PHYSICIAN CHAMPIONS

AS A STRATEGIC RESOURCE IN ALBERTA'S PATIENT'S MEDICAL HOME TRANSFORMATION JOURNEY

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EnACt

ALBERTA MEDICAL ASSOCIATION

ACTT
Accelerating Change Transformation Team

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INTRODUCTION

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Family physicians in Alberta, who successfully engage other members of the practicing community, health organizations, and the public, are well-positioned to build awareness about provincial transformational initiatives, affect positive change, be the voice of primary care in the province, and create system level transformation.

These physicians, commonly referred to as "Physician Champions," are critical in the strategic efforts of the Alberta Medical Association - Accelerating Care Transformation Team (AMA-ACTT) to spread the Patient's Medical Home (PMH) in Alberta.

PROJECT GOALS

This pilot project started with the premise that the better one understands a strategic resource, the more effective one can support it. As such, the initial goal of this pilot project was to assess how internal members of AMA-ACTT and select senior Physician Champions understand what makes an effective Physician Champion. As the project progressed, the goals broadened to include understanding the different processes involved in championing, as well as eliciting thoughts about the challenges and opportunities of effectively training and supporting Physician Champions for knowledge and skills building moving forward.

This report is designed to offer a broad, synthesized view of the findings to date. We hope it will help spark continued discussion, provoke insights, raise questions, and help identify the most strategically fruitful areas for deeper investigation. Using the report in this way will serve to build a deeper and more shared understanding (or mental model) of Physician Champions and the championing process. This includes what Physician Champions are, what they do, and how to identify, develop, support, deploy, retain, and ultimately engage them.

METHODS

This pilot project was conducted in three intentionally iterative phases of knowledge elicitation, representation, and building. We asked the internal members (directors, program leaders, improvement advisors (IAs) and senior administrators) of AMA-ACTT (hereafter "participants") to participate in interviews, a survey, and three Working Focus Groups (WFGs)[1] . The Research Ethics Office at the University of Alberta deemed the study to be a Quality Improvement project, and as such IRB exempt.

Between each phase the research team prepared the data so participants could react to it in the next phase. This preparation consisted of reflecting on the data, identifying themes and issues, drawing connections between different concepts, making connections to concepts from different organizational literatures. Given this degree of researcher participation in building shared understanding, what we offer here is a blend of researcher and participant understanding of how Physician Champions are supported in Alberta, including issues, challenges, gaps opportunities, as well as discrepancies among participants.

[1] A working focus group is a blend between a focus group where knowledge is elicited, and a working group, where the implications of the elicited knowledge are then brought to bear on the participants' actual and potential work.

PHASE 1:
INTERVIEWS

We conducted 22 individual semi-structured, Cognitive Task Analysis interviews with participants (Potworowski & Green, 2013). Interviews were audio-recorded and transcribed. Because of time constraints, only 12 were selected for coding based on interviewers' perceptions of the richness and uniqueness of their content. Two coding pairs reviewed six of the 12 selected interviews; we coded individually using a preliminary coding framework before coming together as a group to discuss codes applied, and solve or negotiate any discrepancies between the coding team members. Two interviews were also coded within our framework based on the notes taken at the interview prior to the interviews being transcribed. Once compiled, we reviewed the coded data for key themes in which to form a survey for participants to complete.

PHASE 2:
QUESTIONNAIRE

Using the key themes found in the selected interviews, we created a survey that was sent to a select group of 12 AMA-ACTT members that were invited to participate in the WFGs as part of phase 3. Ten participants completed the survey. Survey results were compiled, analyzed to confirm key themes, and used to create a foundation for which to conduct WFGs.

PHASE 3:
WORKING FOCUS GROUPS

We conducted three separate WFGs with the same 12 participants who were invited to complete the survey. In each WFG, three to five participants focused on one of the three main strategic processes to manage Physician Champions that emerged from our data: 1) identification and recruitment, 2) development, and 3) deployment and support. Each WFG was audio and video recorded for future transcription and analysis. Two team members took detailed notes during the WFGs, while the other two led and facilitated. These notes formed the basis of our observations, and were compiled and reviewed for common themes, new ideas, questions, and potential activities or strategies suggested by each group.

FINDINGS

Our findings are divided into two main parts.

The first part focuses on key language issues and proposes three basic conceptual frameworks to help characterize Physician Champions and how they are supported. These provide common ground which should help structure and facilitate subsequent conversations. Although the frameworks are certainly not final, they were developed and refined over the three phases of the study. The three frameworks are:

1. **Key Championing Dimensions**
2. **Three Essential Physician Champion Characteristics**
3. **The Five Strategic Processes in Physician Champion Management.**

The second main part of the report delves more deeply into three of the five strategic processes, namely:

- **Identification and Recruitment**
- **Development**
- **Deployment and Support**

ISSUES WITH THE TERM "PHYSICIAN CHAMPION"

One of the issues we encountered in several of our interviews and working focus groups (WFGs) was that the term "Physician Champion" was itself problematic. On the one hand, participants explained that some physicians embraced the term with pride, and even felt it offered them some status and recognition. On the other hand, some felt that it connoted a level of superiority and an expectation that they were not comfortable with. The latter may partly explain the reports of physicians being reluctant to share their stories because they felt their practices did not live up to a standard implied by "champion." Moreover, it may keep some physicians from perceiving their accomplishments as worthy of sharing.

The term "physician leader" was also used by participants in the interviews and WFGs and we did not ask respondents to comment on how the two terms were related. The literature on Physician Champions and physician leaders treat these terms as distinct. We propose AMA-ACTT team members investigate the literature and distinguish between the two terms to create standard terminology and assist in building the shared mental model. One suggestion from the research team (GP) is to distinguish a "Physician Champion," who in the literature refers to an individual who leads an implementation initiative, from "vanguard," who is an individual who helps others with the adoption or implementation of an implementation initiative by sharing the experiences, insights, or materials they gained by implementing that initiative.

