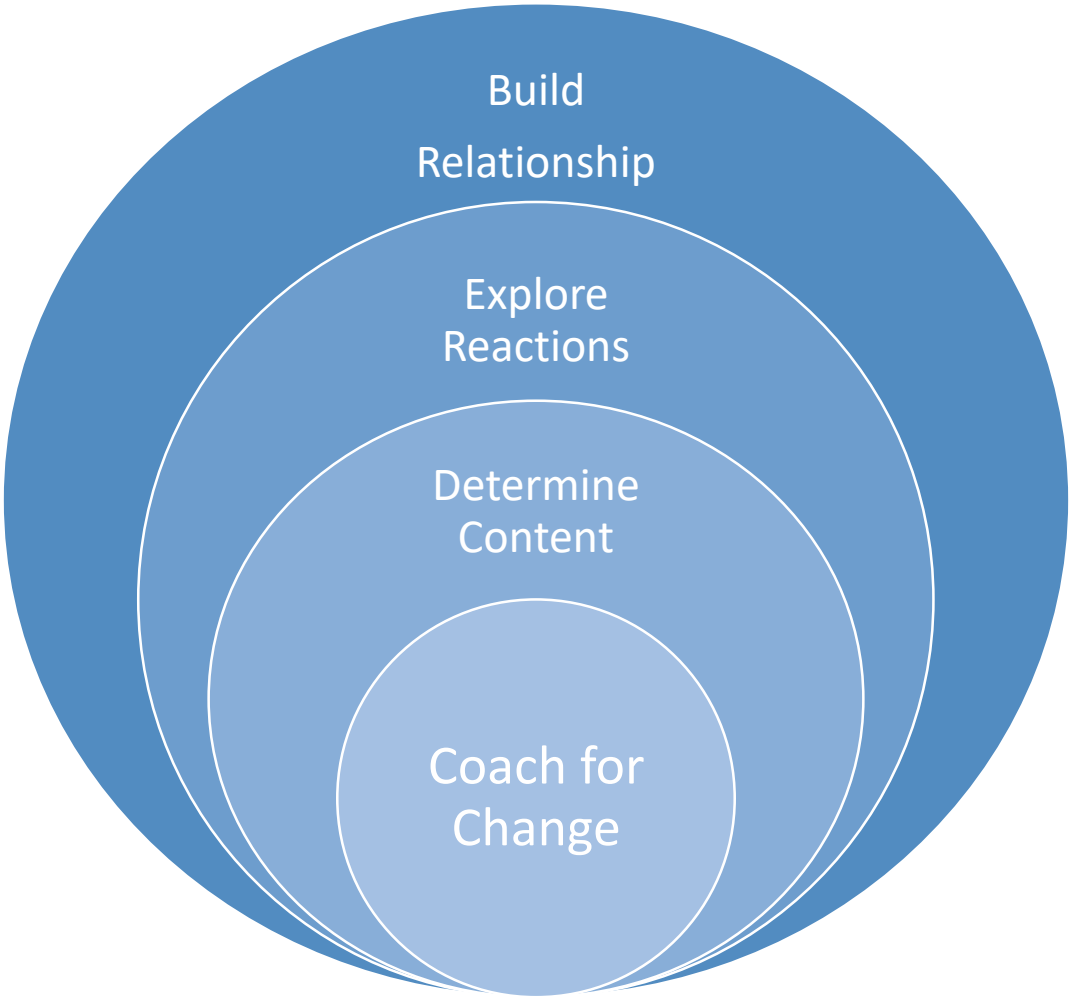
R2C2

Evidence-Informed Facilitated Feedback and Coaching Tips



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Background

We now recognize that performance data and feedback are critical for learners and for practicing physicians to guide their performance and ongoing development, and that the manner in which these are provided influences whether the recipient will accept and use them. For example, the data may be difficult to interpret, particularly if they disconfirm how one sees oneself, or presented in ways that make it difficult to implement. They may also cause angst for the recipient. As a result, while feedback may often be accepted and used, it is also often ignored, rejected, or not fully used.

Current research demonstrates that feedback is most effective when shared in a dynamic two-way, learner-centered conversation with the goal being development of the individual through fostering feedback acceptance and use. Coaching is suggested as a development strategy which fosters learner engagement, collaboration between feedback provider and recipient, and co-development of action plans based upon the data.

