THE UNLIKELY SECRET TO THRIVING IN THE NEW HEALTHCARE ENVIRONMENT

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LEARNING OBJECTIVES

Participants will be able to:

- See the current stressful changes in healthcare as part of a shift from independent autonomy to interdependent autonomy (system-based care).
- Describe the critical importance of relational quality in the creation and functioning of a successful integrated delivery system.
- Identify one new practice or behavior that they will implement to improve the relational culture of their work environment.

Our goal today is to zoom way out to look at the changes in healthcare that we're living through, to explore the deeper dynamics of what's going on — what these changes are really about — and to think together about how they can help shape the new environment and what we need to do to thrive.

MAKING SENSE OF CURRENT CHANGES

Let's start with the patients and their families (why we're here). Here's how their care has been:

- Mostly reactive: after I've already gotten sick.
- Fragmented: starts with have to tell my story multiple times, fill out the same health history form multiple times, hearing different things from different practitioners, uncoordinated (decisions of one practitioner made in isolation from those of others).
- I'm relegated to a passive/obedient role.
- Unbearably expensive.
- Impersonal — nobody knows me, I'm just a liver or a knee or a mole.
- Error-prone, risky.

Here's the corresponding experience of clinicians:

- Individualistic: I do whatever I deem appropriate. Nobody looks over my shoulder. (Independent autonomy)
- Care process organized around my needs as a doctor. (We could call this doctor-centered care.)
- Hard to know what other clinicians are doing, especially in real-time. The patient is the source of integrating information. ("What medicines did that other doctor prescribe for you?")

- Doctor-centeredness is not as good a deal as it might appear. I'm responsible for the results I get (even though I can't control all the inputs). It's all on my shoulders.
- I'm feeling vulnerable but I don't really want to know about that, and I certainly don't talk about it with anyone. So I'm alone.
- I cope in a variety of ways, most of which are not too healthy: overwork, acting out, self-medicating…

So this fragmentation is not good for our patients and is not particularly good for us, either. Even so, it's a known evil. We know how to get by. It's easier to continue with what we're doing than to head into the unknown.

Now let's look at where we're trying to go, my experience as a patient under **Patient-Centered Care**:

- Helping me stay as healthy as possible, helping me stay out of trouble and need less care.
- Co-creating results, taking more responsibility for myself (supported in doing that; the clinical staff is receptive and encouraging).
- Feeling respected, care is more on my terms than it was before — convenient, oriented around my personal goals and values.
- Building my capacity to do things for myself.
- My team knows me — I can tell that they share information about me with each other and I feel like they know what each other is doing, they're coordinated.
- My care is more efficient, less wasteful, so it costs less.
- My care is safer.

None of us can deliver Patient-Centered Care by ourselves. It takes a medical village, it takes a system, it's patient-centered system-based care.

That requires us to work in a whole different way. So over on the clinician side, everything we're struggling with is about building this unprecedented level of "systemness."

- Shared electronic records to make our work more visible to each other and to provide automated decision support. (Far from perfect right now, but it's a start.)
- New organizational structures like ACOs and medical homes to bring us together across our different disciplines…
- New payment models like bundled payments, which are supposed to align the interests of practitioners and hospitals, or pay-for-performance which is intended to shift our attention from volume to outcomes, to the value we are producing.
- New performance measures and feedback reports addressing such diverse domains as wait times, intensity of effort, patient satisfaction, deviations from clinical protocols and clinical outcomes.

RELATIONAL LEADERSHIP

These are all **technical tools of systemness**, but they are only half the story. Every technical tool is used in a social context.

Work = technical task + relationship

That applies as much to administrative as to clinical work. The quality of relationships determines the benefit we get from the technology.

Consider practitioner performance reports. These can be used to foster self-directed learning and process improvement or they can be used in a highly controlling way, which is demotivating. (There's an important theory about this in Motivational Psychology called Self-Determination Theory). The social context in which performance reports are used makes all the difference. The same is true about EHR implementation: it can be supportive and responsive or mechanical and inflexible, with profound consequences for the users.

We need **relational leadership** backstage that treats the staff in the same respectful, engaging way that we want the front-line staff to treat the patients and their families. Relational approaches to change management will be much more successful than impersonal and bureaucratic approaches. (See chapter of Relational Administration)

It's easy to blame leaders for not practicing relational leadership, but that's not fair. There's been no training about this, there are few role models. Leaders often feel a crushing personal responsibility — remember the clinician's vulnerability and isolation — and they use the tools they know. We cut them some slack and develop our skills at managing up. "I know you are accountable for ____ and I want to do everything I can to help you succeed. Here's what you can do that will help me to help you most effectively."