KEY CHAMPIONING **DIMENSIONS**

Based on the interview data, and subsequently refined through the survey and WFG sessions, we found that Physician Champions and championing can be meaningfully characterized by three dimensions: type, level, and modality. *Table 1 (below)* represents what types of Physician Championing exist at what levels. This table is meant as a draft representation of how Physician Championing was understood by participants. *Table 1* and other knowledge representations in this report are meant to further the conversation about what makes Physician Champions effective, the current Physician Champion situation, and where strategic efforts should be directed to maximize their effectiveness. For example, *Table 1* could be used as a tool to assess the current and anticipated supply and shortages Physician Champions at the PCN or provincial levels.

Table 1: Types of Championing by Level

		Type of Championing				
Level	**Description**	**Clinical** Leads or actively promotes implementation of a clinical change (e.g., panel)	**Operational** Leads or actively promotes implementation of an organizational change, (e.g., team-based care)	**Governance** Leads or actively supports change through governance mechanisms, (e.g., board membership)	**Program** Leads or actively supports change by helping develop programs before they are launched	**Policy** Leads or actively supports change by helping develop and shape relevant policy
0*	Implements on own without team					
1a	Helps own team implement	✓	?			
1b	Helps others in own clinic implement	✓	?	✓		✓
2a	Helps another clinic implement	✓	?			
2b	Helps many clinics in PCN implement	✓	?	✓	?	✓
3	Helps many clinics in zone implement	✓	?	✓		?
4a	Helps clinics outside of zone implement	✓	?			
4b	Helps many clinics in province implement	✓	?			
5	Province-wide effort	✓	?	✓	✓	✓

** Although level 0 is not championing, improvement advisors often actively support MDs in the implementation if they perceive them as potential future champions.*

Note: The ✓ and ? Symbols in the table represent only our assumptions about the levels at which different types of championing occur

In addition to characterizing Physician Championing by type and level, participants indicated that physicians engage in different types of activities when they champion, which we labeled "championing modalities." The list of championing modalities on *Table 2 (below)* illustrates some of the ways in which physician implementation experience and insights have been shared with others. In the survey, participants indicated that "informal fireside chat e.g. at change event day," "good news videos," and "allowing others to shadow at clinic" were the modalities with the greatest potential to help spread PMH in Alberta. Participants in the WFGs argued that committee work was becoming an important modality of championing. It was noted in the WFGs that the AMA-ACTT team and others e.g. Practice Facilitators, often assume Physician Champions would champion by giving presentations, but that other modalities may be more feasible and just as persuasive.

Table 2: Championing Modalities - How the Physician is Championing

1. Presentation (e.g., in person, webinar)
2. Workshop
3. Leading group discussions (e.g., fireside chats, focus groups, webinar)
4. Developing implementation materials (e.g., checklists, guides, EMR modules)
5. Video or stories
6. 1-on-1 (discussion, training, coaching, mentoring)
7. Allowing others to shadow (directly and indirectly)
8. Committee work

PHYSICIAN CHAMPIONS AND CHAMPIONING CAN BE MEANINGFULLY CHARACTERIZED BY THREE DIMENSIONS: TYPE, LEVEL, AND MODALITY.

THREE ESSENTIAL CHARACTERISTICS OF **PHYSICIAN CHAMPIONS**

Our study generated a list of knowledge, skills, attitudes, and other characteristics (KSA) that participants indicated play a role in Physician Champion effectiveness. We propose that these characteristics contribute to one or more of the following essential characteristics of Physician Champions:

1 CREDIBILITY

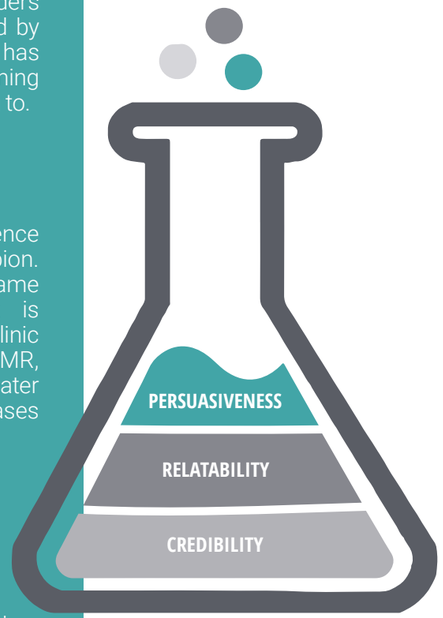
Credibility is whether one's audience considers the physician a good clinician who is liked by patients and staff, has good outcomes, and has implemented the change they are championing successfully (enough) to be worth listening to.

2 RELATABILITY

Relatability is the point to which the audience sees themselves in the Physician Champion. Part of this is personal e.g. likeability, same concerns, initial skepticism and part is contextual e.g. clinical responsibilities, clinic location, staff size, payment model, panel, EMR, etc. We inferred from interviews that greater Physician Champion relatability increases audience engagement with the champion.

3 PERSUASIVENESS

Persuasiveness is the degree to which the Physician Champion can convince the audience that the change is worth doing and possible to accomplish for them. One measure of persuasiveness is how many audience members try the implementation (especially ones who flipped from being cynics).



FIVE STRATEGIC PROCESSES IN **PHYSICIAN CHAMPION MANAGEMENT**

Physician Champions are, for the most part, volunteers and as such those supporting them have no authority over them. In the analyses between the different phases of data collection, five processes emerged as critical to this management of Physician Champions. We have presented these below *(Figure 1)* in a linear fashion because this is the general sequence they follow. Some of the recursive dynamics between processes are addressed in the more detailed descriptions of Identification and Recruitment, Development, and Deployment and Support processes.

