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Transform difficult conversations into productive learning opportunities

How often do you walk away from a conversation wondering whether you've got your point across, been understood, actually resolved the issue or reached an agreement that will result in the outcomes you want? Were you able to have a real conversation and tell the truth in a way that honoured both your reality and the other person's, so that together you learned something new and were able to move forward in a stronger alliance? Too often our conversations fail that test and constrict rather than enrich relationships.

Advertisements promoting "Mastering Difficult Interactions Workshops" feature regularly in ARCHI (Australian Resource Centre for Healthcare Innovations) Net News. Successful inter-personal communication is an area of high interest to health managers everywhere.

Manya Arond-Thomas, of Encompass Health LLC, a U.S. executive coaching and consulting firm for health care organizations coaches physicians, health-care executives, and teams aspiring to build capability and breakthrough results in leadership and organizational effectiveness.

She promotes robust high-quality conversation as the linchpin to productive work relationships in high-performing teams, organizations and businesses. She suggests our relationships succeed or fail one conversation at a time. High-stress, fast-paced, action-oriented environments such as health care settings can predispose to communications that are quick, telescoped or truncated, easily leading to misunderstanding and breakdowns in relationships, teamwork, and organizational climate, all of which impact employee satisfaction and customer satisfaction.

No matter how skilful we are at communication, difficult conversations are a fact of life. What usually happens in difficult conversations is a cycle of non-agreement in which there is a strong conflict of views about what to do that is **not** expressed, leading to a compromise "agreement" or delay. What follows are non-existent, half-hearted or incompatible actions that generate lousy results and mutual blame. This then becomes a self-perpetuating cycle.

Typically we find ourselves with two unsatisfactory options: we are anxious and therefore take no action - which is costly, or we overcome our anxiety and take action but in an unhelpful way - which is also costly. If we can transform difficult conversations into learning conversations, we create better working relationships, ease communication problems, improve decision-making, get better substantive results, increase productivity and decrease the cost of conflict. The bottom-line benefits are increased employee and customer satisfaction, two key drivers of business results.

The precondition for a learning conversation requires that we risk three conditions: *a willingness to be known, a willingness to be seen, and a willingness to be changed*. Learning does not occur otherwise.

Given those preconditions, how do you now change the course of a difficult conversation, either one that has already occurred or one that you may be anticipating with dread or res-

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Manya Arond-Thomas

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ignation? There are five core strategies and tools which, when practiced consciously, facilitate a significant shift in the course of a conversation and relationship.

1. Shift from Blame to Contribution

When things go wrong, there is an almost instinctive response to attribute blame to someone. Yet blame inevitably provokes defensive reactions and shuts conversations down. Therefore, we need a different mindset to understand the mistakes and failures that lead to breakdowns. That mindset is one of "contribution." If the intention behind blaming is to judge or punish, assuming an "either/or" attribution, then the intention behind contribution is to mutually understand and improve the situation by asking "What did we each do or fail to do that put us here?"

It's important to remember that acts of omission as well as commission are forms of contribution. For example, avoiding something or being unapproachable, role assumptions, not considering another's choice, not preparing adequately, or not making necessary trade-offs are all forms of contribution.

Even if your contribution is only 5% of the problem, you will find that a willingness to own your contribution disarms the other person and offers you a window of leverage to do something different.

2. Engage in Empathic Listening

One of the deepest human desires is to be listened to, heard, and understood. Listening to others helps them listen to you, thereby transforming the conversation. In emotionally charged conversations where opinions vary and the stakes are high, the key is empathic listening. There are three core listening skills to practice:

Inquiry: Ask open questions that provide information and meaning, such as "What did you notice?" or "What did you think?" or "What conclusions did you draw?"

Paraphrasing: Ask questions that check your understanding against what the other person meant, such as "When you said this, did you mean..."

Acknowledgment: This may be the most under-utilized but powerful tool for defusing negative emotions. What makes conversations difficult is that people have strong feelings. Acknowledgement of another's frustration, upset, or anger goes a long way to defusing the emotional charge that blocks ease of communication. Phrases such as "I can see how angry you feel" or "If I were in your shoes, I would probably feel just as frustrated" honour the other person's reality even if you don't agree with their perspective.

