize staff.

Talk to your staff before & after rounding. Forward log sheets to your senior manager each week.

<table>
<thead>
<tr>
<th>Room #</th>
<th>Notes: Behavior Recognized</th>
<th>Reward (R) or Coach (C) Opportunity</th>
<th>Staff member to Reward or Coach:</th>
</tr>
</thead>
</table>

Shadow Rounding with Staff/Physicians

<table>
<thead>
<tr>
<th>Behaviors Observed:</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMELT Skills:</td>
<td>Comments</td>
<td>Comments</td>
<td>Comments</td>
</tr>
<tr>
<td>Acknowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intro (Inquire Confidence)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do Your History/Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration/Explaination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thank</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coaching Other Skills: Rounding Follow-up Phone Calls Teamwork
Self-Test for Physicians/App’s

1. Do you acknowledge and make physical contact with the patient and others in the room when you first enter? 1 2 3 4 5

2. Do you introduce yourself and share your experience and commitment? Do you manage up the rest of the team? 1 2 3 4 5

3. Do you sit down at the patient’s bedside? 1 2 3 4 5

4. Do you give the patient and family 2 minutes to tell their story? 1 2 3 4 5

5. When you get up to perform the physical examination, do you tell the patient? Do you articulate your findings? 1 2 3 4 5

6. Do you explain to patients/families what you have found and the meaning of their diagnostic and therapeutic results? 1 2 3 4 5

7. Do you explain to patients/families the expected duration of the illness, diagnostic work-up, or healing process? 1 2 3 4 5

8. Are you using key words to convey to patients your commitment to their comfort and safety? 1 2 3 4 5

9. Are you collaborativelyrounding on patients with the nurse in the room as a vital team member? 1 2 3 4 5

10. If a patient hand-off is required, are you managing up the oncoming provider? And whenever possible doing the hand-off at the bedside? 1 2 3 4 5

11. Are you completing the patient visit with “What questions do you have for me? Is there anything you would like for me to go over again? 1 2 3 4 5

12. Are you closing the patient encounter with a statement of gratitude and/or appreciating the patient? 1 2 3 4 5

Do You Have Any Franchise Players?
Do You Have Any Vampires?

Graph Your Physicians – Build Critical Mass

- 1st Priority (Engagement and Importance)
- 2nd Priority (Engagement and Importance)
- 3rd Priority (Engagement and Importance)
The Work Environment
Compliment to Criticism Ratio

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Compliments</th>
<th>Criticisms</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 to 1</td>
<td>3</td>
<td>1</td>
<td>Positive!</td>
</tr>
<tr>
<td>2 to 1</td>
<td>2</td>
<td>1</td>
<td>Neutral</td>
</tr>
<tr>
<td>1 to 1</td>
<td>1</td>
<td>1</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Source: Tom Connellan, “Inside the Magic Kingdom”, pages 91-95

Say Thank You More

The Simplest Recognition: Saying “Thank you” at the end of the day (shift)
What Happens If People Don’t Get On Board?

- If you permit it, you promote it
- What you can do is to not permit it

YOU GOT ALL D’s.

YES, BUT THAT’S WELL WITHIN THE MARGIN OF ERROR.
Learning How To Communicate

5. Treats ED staff in a professional and courteous manner
6. Effectively communicates patient differential dxs/treatment plan to nurses
7. Explains the problem and treatment to patient and/or family satisfactorily
8. Is easily approachable with questions, problems, and/or suggestions by staff
9. Is able to remain calm under stress and is able to handle crises well

Self-Perception is Reality?

9. Is able to remain calm under stress and is able to handle crises well
Crucial Communications

- “May I Speak Freely?”
- “My purpose in talking with you is …” (a mutual goal)
- “When you … I feel . . . ” (action you are giving feedback on – something they can change)
- “I imagine that …” (positive intent/benefit of the doubt)
- “And because we both want …” (common goal)
- “I need …” (specific alternative behavior requested)
- Affirm him or her as a person

Dealing with Unprofessional Behavior - Guided Interventions

- Vast Majority: No Issues
- Single Incident “Unprofessional”
- Apparent Pattern
- Pattern Persists
- Improvement & Eval Plan + Accountability
- Aggregated Data Presented by Peer or Authority
- “Cup of Coffee Conversation”
- Mandated Issues
- Boundary, sub abuse, impairment

Failure to Respond → Restriction or Termination → Reporting

Level 3: Disciplinary Intervention

Level 2: Authority Intervention

Level 1: Awareness Intervention

Failure to Respond

Crucial Confrontations
(Beyond the “Cup of Coffee”)

- Prepare...
  - Gather facts
  - Prepare a script
  - Rehearse
- Choose your setting
- Define your roles

Crucial Confrontations
(Beyond the “Cup of Coffee”)

- Language Matters
  - “This is business; not personal”
  - Avoid “Why?”
    - But consider what underlying issues might be....

Crucial Confrontations
(Beyond the “Cup of Coffee”)

Language Matters
- Separate process issues from the point of this intervention
- Use “Nevertheless, the fact remains....”
- Address the “Target Syndrome”


Remember Change Is Not Easy . . .
- Without challenge there is no change.
- If you are always in your comfort zone, you are not where you need to be.
- We have got to get comfortable with being uncomfortable.
- Just because you can ride in spin class . . .
  Doesn’t mean you can ride on the open road . . .
Thanking you . . .

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