The R2C2 feedback and coaching model draws on various theoretical perspectives which underpin the above findings. These include person or learner-centred approaches, particularly humanism and motivational approaches to promote personal development, change and agency; understandings of self-awareness, self-reflection and self-assessment; and implementation science including the cognitive influences on behavior change, commitment to change and the criticality of the facilitator.

The R2C2 model promotes feedback use and learner agency for development and performance improvement. It does this predominantly through using open questions to encourage reflection on performance data and feedback; seeking the learner's self-assessment, perspectives, and ideas; promoting feedback acceptance; fostering self-direction for improvement with guidance as needed; and coaching for change.

The R2C2 model has four phases:

1. Build **R**elationship. In this phase, the supervisor/ facilitator builds the relationship in order to engage the learner. Facilitators/ supervisors show interest in the learner/ physician and are genuinely curious about their experiences, challenges, successes and goals, providing the learner with an opportunity to describe their experiences and their goals for the discussion. The facilitator also describes the purpose of the feedback and responds to questions about this.

2. Explore Reactions. Here, the supervisor explores the learner's reactions to the performance data to ensure the learner feels understood and that their perspectives are heard and respected. The facilitator queries initial reactions, surprises, and asks how this feedback compared with previous performance feedback. It is an opportunity to explore the learner's emotional reactions.

3. Determine Content. In the third phase, the supervisor explores and helps the learner determine the content of the performance data and feedback to ensure the learner is clear about what it means and the opportunities it suggests for improvement. The supervisor clarifies the learner's perceptions about the content by going through it in a systematic way and by asking open questions to understand what the learner believes about their own performance.

4. Coach for Change. In the final stage, the facilitator coaches for change by helping the learner identify priority areas for change in order to co-develop an achievable learning change plan. The supervisor will ensure the learner can describe and commit to goals and specific observable changes, along with the actions that will be required, when they will begin, the resources needed, anticipated barriers, how they will overcome the barriers and how they will know they have achieved their goal. The facilitator will ensure that there is a record made of the discussion for guidance and follow-up, whether this is by the learner or the facilitator will depend on the setting and requirements. Having a written plan ensures that the plan is more likely to be followed as well as providing a vehicle for monitoring. Importantly, the supervisor will also guide the learner in identifying a follow-up strategy to assess the progress made.

The R2C2 model is iterative and encourages returning to previous stages as the plan develops, clarification is needed or content needs to be reinforced.

The model has been used in medical education settings with individual learners (undergraduate medical students, post graduate trainees); with licensed physicians participating in practice reviews; and with groups and clinics of physicians where the practice has been assessed.

The model has been tested with practicing physicians and residents. Peer-reviewed publications pertaining to model development are provided in the reference section.

To date, four versions of R2C2 have been developed for use in different contexts. While they are similar and follow the four phases, some of the phrases and approaches that are suggested differ. For each, a tri-fold brochure has been developed to provide specific guidance in each context. Tri-folds include the goal of each of the 4 phases and suggest specific phrases and strategies for each phase. They are available on the R2C2 website (https://medicine.dal.ca/departments/core-units/cpd/faculty-development/R2C2.html). The versions are:

1. Physicians in practice. This version is being used to guide facilitated discussions about a physician's collated performance data in order to develop an action plan for improvement. Currently, it is being used in conjunction with:
    a. the Medical Council of Canada's MCC 360 assessment tool which provides performance data and feedback on professionalism, communication and collaboration from the perspectives of patients, physician colleagues, and health care professionals (e.g., nurses, pharmacists) working with the physician;
    b. performance data provided by several Canadian regulatory authorities and
    c. performance data provided by Health Authorities for regular review

2. Resident formal. This version is being used where performance data (e.g., daily encounter forms, EPA forms, multisource feedback) are collated and used to guide regular composite reviews at the end of rotations, 4 – 6 month reviews, or end-of-year reviews. The intent is to help the learner develop a learning plan for the next phase of learning. While it has been formally tested only with residents, it is also being used with students.

3. Clinics and groups of physicians. This version is being used in settings in which there is group as well as person-specific data. The intent is guide improvement at both the group and individual levels.

4. In- the- Moment. This version is being used in clinical settings with medical students and post graduate trainees following a clinical experience, procedural observation or a challenging case, to provide immediate feedback and coaching, which can be adopted with subsequent patients, clinics, or other experiences.