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3. Move From Certainty to Curiosity

The tension of conflict, either explicit or implicit, derives from each of us being attached to a conclusion or position that we *believe* to be right and the truth. What we know is our truth. But it is not the *whole* truth, ever.

We all continuously select and pay attention to different data in the environment, interpret it and make assumptions in different ways based on our unique life history and personal values, and draw different conclusions. It is from our conclusions and accumulated beliefs that we take action. People usually argue about their conclusions.

Use inquiry to understand the assumptions about reality that others hold and how they've arrived at the conclusions they hold. Then explain your view, the interpretations you made about the things you noticed and the conclusions you've drawn. By being curious about and exploring the other person's view, you understand each other's meaning making which then changes the perception you have of the other.

4. Separate Impact From Intent

Actions often have unintended consequences. When people experience a negative impact, in the absence of information to the contrary, they frequently assume a negative intent or motivation, and then act accordingly.

A common dynamic in conflicts between groups is attributing intention, defending ourselves, and ignoring the impact we've had on others. If you're aware of causing negative impact, acknowledge it. If you're on the receiving end, if need be, clarify the other's intent. The bottom line is - if you're doing anything that impacts anyone, the more information, intentions, and desired outcomes you share, the better the understanding and results.

5. Make Effective Requests

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Top 10 U.S.A. Health Policy Stories/Issues of 2003

The Commonwealth Fund has identified the top ten health policy stories or issues in the U.S.A. for 2003. The list, posted below, includes links to a source document. Despite our quite different structures and delivery mechanisms, the broad issues have a familiar ring. In view of current debate in this country, Issue 10 should be read by commentators from all sides of the political spectrum.

1) Major Medicare prescription drug legislation is enacted

A much-debated bill signed into law Dec. 8 provided the largest expansion of Medicare benefits since the program started in 1965, offering significant prescription drug assistance to 14 million low-income Medicare beneficiaries with incomes below 150% of the federal poverty level, and catastrophic drug protection for all 40 million beneficiaries. The voluntary outpatient prescription drug benefit starts in 2006, with an estimated \$420 annual premium and \$250 deductible. Beneficiaries pay 25% of drug expenses up to \$2,250, the entire bill between \$2,250 and about \$5,100, and 5% of any remaining drug expenses. Low-income beneficiaries get subsidies for premiums and out-of-pocket expenses. The measure also established a series of private, regional demonstration plans that will compete with traditional Medicare. See [Medicare Prescription Drug Legislation: How Would It Affect Beneficiaries?](#) Marilyn Moon, October 2003.

2) The number of Americans lacking health insurance increases-again

With a weak economy, high unemployment, and deteriorating employer-based coverage for low-wage workers, data released this past year showed that the numbers of uninsured jumped to 43.6 million in 2002-up 9.5% from 2000. Employment-based coverage declined from 63.6% of the population in 2000 to 61.3% in 2002. New studies from the Institute of Medicine documented the economic and health toll this growing national problem inflicts, including 18,000 preventable deaths annually and \$65 billion to \$130 billion lost economic value. High charges for uninsured or underinsured patients contribute to medical debt, which all too often results in financial bankruptcy. See [Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem.](#) Pamela Farley Short et al., November 2003.

3) Overall health care costs continue to rise, with patients bearing more of the burden

Rising health insurance premiums dominated the business story on health coverage. Employer-sponsored health insurance premiums rose 13.9% in the spring of 2003 over the prior year. Higher cost to workers-higher premiums, higher deductibles, and higher cost-sharing-was the major consequence, putting low-wage workers and chronically ill adults particularly at risk. Total health care spending, however, did not increase as fast as insurance premiums, suggesting that premiums may slow as insurers recover from losses in earlier years and build up reserves. Preliminary data for the first half of 2003 indicate that health care spending is rising at an 8% annual rate. See [American Health Care: Why So Costly?](#) Testimony for the Senate Appropriations Subcommittee. Karen Davis, June 2003.