Figure 1: Processes in the Strategic Management of Physician Champions in PMH Transformation

Implementation support involves supporting physicians who are the first in their PCN or Zone to implement an initiative. This support is given so that the physician can serve as local proof of concept and potentially be a future champion of that initiative once they have had some success. One IA called this "planting a seed," and is a mechanism of potential Physician Champion identification.

Identification and Recruitment is the process of finding a physician who could serve as a champion, vetting the physician, and convincing them to become a champion. There are different mechanisms by which physicians are identified as champions, each involving one or more change agents (e.g. IAs, Practice Facilitators, from within PCNs, other Physician Champions, or individuals in AMA-ACTT programs).

Development consists of any efforts to improve the physician's general ability to champion. This can happen before a champion is deployed, after they have been deployed, or as they change type, level, or modality of championing. It can include developing knowledge (e.g. a vision of how things fit), skills (e.g. question asking in presentations), or attitudes (e.g. confidence building). Development can be done in many ways, including workshops, coaching, and peer mentoring.

Deployment and Support consist of choosing the best available Physician Champion for the job, and then helping them get that job done well. Support involves managing the logistics of the championing modality e.g., booking a room and AV equipment. It may include working with the Physician Champion to decide the best story to tell, preparing and reviewing presentations with the Physician Champion, co-presenting, or debriefing and development e.g. coaching, after the championing event.

Progression and Retention consist of helping Physician Champions change type, level, or modality of their championing. Although this has typically meant moving them up a level, there are cases where Physician Champions need to change modality or are recruited to champion topics related to ones they have championed before. Retention is the process of keeping Physician Champions from quitting altogether by either changing deployment patterns e.g. reducing or making them more local, or working on progression.

IDENTIFICATION & **RECRUITMENT**

We focused on two key parts of the Physician Champion identification process 1) identification mechanisms, and 2) selection criteria. Identification mechanisms consist of descriptions of the impetus, steps, and individuals involved in finding physicians willing to serve as champions at level 2b (Helps many/most other clinics in PCN) and up. Selection criteria consist of the knowledge, skills, attitudes, and other characteristics (KSA) that our participants a) look for in physicians before recruiting them to be champions and b) thought every Physician Champion should have.

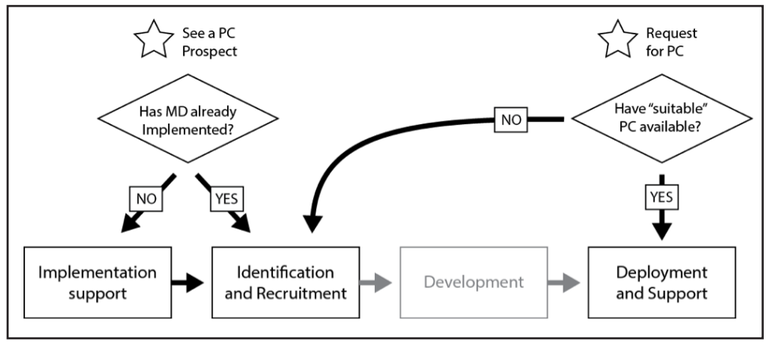
IDENTIFICATION MECHANISMS

We found that the mechanisms for identifying and recruiting Physician Champions could be categorized as either reactive or proactive. Reactive mechanisms are demand or need driven, as when AMA-ACTT needs a Physician Champion to talk about a certain initiative. Proactive mechanisms are supply driven, as when an IA sees a physician doing great work and thinks there is potential to get to champion an initiative in the future *(see Figure 2)*. Proactive mechanisms may include physicians volunteering or self –identifying, as one participant recalled being asked by a physician: "Why am I not on the list?", or being invited by colleagues to get involved because they were noticed for the good work they do.

It was noted in the WFGs that the proactive mechanisms of self-identification or peer identification did not always hit the mark as the physician candidate was not always "champion material." These individuals may be good physicians, but have insufficient credibility or persuasiveness among their peers. One solution that was suggested was a self-rating tool, though one participant added that physicians are notoriously bad at self-evaluation.

Much of our data on identification mechanisms focused on reactive mechanisms, possibly because these are more common. Several of these reactive mechanisms involved multiple steps and multiple individuals. For instance, the program, the IA or the PCN could identify a need e.g. we need someone to present about panel, at which point the program or the PCN may look to the IAs to locate a suitable Physician Champion. In turn the IAs would look to Practice Facilitators, another PCN or Executive Director (ED) of a PCN to locate a suitable champion. Such a mechanism is potentially problematic if as some stories suggested Practice Facilitators and possibly EDs do not always use the same selection criteria as IAs when identifying champions.

Figure 2: Physician Champion Identification Mechanisms



MECHANISMS FOR IDENTIFYING AND RECRUITING PHYSICIAN CHAMPIONS COULD BE CATEGORIZED AS EITHER REACTIVE OR PROACTIVE.

Participants in the WFGs stated that AMA-ACTT should "arm Practice Facilitators and PCNs with looking to see potential Physician Champions to watch who is doing what." It was agreed that this training and encouragement could have a positive impact on the identification and recruitment of effective Physician Champions. A "screening process" by AMA-ACTT was also mentioned in the WFGs whereby "if they [potential Physician Champion] can't convey to us about a topic then they can't convey knowledge or passion to other physicians so they won't be respected", at which point they would be "screened-out."

The lack of explicit consensus on what criteria to look for in Physician Champions among those involved in the proactive of reactive identification of Physician Champions is an important gap. It underscores the importance of having clear and even measurable criteria that could be shared with all individuals involved in identifying Physician Champions. The next section begins to address this issue.