Please consult the tri-folds for a general overview for each of the versions: https://medicine.dal.ca/departments/core-units/cpd/faculty-development/R2C2.html. The tri-folds contain the goals for each of the four phases, and suggest specific strategies and phrases for each, developed from the research conducted to date. Recognizing that additional guidance may be required in some instances, the next section contains tips to supplement the tri-fold information.

GENERAL TIPS and Strategies

General principles for using the R2C2 feedback and coaching model:

1. The goal of the R2C2 feedback and coaching model is to promote learner/physician/group critical reflections on their performance data and feedback and through that, identification of opportunities for improvement and development of a plan for addressing them. The overall goal is development and improvement.

2. When the feedback suggests a need for change, the challenge in some cases is to conduct the feedback conversation in a non-threatening manner that encourages the learner/physician/group to take on the feedback in a positive way and move ahead with improvement.

3. One approach that helps is "finding common ground". Learn what they value in their education and work identifies this common ground. For physicians and groups, ideas such as "good patient care" or "providing an efficient service" may be identified. Framing the improvement in terms of what is valued helps create buy-in.

4. There will be situations in which the learner/physician/group are truly excelling and there is nothing on the report or observation to indicate performance gaps. In this case an approach is to ask a general question to determine if there is something they aspire to improve, learn, or do differently. The premise is that everyone can improve or enhance practice. Such a discussion may lead to planning a change and create opportunities for highly-performing learners, physicians and groups.

Additional tips and strategies for using R2C2:

1. Pay attention to both the **process** of the feedback and coaching discussion and its **content**. Doing so promotes learner engagement and agency. Process and content are interconnected and both need attention.
    a. Process skills include preparing for the session, developing and maintaining the relationship, using facilitative communication skills and techniques to promote reflection and self-assessment, and being flexible so as to respond to the learner.
    b. Content skills relate to the specific performance data and feedback content. They include engaging the individual in discussion of this content, ensuring the discussion is collaborative and focused on goal setting, co-developing an Action Plan, ensuring commitment and following up on the plan.

2. Ensure that the discussion is a coaching dialogue and not a teaching/telling monologue.

3. Encourage critical reflection: (promoting reflection is a goal of the coaching model)
    a. Can you say more about that?
    b. I'm curious about that, can you tell me more
    c. That sounds like it was difficult [disappointing, rewarding], can you tell me more?
    d. You said you were surprised by that? Tell me more

    e. Minimal facilitators such as pauses to enable people time to speak, ‘uh huh’ (particularly if the conversation is by phone)

4. Confirm what is being said
    a. So, I’m hearing you say
    b. I heard you say a couple of things. One is…
    c. So it sounds like…
    d. This seems to be something important to you that you’d like to maintain
    e. This was a bit of a surprise to you
    f. This wasn’t a surprise, but something you need to look at
    g. Something pretty important to you
    h. Going through the report together gave you some ideas

5. Provide positive reaffirmation or confirmation
    a. It looks like you’re doing … X …really well, that’s great!”

6. Sign-post and navigate the discussion
    a. Let’s hold on to that idea and come back to it
    b. That’s a good point to come back to, and let’s for now turn back to the report

7. Summarize
    a. If i can just summarize what I heard you say…
    b. If I can just summarize what we've done so far …
    c. Let's summarize this section/ item before moving on...
    d. Did I summarize that accurately for you?

8. Build relationship and validate reactions
    a. You’re teaching me something today. I appreciate that…
    b. You have more experience in X than I do. I appreciate your perspective

9. Adopt non-verbal facilitative strategies
    a. Keep an open body posture, eye contact, relaxed
    b. Use tone of voice to convey sincerity, interest and respect
    c. Look at report together (if face-to-face)
    d. Allow time to respond and for reflection

10. Facilitate the creation and storage (if needed) of a record of the discussion that can be retrieved for follow-up

TIPS FOR IN-THE-MOMENT FEEDBACK AND COACHING

Having effective feedback and coaching discussions in busy clinical settings "in-the-moment" following a clinical experience, observation or challenging case, when time is at a premium, is challenging. It is quite a different situation from the planned, formal feedback conversations which occur periodically and are based on collated performance data, and typically range in length from 30 to 60 minutes. The R2C2 model, developed in the latter contexts, has been adapted for "in the moment" situations where the setting is more immediate and time is necessarily limited to a few minutes.

