Relational Coordination Workshop:
Building Relationships for High Performance

Massachusetts Medical Society
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Chief Scientific Officer, Relational Coordination Analytics
RELATIONAL COORDINATION is a mutually reinforcing process of communicating and relating for the purpose of task integration. Relational coordination is particularly useful for improving quality and efficiency performance under conditions of reciprocal task.
Challenges we face

- Pressure in every industry to deliver better outcomes at lower cost
- First in manufacturing, now in healthcare
- Need to do more – but with less
- Is this even possible? How?
2:10-2:30  What is relational coordination?
2:30-3:00  Relational coordination and performance
3:00-4:15  Relational mapping, RC measurement
4:15-4:30  BREAK
4:30-5:00  Organizational practices that support RC
5:00-6:00  Getting from here to there – case studies
What is relational coordination?
Flight Departure Process:
A Coordination Challenge
“Here you don’t communicate. And sometimes you end up not knowing things... On the gates I can’t tell you the number of times you get the wrong information from operations... The hardest thing at the gate when flights are delayed is to get information.”
“Here there’s constant communication between customer service and the ramp. When planes have to be switched and bags must be moved, customer service will advise the ramp directly or through operations…Operations keeps everyone informed. It happens smoothly.”
“If you ask anyone here, what’s the last thing you think of when there’s a problem, I bet your bottom dollar it’s the customer. And these are guys who work hard everyday. But they’re thinking, how do I stay out of trouble?”
“We figure out the cause of the delay. We don’t necessarily chastise, though sometimes that comes into play. It’s a matter of working together. Figuring out what we can learn. Not finger-pointing.”
“Ninety percent of the ramp employees don’t care what happens. Even if the walls fall down, as long as they get their check.”
“I’ve never seen so many people work so hard to do one thing. You see people checking their watches to get the on-time departure. People work real hard. Then it’s over and you’re back on time.”
Employees revealed little awareness of the overall process. They typically explained their own set of tasks without reference to the overall process of flight departures.
Employees had clear mental models of the overall process -- an understanding of the links between their own jobs and the jobs of their counterparts in other functions. Rather than just knowing what to do, they knew why, based on shared knowledge of how the process worked.
“There are employees working here who think they’re better than other employees. Gate and ticket agents think they’re better than the ramp. The ramp think they’re better than cabin cleaners -- think it’s a sissy, woman’s job. Then the cabin cleaners look down on the building cleaners. The mechanics think the ramp are a bunch of luggage handlers.”
“No one takes the job of another person for granted. The skycap is just as critical as the pilot. You can always count on the next guy standing there. No one department is any more important than another.”
Relationships shape the communication through which coordination occurs ...
For better...

Shared goals
Shared knowledge
Mutual respect

Frequent
Timely
Accurate
Problem-solving communication
... Or worse

Functional goals
Specialized knowledge
Lack of respect

Infrequent
Delayed
Inaccurate
“Finger-pointing” communication
This process is called "Communicating and relating for the purpose of task integration"
Investigated performance effects of relational coordination

- Nine site study of flight departures over 12 months of operation at Southwest, American, Continental and United
- Measured relational coordination among pilots, flight attendants, gate agents, ticket agents, baggage agents, ramp agents, freight agents, mechanics, cabin cleaners, fuelers, caterers and operations agents
-Measured quality and efficiency performance, adjusting for product differences
Relational coordination drives flight departure performance

<table>
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<tr>
<th></th>
<th>Efficiency</th>
<th>Quality</th>
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<tr>
<td></td>
<td>Gate time/flight</td>
<td>Staff time/passenger</td>
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<td>Relational coordination</td>
<td>-0.21***</td>
<td>-0.42***</td>
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<tr>
<td>Flights/day</td>
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<td>-0.37***</td>
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<td>Flight length, passengers, cargo</td>
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<td>Passenger connections</td>
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<tr>
<td>R squared</td>
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</table>
Relational coordination drives flight departure performance.