PHYSICIAN CHAMPION SELECTION CRITERIA

In each of the three phases of our study we tried to identify and assess the criteria that make physicians effective champions. The list of characteristics we compiled could be broken down into KSAs, e.g. confidence, and other e.g., rural vs urban. It seemed more important however to assess whether each criterion contributed to a Physician Champion's credibility, relatability and persuasiveness, how important each criterion was, the degree to which it was trainable, and whether participants used the criterion to vet physicians. The logic was that physicians should be vetted using a common shortlist of KSAs that were critical for effective championing and hard or impossible to train. To this point, when asked for suggestions on how to better identify Physician Champions, one survey respondent described needing "eyes in the field, with certain criteria to look for potentials."

This list was formed from interview data, further reduced by survey respondents selecting what characteristics were "Essential" and "Important," and then further categorized into "Must Haves," "Important," and "Other" by our second WFG. *Table 3 (right)* presents the twenty-two characteristics that were deemed to be "Must Haves" when it came to identifying and recruiting Physician Champions.

Although we did provide opportunities for participants in different WFGs to discuss and evaluate key KSAs, there was insufficient time for in-depth discussions and the list in *Table 3* does not represent a consensus. As such we strongly recommend this be used as a tool to continue those conversations, and not be used as a definitive list of selection criteria. Indeed, *Table 3* illustrates that although these characteristics were deemed to be "Must Haves" or "Important" in the WFGs, and either "Essential" or "Important" in the survey, most criteria are not used to select physicians.

Although not conclusive, the WFGs discussion around critical criteria identified two criteria that had until then not been identified. The first was a physician's authenticity. Although not included in the *Table 3*, one participant suggested that authenticity would be a "Must Have" for credibility, relatability and persuasiveness. This participant noted: "you are who you are…capture who you are, be that person, use that."

The second concept that came up in the identification of Physician Champions, one that is also relevant to progression and retention, is "calling."[2] Calling is a form of job orientation in which the individual is willing to give up financial rewards and advancement, for the opportunity to do personally meaningful work. Once the concept was raised, one participant described calling as the "classical nominator of who we recruit, and all Physician Champions have this." The ensuing conversation led to the insight that although change agents involved in the support of Physician Champions cannot create a calling in physicians, they can help awaken it, keep it burning, and help it evolve. One participant suggested asking physicians "what drives your calling, your passion?"

[2] Bellah, R. N., Madsen, R., Sullivan, W. M., Swidler, A. & Tipton, S.M. (1985). Habits of the heart: Individualism and commitment in American life. New York. Harper & Row.

ALTHOUGH CHANGE AGENTS INVOLVED IN THE SUPPORT OF PHYSICIAN CHAMPIONS CANNOT CREATE A CALLING IN PHYSICIANS, THEY CAN HELP AWAKEN IT, KEEP IT BURNING, AND HELP IT EVOLVE.

Table 3: Key Characteristics of a Physician Champion[3]

Characteristic	Credibility	Relatability	Persuasiveness	Select for this[4]
Has content Knowledge**+**	✓			70%
Reads room effectively		✓		60%
Presentation/communication skills**^+**			✓	60%
Speaks Clearly			✓	60%
Tells a compelling story			✓	60%
Has small wins to share*****	✓	✓		50%
Answers questions effectively	✓			50%
Respected*****	✓			50%
Has vision for change			✓	50%
Presents outcome clearly	✓		✓	40%
Good clinician*****	✓			40%
Willing to have tough conversations**^**		✓	✓	40%
Practicing physician*****		✓		40%
Humble and open about challenges/failures[5]			✓	40%
Explains consequences for patients	✓			30%
Adapts to heterogeneous audiences		✓	✓	30%
Open to input and learning from others		✓		22%
Explains consequences for clinicians/staff	✓			20%
Lifelong learner*****	✓			20%
Asks audience questions and awaits answers**~**		✓	✓	20%
Honest about need for improvement		✓	✓	20%
Cares about community*****			✓	0%
Knows audience's past change experience[6]		✓		N/A

+ Some foundational amount required, which can be improved
***** Needs to pre-exist as AMA-ACTT doesn't coach for this
^ Modality dependent
~ Facilitator or person supporting the Physician Champion could handle this

[3] Not all characteristics we asked about are listed here, only those deemed "Must Haves" or Important" by the WFG.
[4] This was from survey respondents, n=10
[5] The survey included the characteristic "humble," but the WFG activities did not. Humble was also listed separately in survey and deemed "useful" by most respondents, whereas the WFG participants thought it was "Important."
[6] This characteristic was identified in an open-ended response on the, and so there is no data on if or how many select for this.

CHALLENGES TO IDENTIFICATION AND RECRUITMENT

A key challenge to identifying new Physician Champions that participants identified is that IAs no longer work directly with clinics and physicians. As such they often rely on Practice Facilitators, EDs, and others to identify champions. This can present a problem as PCN cultures shape how Practice Facilitators and EDs think of Physician Champions. One participant pointed out that in some PCN cultures, "we don't make demands of our doctors" or "bug the doctors." This affects how and how effectively Practice Facilitators can work to identify, develop, or deploy Physician Champions. In addition, it was noted that Practice Facilitators are not empowered in the PCN to bring physicians to the next level, but that they should be since "they are the arms and legs of the PCNs". According to several participants, a key barrier is the typical Practice Facilitator's limited knowledge of the full picture of the vision and what is coming up. This shortcoming is also found in some EDs and PCNs.

The result is that Practice Facilitators can be reluctant to approach physicians and may not use the same criteria as IAs to identify potential Physician Champions in the first place. Participants stated that, compared to Practice Facilitators, the IAs' view (previously and currently) was on a different level and they had "more of a pulse" on what was and is going on provincially. Interestingly, when asked on the survey "To what degree do you think those identifying Physician Champions are looking for the same things as you do" 70% of respondents thought Practice Facilitators were looking for "similar" things while 40% thought PCN EDs were looking for different things and 30% similar.