It is possible to use all four phases of the R2C2 model in these feedback discussions taking into account whether the learner is:

1. New to that clinical setting and unknown to the preceptor and requires information to work effectively in that setting, or

2. A longitudinal learner and someone with whom the preceptor has worked with that week/month and this is a continuing experience

The preceptor begins to build the relationship at the beginning of the day/session. For a new learner, rapport will be built by learning about the learner and their previous experiences; explaining how the preceptor works and the plan related to supervision, observation and feedback; and identifying the learner's goals for that session (or upcoming block). For a continuing learner, rapport will be built by asking about experiences; recalling the previous session and co-developed plan; inquiring about progress made since the previous session; and goals for this session.

Generally, feedback and coaching are done at the end of a session. However, if the learner has a series of similar tasks (e.g., anesthetic or surgical procedures), providing the feedback and coaching to develop a plan for the next task may be more appropriate. In many instances, there will be a gap between the initial rapport building (phase I) and the other three phases. At the end of the day, asking how the experience went will help re-establish the rapport and relationship.

Coaching in order to co-create an action plan is as important as with any uses of the R2C2 model. Identifying 1 priority/goal for action is likely all that can be handled and later recalled in a short session. Committing the plan to writing or into an e-portfolio will help ensure that the plan is carried out and seen as part of the learner's plan for growth and development. While approaches to recording it may vary , it may be incorporated into daily encounter sheets or Entrustable Professional Activity records. Importantly, feedback and coaching in-the-moment are intended primarily for formative purposes to guide development and inform progress.

Following up on the plan will differ based on whether this is a single session with the preceptor or whether the learner will continue with the same preceptor who can provide the follow-up. In instances where the learner will be in a different clinical setting, it is important to ensure that the learner has identified in their plan their next preceptor/ supervisor or other knowledgeable practitioner for follow-up.

TIPS FOR GROUP FEEDBACK AND COACHING

Working with a group of physicians, whether they are from a single clinic, clinical unit, or do similar work (e.g., all are from the same discipline but don't all practice in the same location or see one another regularly) offers special challenges. There may be individual or group history that enables or impedes discussion. There may be past/present power hierarchies and dynamics. The session may include managers, professional and administrative staff, or other health professionals.

It can be helpful to recognize and mention to the group that groups go through several stages when coming together: forming, storming, norming, and performing. Depending on the facilitator's 'contract', they may need to consider this as they develop, implement and monitor plans that are developed. See: https://www.mindtools.com/pages/article/newLDR_86.htm

1. Consider
    a. Changes that are required (vs nice to do) from the data in the report and their complexity, the relative advantage they bring, and degree of fit with the group
    a. The physicians and other personnel who will need to make or facilitate these changes
    b. How best to promote them
    c. The group including leadership, culture, mechanisms for supporting change, past experience with change, clinic priorities, clinic stability
    d. The broader environment including the health care system, regulations, incentives, degree of stability vs change, politics, and relationships and networks outside of clinic

2. Remember the facilitator helps the group
    a. Reflect on the performance report, salient data and what it means to the group
    b. Identify priority issues from the data
    c. Ensures goal setting and consensus building related to priorities
    d. Assess factors that will enable or hinder the change(s) including: unit context factors (e.g., communication and feedback channels, policies and procedures, organizational priorities, relationships, staffing); and the broader context (e.g., health care system, workplace safety, billing/income constraints, human resources policies and procedures).

3. Engage the group by
    a. Asking open questions
    b. Being genuinely curious about the views of others
    c. Actively asking for their views and suggestions. Build on these ideas.
    d. Involving all members in the group and ensuring they feel they have something to contribute
    e. Drawing on the individual skills and experiences of each to help others
    f. Ensuring input into the plan and encourage the group to be specific in answering each question

4. Monitor yourself
    a. Do not provide the answers. Involve the team members.

b. Where necessary, draw on experiences/suggestions with other groups. Remember what works in one setting may not work in another. Be very careful providing suggestions.
c. Don't feel anxious if you don't have answers. Remember there are others (outside the group) who may be able to help or be resources for the group.

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R2C2 resource website: https://medicine.dal.ca/departments/core-units/cpd/faculty-development/R2C2.html