Quality/efficiency performance index

Relational coordination

AMR2
CON2
SWA2
UNI1

AMR1
CON1
SWA1
UNI3

UNI2
Does relational coordination matter in other industries?
“The current system shows too little cooperation and teamwork. Instead, each discipline and type of organization tends to defend its authority at the expense of the total system’s function.” (2003)
Physicians recognize the problem

“The communication line just wasn’t there. We thought it was, but it wasn’t. We talk to nurses every day but we aren’t really communicating.”
Nurses observe the same problem

“Miscommunication between the physician and the nurse is common because so many things are happening so quickly. But because patients are in and out so quickly, it’s even more important to communicate well.”
Same study conducted in surgical setting

- Nine hospital study of 893 surgical patients
- Measured relational coordination among doctors, nurses, physical therapists, social workers and case managers
- Measured quality and efficiency performance, adjusting for patient differences
Relational coordination drives surgical performance

<table>
<thead>
<tr>
<th></th>
<th>Length of stay</th>
<th>Patient satisfaction</th>
<th>Freedom from pain</th>
<th>Mobility</th>
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<td>.26***</td>
<td>.08*</td>
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<td>Surgical volume</td>
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<td>.10*</td>
<td>.06+</td>
<td>.03</td>
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<tr>
<td>R Squared</td>
<td>.82</td>
<td>.63</td>
<td>.50</td>
<td>.22</td>
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</table>

Observations are patients (n=878) in hospitals (n=9). Model also included gender, marital status, psychological well-being and race. Standardized coefficients are shown.
Relational coordination drives surgical performance
RC has been studied in many contexts

- Airlines
- Software
- Banking
- Pharmaceuticals
- Early intervention
- Early childhood education
- Long term care
- Surgery
- Med/surg
- EDs
- ICUs
- Maternity
- Peri-operative
- Primary care
- Chronic care
Efficiency outcomes

- Reduced turnaround time
- Reduced product development costs
- Increased employee productivity
- Reduced length of hospital stay
- Reduced total cost of hospital care
- Reduced inpatient hospitalizations
- Reduced inpatient and outpatient costs of chronic care
Quality outcomes

- Increased patient satisfaction with care
- Increased patient psychological well-being
- Increased patient intent to recommend
- Improved postoperative pain/ functioning
- Reduced medication errors
- Reduced hospital acquired infections
- Reduced patient fall-related injuries
- Improved quality of chronic illness care
- Increased quality of life for elderly
- Reduced family complaints
Worker outcomes

- Increased job satisfaction
- Increased career satisfaction
- Increased professional efficacy
- Reduced burnout/emotional exhaustion
- Increased work engagement
- Increased proactive work behaviors
- Increased psychological safety
- Increased learning from failures
- Increased reciprocal learning
- Increased equity of team member contribution
- Increased collaborative knowledge creation
Client/family/community engagement

- Increased trust/confidence in care team
- Increased family preparation for caregiving
- Increased self-management support
- Increased decision support
- Increased evaluation, enrollment and retention of troubled families
- Increased community linkages
- Reduced parenting stress
- Increased family functioning
Relational coordination shifts out the quality/efficiency frontier, creating greater value.
There are *other* useful responses to coordination challenges...

- Reengineering
- Total quality management
- PDSA
- Redesigning work flows
- “Lean”/ six sigma
Addressing technical issues is necessary but not sufficient

“We’ve been doing process improvement for several years, and we think we’re on the right track. But we’ve tried a number of tools for process improvement, and they just don’t address the relationship issues that are holding us back.”

- CMO, Tenet Healthcare Systems
Why do relationships matter?

Relationships of shared goals, shared knowledge and mutual respect provide the cultural underpinnings for process improvement or “lean” strategies.
Why do relationships matter?

Relationships of shared goals, shared knowledge and mutual respect enable participants to connect across functional and organizational boundaries.

So they can coordinate “on the fly”
When does relational coordination matter most?