NEED FOR MORE AND DIFFERENT TYPES OF PHYSICIAN CHAMPIONS

Along with the challenges, it became apparent from the data that there is a need for more and different types of Physician Champions if AMA-ACTT's transformation goals are to be met. More and different types of champions may also assist in dealing with the problem of current Physician Champion over-deployment and burnout: As one participant reported, there is an overuse of certain Physician Champions and good speakers and "they don't all have to be shiny and polished."

Below are listed new types of champions that were suggested by participants.

More Diverse Champions

Various concerns around the diversity of Physician Champions were reported, including the need for more female Physician Champions, as currently it is "male-centric." In addition, a younger generation of physicians could be tapped into if AMA-ACTT team members are willing to explore differing approaches and modalities. It was noted that the newer generations of medical graduates are open and enthusiastic to practice better, but less likely to give up their free time. One participant reported that 40% of new graduates in primary care want to be locums and many new graduates limit their panels.

Urban vs rural vs rural vs remote

The interview and WFG data also revealed the importance of considering geographic location. While many agreed that sending in an 'urban' family physician into a 'rural' setting would likely fail because of low relatability, questions did arise around differences and diversity among the rural populations. Would a rural Physician Champion from the northwest of Alberta have sufficient credibility in the rural northeast part of Alberta? Would a southern rural Physician Champion be welcomed in northern areas of the provinces that may be considered remote rather than rural? As one participant stated, "living in urban, we lump rural." These differences should be considered when considering how to improve both Physician Champion identification and deployment.

Specialist Physician Champions

Following our first WFG, a separate discussion about the need for "specialist" champions occurred. This discussion raised questions around how to generalize the findings of this study, since experience has shown these champions cannot be integrated one at a time. It also provided insights into the need to think outside the box and not to replicate but find nuggets of truth in past experiences and create standardization from there, and the need to change mental models first. Further insights included: knowing that primary care physicians no longer feel supported by specialists as they face challenges referring patients to specialists and that each specialty defines panel differently. One next step suggested was "integration champions," namely primary care and specialist champions who can speak to each other.

Cluster Champions

The idea of "Cluster Champions" was raised during the interview phase where it was noted that effectively creating practice transformation and improving care requires implementing change not piecemeal, but with an eye to how each change connects with others e.g. effectively caring for chronic illness requires changes around use of EMR, panel management, registry, and care management.

When asked in the survey how important it was to develop cluster champions to spread the PMH in Alberta, 7 of the 10 respondents said it was essential, 2 labeled it important and 1 as moderately important. Furthermore, in two of the three WFGs, participants discussed the need to help more Physician Champions' progress into cluster champions. Participants also agreed that focusing on panel and continuity (under the PMH umbrella) would be the priority areas for cluster championing, as they lead to and intersect with both access and EMR.

Participants identified two key challenges to developing cluster champions: 1) a lack of time or opportunity to build champions to that level, and 2) finding Physician Champions that have the knowledge and skill in all the areas required. However, participants also pointed out that moving to become a cluster champion was a natural process that just needed dedicated effort and time to plan. It was noted that physicians did not need to have all the skills and knowledge, but could rely on the practice team to supplement the Physician Champion with their expertise and skills. This may be one area where AMA-ACTT would like to have further discussions or plan for further development.

Non-Physician Champions

Several interviewees discussed the potential of having non-Physician Champions, including clinic team members (panel managers, clinic managers, MOAs), Practice Facilitators, Improvement Advisors, and others. Eight of the 10 survey respondents said non-Physician Champions were essential and the other two said they were important to spread PMH in Alberta. A WFG participant also noted that "if we walk further into interdisciplinary teams we will need more team involvement" to implement and champion transformation initiatives. Another participant recalled times where a Physician Champion was sent to an event when another type of champion would have been just as effective and cheaper. This suggests that using non-Physician Champions could be a cost-effective alternative to address the shortage of Physician Champions, so the AMA-ACTT team can "ensure using them [Physician Champions] when really needing them."

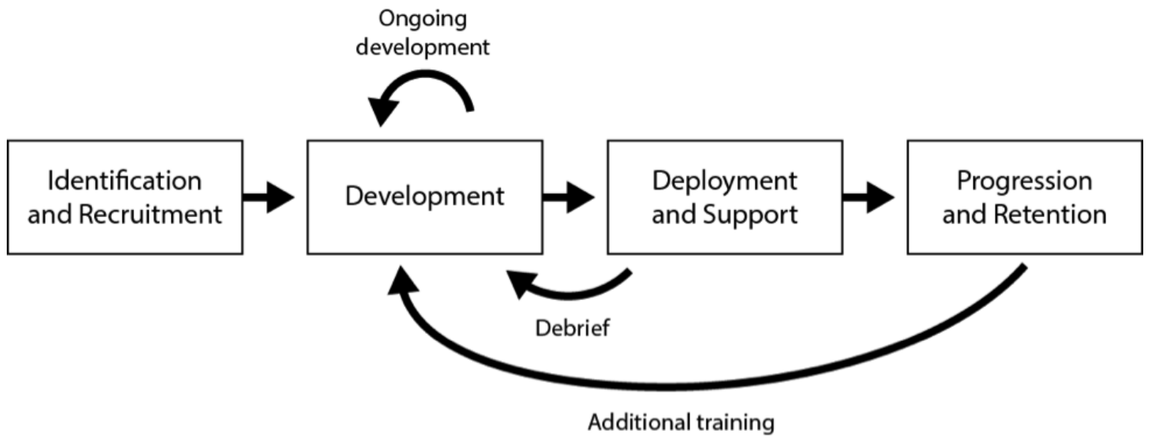
However, it was also noted that it is unclear how much non-Physician Champions can influence other non-physicians and physicians; typically, physicians want to hear from other physicians. In addition, there would be challenges around engaging non-Physician Champions because of team culture and lack of confidence or knowing their voice matters. Lack of time and resources was also identified as respondents noted "who pays for their time?" and who provides "time away from their 'usual' work to dedicate to the effort(s)"?