4) Presidential candidates embrace issue of covering the uninsured

With the 2004 presidential election less than a year away; national health reform emerged as a major campaign issue for the first time in a decade. As at December, eight candidates, including President Bush, had offered proposals to extend health coverage to millions of uninsured Americans. Most proposals would build on the existing U.S. system of health insurance rather than fundamentally reform the health care system, and include many similar features within varied designs. The Democratic candidates' plans generally build on group health insurance options, while President Bush's plan is structured around the individual insurance market. With the exception of the Kucinich single-payer plan, the proposals leave the employer-sponsored health insurance system intact, but vary in the degree to which they seek to strengthen it. The plans would cover between 4 million and all of those now uninsured. Costs to the federal budget over a 10-year period are estimated to range from \$89 billion to \$2.5 trillion. Many of the candidates propose to finance the cost of their health plans by repealing some or all of the Bush Administration's tax cuts. See [Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates' Proposals.](#) Sara R. Collins, Karen Davis, and Jeanne M. Lambrew, Updated November 2003.

5) Maine and California take the lead in enacting state-level expansions of health coverage

Despite fiscal stresses on states, new initiatives from Maine to California led the way in practical strategies for improving health insurance coverage. Maine created the Dirigo Health Plan to make insurance more affordable. Dirigo would contract with insurers to group small firms and individuals together and to provide premium assistance to low-wage workers and individuals with

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incomes below 300 percent of poverty. California enacted legislation to ensure that all firms with 200 or more employees share in the cost of health insurance coverage for working families, and in doing so help to reduce the cost of public health insurance programs.

[Ongoing Fund work](#) is helping to implement the Dirigo Health Plan and to assess its viability as a model for the rest of the country.

6) States band together to battle rising prescription drug costs

Intent on reducing spending on prescription drugs, some Medicaid and CHIP programs, state employee benefit plans, and private companies are banding together within and between states to see whether consolidating purchasing power and collaborating on drug formularies can affect spending. Most of these efforts are still in the early stages, but a few states say pooling covered lives has given them greater negotiating power, resulting in lower drug prices. The purchasing initiatives rely on two main strategies: using a common organization to manage pharmacy benefits, including negotiating prices on their behalf, and creating a shared, evidence-based preferred drug list/formulary. So far, 24 states have joined a multi-state or multi-agency purchasing initiative, with Massachusetts, Michigan, Oregon, Texas, and Vermont, being among the early innovators.

7) Research shows only 55% of Americans get indicated care

A [study](#) by the RAND Corporation, *The Quality of Health Care Delivered to Adults in the United States*, published in June in the *New England Journal of Medicine* and available through the Fund's website, underscored concerns that clinicians are not providing many patients with the most clinically appropriate care, despite ongoing efforts to develop evidence-based guidelines designed to help them do so. The results held across preventive care, care for acute conditions, and care for chronic conditions. Quality and efficiency are both less than optimal, as patients fail to obtain services that would help control chronic conditions such as diabetes or prevent disease, or as money is wasted on unnecessary care such as antibiotics for colds.

8) Clinical IT standards gain traction thanks to government efforts

The U.S. Department of Health and Human Services adopted several standards for clinical information technology that are expected to increase the interoperability of clinical information systems and improve exchange of clinical information. In the future, IT systems sold to the federal government will have to adhere to these standards. In addition, the new Medicare prescription drug bill included a provision that called for the HHS Secretary to promulgate final standards within a year for electronic transmission of prescription drug information and authorized HHS to make grants to physicians to assist them in implementing electronic prescription drug programs. Read about [public and private sector efforts](#) to establish IT standards for health care.

9) Quality improvement efforts really start to make strides

Within the last year, medical journals have reported on the significant efforts to improve quality of care and efficiency in the Veteran's Health Administration and on the quality and efficiency of care in the Kaiser-Permanente health system. In addition, more employers and public payers are starting to reward those who provide higher-quality care. There are now more than 50 "pay-for-performance" trials, demonstrations, or plans across the country. The Robert Wood Johnson Foundation's Rewarding Results program, administered by the [Leapfrog Group](#), includes seven large demonstrations of pay-for-performance, and the Centers for Medicare and Medicaid Services has launched its Doctor's Office Quality project and Premier Hospital Quality Incentive demonstration, both of which include a projected pay-for-performance component. See [How Does Quality Enter into Health Care Purchasing Decisions?](#) Neil I. Goldfarb, et al., May 2003.

