The Primary Care Influence Strategies (PCIS) form is intended to help assess the ability of primary care providers to influence the behavior of their patients and be solution suggestive at the same time. *Dashometrics* sees that just as primary care providers get frustrated at their patient's unwillingness or inability to follow medical advice, patients likewise often get frustrated with the means by which such advice is given.

At one level, the PCIS helps health care administrators assess the influence effectiveness of their providers. In some cases, providers themselves might seek this as an instrument to self-assess. At another level, the PCIS is also meant to be solution suggestive. The act of taking this assessment will actually introduce influence strategies that could be helpful. The periodic act of using this assessment will reinforce these ideas more deeply.

It is very common for medical providers in particular and people in general to use "direct influence" or persuasion as their default influence strategy of choice. Yet research suggests this strategy is rarely effective and sometimes counter-productive through the creation of resistance or avoidance (in this specific context, meaning avoidance of providers or clinics or services). Those who want to review interesting research in this area are encouraged to search the internet for the 1975 Miller, Brickman and Bolen study.

The following is an item by item look at the PCIS and what it means:

- Item 1: This item addresses whether respondents experience frustration with their patients when it comes to patients following medical advice.

- Item 2: While most providers understand the importance of communication safety, it can't be emphasized enough. The practice of communication safety incorporates, but is not limited to, being non-judgmental in both the obvious and the most subtle ways. It is axiomatic that patients who feel unsafe communicating are much more likely to simply avoid communicating.

- Item 3: This item assesses the feedback orientation of responding providers. There is no substitute for effective feedback in a socially oriented interaction or service. Those who are likely to have the most influence will continually seek out feedback on how their patients are experiencing their interactions, treatment and service. Our mantra at *Dashometrics* is "why guess when you can ask?"

- Item 4: It is all too easy to fall into the practice of setting prescriptive goals for patients that the patients themselves do not support or agree with. No matter how beneficial these goals might seem to the provider, if patients do not fully support them, there is likely to be frustration for both provider and patient. Sometimes this will result in dishonest dialogue where patients will tell their providers what they think the provider wants to hear. Sometimes it will result in the avoidance of treatment or substitution of provider.

- Item 5: Providers, when appropriate, may want to consider the strategy of expressly (but compassionately) reminding their patients that the ultimate purpose of service and treatment is to make the life of the patient better. The goal of this intervention is to heighten the patient's level of medical self-responsibility.

- Item 6: Interventions that can be framed in terms of how they affect a patient's presenting complaint are more likely to keep service and treatment congruent with patient's motivation and willingness to act on their own behalf.

- Item 7: Patients are also more likely to follow interventions that they regard as wholly or partially "their idea". For more on this concept see "The Heart and Soul of Change" by Duncan, Miller, Wampold and Hubble (2009).

- Item 8: This takes the general concept of Item 1 and puts it in the specific context of provider response to their patient's unhealthy or self-harmful behaviors. If there is ever an area that is more likely to generate 1) provider reactions the patient will regard as judgmental, 2) prescriptive interventions the patient is not ready to hear or follow and 3) resistance or avoidance, it is in this area. Obvious examples are smoking, drinking and obesity.

- Item 9: Even if everything else is aligned for success, provider and patient alike may overlook "external" blocks or barriers to successful treatment. This item will help both provider and patient be aware of these barriers.

- Item 10: This item implicitly encourages provider focus on areas where patients are more likely to make gains because 1) it is in the area of the patient's stated goals and 2) it uses the time proven behavior modification principle of positive reinforcement (which is much less likely to create resistance or avoidance).

- Item 11: The earlier referenced Miller, Brickman and Bolen study provides compelling evidence that reinforcing "target" identity characteristics are actually more effective than positive reinforcement for behavior modification purposes. In the medical context, the target identity characteristic is the internal "trait" or characteristic the provider believes will be most helpful in solving the medical issue. For example, if the issue is a patient using medication more regularly, the patient would be identified as "mindful" and/or "conscientious". Patients are very likely to become the thing you tell them they are.

- Item 12: When patients are able to reference past successful experiences (similar in nature), they are more likely to believe they have what it takes to do the same thing again.

- Item 13: Many providers are aware of placebo-nocebo effect and what is referred to as subject expectancy. Providers are encouraged to be aware of this phenomenon and ethically use it for therapeutic gain.

Like many *Dashometrics* products, the PCIS is focused on "pinpoint diagnostics" rather than a score on an overall concept or construct. The reasons for this should be obvious: this focus on specificity allows 1) improvements to be made where they are needed or useful and 2) the conservation of time, energy and resources—not putting time and effort out when it isn't needed.