DEVELOPMENT

We identified at least three times when Physician Champions are or could be developed to be more effective *(see Figure 3).* One example that sometimes follows championing events is debriefing. Several participants reported coaching Physician Champions after presentations to build Physician Champion confidence, improve presentations, and improve presentation skills. A second form of development is ongoing, whether through the Physician Champion Network, change agent day training, AIM, or other events. A third form of development discussed in a few interviews is a Physician Champion's progression. When a Physician Champion changes the type, level, or modality of championing, they often require additional skills e.g. being an effective board member, or sitting on a provincial committee.

Although the bulk of the data focuses on direct Physician Champion development, participants indicated that because various change agents are involved in many of the strategic processes supporting Physician Champions, they too could benefit from development. From a system perspective, such "indirect development" would ultimately improve Physician Champion performance. In principle, both direct and indirect development can help Physician Champions become more effective. Direct development focuses on improving the Physician Champion's own KSAs, such as building confidence. In contrast, indirect development focuses on improving the KSAs of the change agents that work with Physician Champions. An example of indirect development would be helping an Practice Facilitator develop a more accurate mental model of how to identify and recruit a champion, which would result in a larger or better pool of Physician Champions.

Figure 3: Three Opportunities for Physician Champion Development



SPECIFIC AREAS FOR DIRECT DEVELOPMENT

Overall vision of the Patient Medical Home

Knowledge of the overall vision, ability to see the bigger picture, and sharing a master plan or road map of previous and future initiatives were identified as crucial to the direct development of successful Physician Champions. This would contribute directly to the development of "cluster" champions. Being able to see the bigger picture was also said to be important for other change agents. Data collected shows that participants view the role of change agents and non-Physician Champions as essential to spreading the PMH in Alberta. As such, those change agents or non-Physician Champions would also require an understanding of the bigger picture to be effective.

The consensus was that an effective Physician Champion was one who can adapt to and engage a heterogeneous audience and clearly explain initiatives. Building a good and compelling story was also highlighted as essential to the development of effective Physician Champions. The story building process involves tapping into a Physician Champion's strengths, listening to their story, and "building a deck" i.e., slides that include the evidence, their journey of the how, the why, the challenges, and some self-reflection of the value gained. Investing time one - on-one to listen and build a good narrative is important, because as one participant stated: "what they tell you one-on-one might not be what they should say to a group."

Presentation Skills

Despite the potential of other championing modalities, the most common mode of championing is oral presentations. To convey their story persuasively, participants in one WFG agreed that Physician Champions need come to the table with basic presentation skills. That said, basic presentation skills and presentations can and need to be developed. IAs currently provide guidance in the design and delivery of presentations that enable a Physician Champion to effectively communicate their narrative, outcome data, and anticipate the audience's questions and concerns, it is essential to audience engagement. As one participant remarked, "we're coaching as an art, not as a reliable practice, and we should be coaching as practice." Debriefing as soon as possible after a presentation, about how it went and what can be improved, seems to be invaluable to the ongoing success of a Physician Champion, and helps develop their skills at building relatability with the audience, and their ability to be persuasive. Additional activities to help the development of presentation skills are described in Table 4.

Table 4: Suggested Activities Developing Better Presenters and Presentations

Building a story	Presentation skills	Building Confidence
What makes a good story? • At an event (e.g. Change Agents day) have a workshop where participants create two minute presentations- • Creating 2-3 slides of a story that builds a slide deck. • Everyone gets to be a story teller and recipient. • Provide feedback that builds a physician's confidence in telling their own story, so that they feel rewarded that they have something to share.	Create Dyads[1] • Dyads can support the cycle of presenting together, debrief/ feedback to each other and adapt the presentation and delivery according to the audience(s). • Send Physician Champions with a high relatability factor to listen, watch, and provide feedback to a new Physician Champion who is presenting.	Awareness and honesty • Encourage Physician Champions to answer questions honestly, replying 'I don't know' or referring to another team member/dyad. • Encourage Physician Champions not to make assumptions about an audience, and be aware of audience cultural sensitivities.

[7] Dyads are discussed in deployment and originally included pairing a Physician Champion with an IA or other change agent or support person e.g. panel manager; however, here we are suggesting pairing a new Physician Champion with an experienced Physician Champion or IA.

Discovering Authenticity

As mentioned earlier, an important part of being credible, relatable, and persuasive is to be authentic as a presenter. Physician Champions must be themselves and present and engage in their own style. Inspiring Physician Champions to be authentic requires building their confidence and may involve encouraging them to try different approaches until one seems right. Equally, recognizing the importance of balancing confidence and humility, particularly amongst physician peers and/or audiences, being open about the challenges and failures, or willing to have tough conversations about championing primary care initiatives, can also influence how relatable a physician is to an audience.