10) Disparities in health care get renewed attention

The stark findings of the Institute of Medicine's [Unequal Treatment](#) report—that racial and ethnic minorities receive lower-quality health care, even when they have the same income and access to care as whites—continue to spur action. Two legislative proposals have been introduced to eliminate disparities. The "Healthcare Equality and Accountability Act" seeks to improve minority health through insurance expansions, culturally and linguistically appropriate care, and workforce diversity; the "Closing the Health Care Gap Act" would, among other efforts, formalize and expand the role of the Office of Minority Health. After creating the first comprehensive bibliography of key articles on racial and ethnic disparities, Physicians for Human Rights issued [policy and research recommendations](#) to eliminate such problems, emphasizing the need for federal leadership. In the private sector, Aetna began collecting data on members' and participating physicians' race, ethnicity, and language preference in order to understand differences in how patients obtain care and to create targeted prevention, education, and treatment efforts.



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College of Health Service
Executives**

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Inform Editor Bruce Parkes

Seminar Programme

February 23rd

@ Cap Gemini ,18th Floor, 41
Shortland St

5:30p.m. for 6p.m.

**Managerial effectiveness
in the health sector: what
it means in 2004**

Rod Perkins

March 29th

@ Brightside Hospital

5:30p.m. for 6p.m.

**Using Outlook for
Individual Effectiveness**

Jim Huse

Huse Hill Associates

Non Members Welcome

Cost

Members \$20

Non Members \$25

Eurest support our seminar
programme



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Requests and promises are the lifeblood of work-life and business communication. They are the commitment to some outcome occurring based on action. The anatomy of an effective request has four elements:

Say exactly what you want
Say exactly whom you want it from
Say exactly when you want it
Make sure you have the same assumptions about what's needed to ensure the desired outcome
Notice that the operative word in the first three elements is "exactly"! Too often, we sabotage the results we desire by not making requests at all, making unclear requests, not communicating expectations, and promising when unclear about the request. These actions, or lack thereof, coined "linguistic viruses", create confusion, resentment, unmet goals and relationship breakdown.

Putting It All Together

It's important to remember that intent matters more here than technique. Being clear about the purpose of the conversation and staying true to it, even in the tension or heat of the moment, provides a compass for moving forward. Approaching a difficult conversation with a purpose other than learning is perilous and will undermine your success. Perilous purposes include: delivering a message, changing the other, controlling their reaction, controlling the outcome, and venting.

In a learning conversation, uncovering assumptions provide the key to greater mutual understanding. Therefore, explore the other's views and experience first. Then share your views and experience. Only after both parties' views are clear does it make sense to problem-solve.

Although it may seem counter-intuitive, the time taken to engage in empathic listening and respectful sharing of divergent perspectives greatly increases the quality and speed of problem solving. While engaging in difficult conversations often feels risky and challenging, the price of not having them - lost time and productivity and less than optimal results - could cost you and your organization far more than the time and effort of doing so.

More material is available at www.arond-thomas.com

Keep age at bay - eat more chocolate

Is chocolate anti aging? Just in time for Christmas, the December 23rd Financial Times reported that a three-month study will begin January 2004 in France and Canada to see if a diet rich in cocoa beans will have the same effect on humans as recently observed in tests on rats. The rat experiments showed that a cocoa-bean rich diet helped to reduce stress, put off aging and protected cells from disease. Polyphenols in chocolate are believed to be responsible for the anti-aging and stress reduction. Polyphenols are a form of anti-oxidants, compounds that protect cells from being attacked by 'free radicals' that damage blood vessels and contribute to cardiovascular disease. This study looks like a license for chocoholics. Guilty feelings about over-indulging on chocolate become a thing of the past.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.

The four elements of an effective request:

- * Say exactly what you want
- * Say exactly whom you want it from
- * Say exactly when you want it
- * Make sure you have the same assumptions about what's needed to ensure the desired outcome