RELATIONAL COORDINATION ON WORK TEAMS

But there's a more important level of relationship in an integrated system. We've already described the patient-clinician relationships of Patient-Centered Care and we just looked at relational leadership. Let's now look at the third level — team relationships. The good news is that it's even more powerful than relational leadership and it's completely in our hands to implement.

Brandeis researcher Jody Hoffer Gittell developed a theory called **Relational Coordination** (RC) that describes 7 characteristics that help team members coordinate their efforts in highly interdependent work:

- **Shared goals** (all the team members are working towards a common purpose)
- **Shared knowledge** (the work of each team member is understood by the others)
- **Mutual respect** (the work of each team member is valued by the others)
- Communication that is **frequent, timely, accurate**, and when a problem arises, focused on **solving the problem rather than assigning blame**.

Jody developed a survey to measure these characteristics, and in a wide variety of work settings, including joint replacement surgery, primary care and long term care, she found that high levels of Relational Coordination are associated with better clinical outcomes, lower cost, greater efficiency, higher patient satisfaction, greater staff satisfaction and resilience, and greater staff capacity to learn and implement new work processes. (See Summary of RC Research)

You can use RC as a framework for exploring the quality of interdependent relationships in your work processes. Which of these 7 dimensions might be particularly relevant to improving your team's performance? You can also measure RC with the RC survey and use the results as a mirror to start conversations within your team. Either way you can go on to design activities to increase one or more of the RC dimensions. (See Learning to Manage Interdependence)

PRACTICE TOOLS FOR FOSTERING A RELATIONAL CULTURE

We've just seen how a culture of high Relational Coordination — of respect, mutual support, seeking out feedback about interdependence, non-blaming — can increase your resilience. It can sustain you in the face of change, even in the face of not-yet relational leadership. At the same time it is associated with better patient outcomes (including clinical outcomes and patient satisfaction) and greater efficiency.

Culture is nothing more (or less) than what you do in each moment. There are a variety of simple steps you can take to change the culture of your work environment. (See the article on Relational Meeting Practices). What would it mean to work in a more relationship-centered way?

Each team can set its own behavioral standards. How aware are you of your behavior and the quality of your relationships? Of your impact on other people? What could you do to become more aware? We all have moments when we step out of line — what can we do to help bring each other back when you lose your way? What organizational process needs to be in place for situations where power asymmetries or personality issues preclude direct feedback/horizontal accountability?

You can apply the relationship skills you use so skillfully with patients…with each other!

Simple practices: Check-in; hearing everyone's opinion; inviting appreciative stories — moments when you've seen teammates make positive contributions to a relational culture.

Case study: The Billings Clinic ICU formed a grass roots ICU Connections Team to guide a teamwork improvement project. After the ICU staff took an RC survey, shared goals emerged as the dimension most in need of attention. The ICU Connections Team created a game — ICU bingo — in which team members would submit praise cards to acknowledge RC behavior exhibited by people in work groups other their own. Each week the group with the highest rate of nominations got a pizza. All nominations (including the associated stories) were published in a newsletter. This helped people become more aware of team behaviors and provided positive feedback. The ICU Connections Team also conducted a fishbowl dialog in which high-scoring doctors could describe what they did; other doctors picked up on their best practices. The ICU Connections Team then aggregated the lessons learned from these activities in a new set of behavioral standards, expressed as a set of New Year's resolutions. The work in the ICU has now spread to orthopedics, primary care and some administrative support functions, with members of the ICU Connections Team serving as internal consultants (and presenting their work at national meetings).

CONCLUSION

We've explored about the move from fragmented independent care towards patient-centered system-based care. We've seen how the technical tools of system integration need to be used in a relational fashion by means of relational leadership that parallels the values and communication processes of PCC. We've also looked at the relational culture of work teams — as described by Relational Coordination theory — and its impact on performance. In closing, we can return to the title of this session: **The unlikely secret to thriving in the new healthcare environment.** The secret is relationships. We need integrated systems to meet the triple aim of better outcomes, lower cost and better patient experience (and actually the quadruple aim, which adds workforce well-being). We can't be an integrated system by ourselves. We need each other; every integrated system ultimately succeeds or fails based on the quality of its relational core.

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