SPECIFIC AREAS FOR INDIRECT DEVELOPMENT

Practice Facilitator Development

Practice Facilitators were identified as being change agents who, if supported and given the right tools, would have greater initial impact in the identification and development and/or support of Physician Champions. Participants emphasized that because Practice Facilitators are positioned in the PCNs and work directly with clinics, Practice Facilitators "know physicians well, so [are] in a place to know [the] narratives." Yet Practice Facilitators are not 'armed' with the tools to identify/develop or support potential Physician Champions. Their individual maturity, experiences and knowledge of the Patients Medical Home or vision of the "bigger picture" differ. The cultures of different PCNs also differ. Practice Facilitators are currently provided with just enough additional training via emails, talking points and ad hoc communications, which are often related to identifying types of Physician Champions for specific projects. Practice Facilitators themselves have identified a current need and desire to learn more about engagement with physicians in their work place. Having quick training workshops was one suggestion in supporting Practice Facilitator development. In addition, the newly formed Practice Facilitator Community of Practice group might be a great place to begin to refine knowledge and skill sharing.

ED/PCN Development

The need to support the development of EDs and PCNs was identified by participants, but they also recognized this is likely to be an "unperceived" need by the PCNs or EDs. It was pointed out that most PCNs believe they are doing "well-enough," while the AMA-ACTT team is aware that there is often a lack of vision or understanding the bigger picture.

Using training sheets and having check-lists and summaries for PCNs and EDs to use may assist them to "see where they are with progression towards initiatives" and thus the bigger PMH vision. As we noted earlier, having common Physician Champion selection criteria could also assist with EDs and PCNs in recruiting effective Physician Champions. Furthermore, it was noted by participants that physicians and Practice Facilitators/IAs desire a working relationship and a feedback loop with each other, supporting the development of PCNs and EDs may in turn encourage support for this relationship and the use of non-Physician Champions working with Physician Champions.

CHALLENGES TO DEVELOPMENT

We have already reported the challenges that link to the development of Physician Champions as well as change agents e.g. PCN culture, lack of vision, lack of shared and known criteria for recruitment/identification, lack of confidence and applied knowledge/skill. An underlying challenge for any development effort that was acknowledged by participants was a lack of financial resources. This included the financial resources to compensate Physician Champions and non-Physician Champions (although it was noted that Physician Champions continue to want to be involved without financial compensation), and the resources to pay for the necessary clinic team members to push the PMH further in Alberta. For example, as participants pointed out, many business models restrict rather than support, as they do not include the necessary team members within their budget line items. This means a PCN trying hard to implement the PMH may get stuck as they do not have the budget to hire or sustain the panel managers and Practice Facilitators required to support initiatives.

SUGGESTED OPPORTUNITIES

Overall, we discovered that the starting point suggested by participants that would have a good initial impact on development would include building the strength of change agents, especially Practice Facilitators. This would include using those who are already 'out in the field' by empowering them with the overall vision and encouraging them to think about current and future Primary Care initiatives and how they interconnect. In addition, further development of Physician Champions may include closing feedback loops between the Physician Champions and the change agents who support/collaborate with them and asking Physician Champions what they want.

Table 5: Suggested Opportunities for Development

Funding	Learn from other programs	Ask Physician Champions what they want
• Funding was an essential component of the success of Peer2Peer – is there a way to secure funding to compensate for the time to develop Physician Champions and possibly non-Physician Champions?	• Peer2Peer is the most reliable and gold standard AMA-ACTT performer regarding structured support. Use what has been learned from this and apply to Physician Champion development (could potentially also be used in other strategic processes such as identification and deployment).	• "Our Physician Champions need more support than we anticipate, we underestimate this and need to ask them how we can support them" • "Academic physicians want to reach out to community physicians, we can support the translation"

IN PRINCIPLE, BOTH DIRECT AND INDIRECT DEVELOPMENT CAN HELP PHYSICIAN CHAMPIONS BECOME MORE EFFECTIVE.

DEPLOYMENT & **SUPPORT**

Deployment and support consists of choosing the right Physician Champion for the job, and then helping them get that job done well. Deployment and support are initiated with a request for a Physician Champion and there is a known and suitable Physician Champion available see *Figure 4*.

Figure 4: Steps to Deployment & Support

MATCH

Initially the "best" available champion for the job needs to be selected. This champion is either drawn from the existing pool of Physician Champions (previously deployed or not), or has to be found, which starts a Physician Champion identification process.

A "good fit" means the Physician Champion has the three essential types of characteristics for this specific job: credibility, relatability and persuasiveness. While all three characteristics are important in the matching process, credibility and basic persuasiveness characteristics are generally selected for in the identification process, and persuasiveness are developed as needed. This means that the focal criteria in matching are those that increase relatability.

In some cases, the matching process can become complicated when the PCN or ED identifies Physician Champions on their own, or when Physician Champions self-identify or are suggested by their peers. Sometimes AMA-ACTT team members prevent these nominated physicians from championing because they feel the physician lacks the credibility or persuasiveness to be a "good fit." Nominating inappropriate candidates was attributed to a lack of common vision about the Physician Champion role and its importance in our PMH transformation journey in addition to a common understanding about what makes a good champion.

PREPARE

The preparation step most commonly involves change agents, who are usually IAs or members of the AMA-ACTT team engaging in one-on-one interactions with the champion to prepare them for the deployment. Preparation can cover anything from developing the presentation, to briefing the Physician Champion on who will be in the audience, to arranging logistics.

The need to interact with the champion prior to deployment is key in identifying gaps in either content or context knowledge. Transfer of content knowledge is about arming the champion with the right information e.g. presentation, speaker notes, key messages, and facts. Context knowledge i.e. information about the audience being championed too, can inform the content presented and plays into preparing the champion to be both relatable and persuasive. These two types of knowledge are related in that choosing what to emphasize in the champion's implementation narrative (content) depends on her audience (context).

The importance of logistical preparation should not be underestimated. We heard several stories of failed and successful logistics, and these were reported to have had a direct impact on Physician Champion retention. One participant noted that to the extent possible, it helps to make things as easy for the Physician Champion as possible. This means distinguishing thinking in terms of "we can be right, we can be reasonable, or we can be successful." The participant explained how the latter mindset and going that extra step has helped her ensure that physicians who give presentations are willing to come back to give more.

A subset of the interviewees and WFG participants spoke of a partnership between a physician and non-physician called a dyad, usually in the presentation modality of championing. Use of dyads was reported to be effective in supporting Physician Champion deployment, development, and retention. A noted gap in the use of dyads was a clear understanding of the roles of the non-physician partner. However, participants described some of what this role might include: "answer questions effectively, deal with any "disturber" in audience, know the Physician Champion and what stories to tell, can interject."

DEPLOY

The deployment step is doing the specific "job" the champion has been asked to do. On the day the Physician Champion presents, support involves ensuring the champion can focus on what she is there to do i.e. persuade the audience to engage the change they're focusing on. Much of the support during deployment is behind the scenes work involving logistics e.g. ensuring transportation arrives, creating a friendly and positive environment e.g. greetings, introductions, and connecting the champion with audience members, noting potentially interested audience members to follow up with, and managing the unknown/unexpected e.g. last-minute changes, hostile or difficult audience members, correcting factual errors by the Physician Champion. In some cases, this support can also include co-presenting with the Physician Champion to supplement her knowledge.

DEBRIEF

Often after presentations, the IA or one member of the Dyad, will reflect on and discuss how the presentation went with the Physician Champion. This step loops back to the development process as it aims to improve the Physician Champion's ability to champion in future. It is an opportunity to identify what went well, what could be improved, and to agree on follow up activities. If the event allows, employing a quick mid-point "mini-debrief" can add value in making last minute adjustments to effectively engage the audience. Not only is this step a means to gauge future development needs for the champion, but time spent on this step can add to the champion's sense of worth in the role and motivate them to continue.

CHALLENGES TO DEPLOYMENT & SUPPORT

Both over- and under-deployment were noted by the participants as carrying unique risks. Over-deployment risks Physician Champion burnout and attrition as well as making the champion less effective because of over-exposure. It isn't clear whether this is because of a reduction in credibility, relatability, or persuasiveness, but it is worth investigating. Participants suggested that part of it may be a mis-match in relatability; specifically, the Physician Champion is too far advanced for her audience. Conversely, under-deployment can risk losing a "window of opportunity" to engage a champion when they're eager to start. Exploring the ideas that emerged from the data such as developing cluster champions or non-Physician Champions as well as different types of modalities could mitigate the risks carried by over and/or under-deployment. To continue to spread and scale change in primary care across the province, new and different ways of championing and engaging physicians and teams will need to be considered outside the conventional modalities used to date e.g. workshops, presentations, and one-on-one discussions.

DEPLOYMENT AND SUPPORT CONSISTS OF CHOOSING THE RIGHT PHYSICIAN CHAMPION FOR THE JOB, AND THEN HELPING THEM GET THAT JOB DONE WELL.

CONCLUSION

This pilot project expanded beyond our original vision and as such has provided us with a wealth of data that we have not yet had time to fully explore or analyze. Our aim here was to report on the key elements that emerged across the three phases of our data collection (interviews, survey, and working focus group sessions). If there are any areas discussed in the report that you would like to explore further, please do not hesitate to contact us.

Our next step will be to apply for funding to examine the data more fully and potentially explore key areas that were identified as gaps or ideal questions to be answered. We will also seek funding to interview Physician Champions, Practice Facilitators, and EDs for their perspectives on Physician Championing and related topics deemed of high strategic priority to the spread of the PMH in Alberta.

SUMMARY OF SUGGESTED **ACTIVITIES & OPPORTUNITIES**

- Develop/discuss and settle on a standard set of criteria for the identification and recruitment of Physician Champions. The criteria should be shared and used by all who may identify and recruit (e.g. EDs, Practice Facilitators, IAs, etc.)
- Develop an identification strategy that is sensitive to (anticipated) need (by topic by area) and supply. Consider asking: what level and type of Physician Champions do we need, where, and what modalities would work. This can then be checked against an updated Physician Champion registry.
- Consider adopting a more focused definition of champion that is consistent with the literature and how others are using them term, and find other terms for change agents performing roles that we are calling championing now (e.g., PCN leadership, sharing insights).
- Discuss and plan for supporting “cluster champions” by focusing on panel and continuity. Build their vision through progression and development.
- Explore the idea and potential of developing non-Physician Champions and dyad partnerships.
- Practice Facilitators are currently being underutilized across all five strategic processes in Physician Champion management. While Practice Facilitators will require training and know-how to support Physician Champions, getting them to do so at scale will require more than just a transfer of knowledge and skill. A change in mental models about what their role entails and should evolve to will be required i.e. an “I can help you with that” mentality. Additionally, an understanding of the greater PMH vision and exposure to how the different system level pieces interact would make them more effective.

There is a wealth of knowledge and know-how and in some cases tools e.g. checklists that exists amongst AMA-ACTT team members in supporting Physician Champions. To transfer this knowledge and know-how to Practice Facilitators it would be worthwhile to engage in future WFGs to source and document this information. In particular the Alberta Peer to Peer EMR Network Program has developed processes, structures and tools that could be adapted for all five strategic processes in effectively training and supporting Physician Champions for knowledge and skills building moving forward. Also, the program's lessons learned from its recent experience in transferring support to a PCN would be worth sharing. Additional suggested topics include:

- How to deal with resistance
- How to be more persuasive
- Developing an effective narrative
- Deployment:
  - Matching lessons learned
  - How to effectively prepare a champion for deployment
  - Tips and tricks during an event
  - Dealing with a hostile audience member
  - How to "read" the crowd
  - Debrief – how to provide constructive feedback (i.e. hard conversations)

Consider the new zonal governance structure and how it may present opportunities and appetite within PCNs to invest in a standardized Physician Champion approach.