- Task interdependence
- Uncertainty
- Time constraints
Is relational coordination important for the work you do?

- Task interdependence
- Uncertainty
- Time constraints
Patient care: A coordination challenge

Perioperative

Operating Room

Specialty Care Providers

Labs

Intensive Care Units

Med/Surgical Units

Home Care Providers

Rehab/ Skilled Nursing

Patients/Families
Mapping relational coordination in your organization
Is your relational coordination strong?

- Shared goals
- Shared knowledge
- Mutual respect

- Frequent
- Timely
- Accurate
- Problem-solving communication
Weak? Or somewhere in between?

Functional goals
Specialized knowledge
Lack of respect

Infrequent
Delayed
Inaccurate
“Finger-pointing” communication
 Identify a work process in need of coordination – e.g. “elder care” or “employment support” or “health promotion”

Which workgroups are involved? Maybe include the citizen and family!

Draw a circle for each workgroup and lines connecting between them

- **LOW RC = RED**
- **MEDIUM RC = BLUE**
- **HIGH RC = GREEN**
RC = Shared goals, shared knowledge, mutual respect, supported by frequent, timely, accurate, problem-solving communication
Reporting back

- Where does relational coordination currently work well? Where does it work poorly?
- How does it impact performance outcomes?
- What are the causes?
- What are some potential solutions?
- Where are your biggest opportunities for change?
How do we measure RC to assess current patterns and provide feedback for learning?
Relational Coordination Survey

- Validated tool to measure RC
  - Within and across workgroups
  - Across highly distributed networks
  - Can include patient, family, community actors
  - Can be measured at any level of leadership and across levels of leadership

- One of two teamwork measures in healthcare that is fully validated *and unbounded*
  - Valentine, Nembhard, Edmondson (Medical Care, 2013)
## Dimensions of relational coordination

<table>
<thead>
<tr>
<th>RC dimensions</th>
<th>Survey questions</th>
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</thead>
</table>
| 1. Frequent communication         | How *frequently* do people in each of these groups communicate with you about [focal work process]?
| 2. Timely communication           | How *timely* is their communication with you about [focal work process]?
| 3. Accurate communication         | How *accurate* is their communication with you about [focal work process]?
| 4. Problem solving communication  | When there is a problem in [focal work process], do people in these groups blame others or try to *solve the problem*? |
| 5. Shared goals                   | Do people in these groups *share your goals* for [focal work process]?
| 6. Shared knowledge               | Do people in these groups *know* about the work you do with [focal work process]?
| 7. Mutual respect                 | Do people in these groups *respect* the work you do with [focal work process]? |
Relational Coordination Survey

- Measures any work process in need of coordination
- Serves as diagnostic tool *and* intervention tool
  - can inform the change process by sharing results with participants
  - reflects back the strength of overall ties, and the strength of specific ties
## Frequent communication

**How frequently do people in each of these groups communicate with you about …?**

<table>
<thead>
<tr>
<th></th>
<th>Not nearly enough</th>
<th>Not enough</th>
<th>Just right</th>
<th>Too much</th>
<th>Way too much</th>
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<tbody>
<tr>
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<td>1</td>
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<tr>
<td>Nurses</td>
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<tr>
<td>Social workers</td>
<td>1</td>
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<tr>
<td>Case managers</td>
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## Timely communication

**How *timely* is their communication with you about ...?**

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<td>Physicians</td>
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### Accurate communication

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Problem solving communication

| When there is a problem with ..., do people in these groups blame others or try to **solve the problem**? |
|--------------------------------------------------|----------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                                                  | Blame others                    | Neither blame nor solve     | Solve the problem            |
| Physicians                                       | 1                               | 2                           | 3                           | 4                           | 5                           |
| Nurses                                           | 1                               | 2                           | 3                           | 4                           | 5                           |
| Social workers                                   | 1                               | 2                           | 3                           | 4                           | 5                           |
| Case managers                                    | 1                               | 2                           | 3                           | 4                           | 5                           |
| Front office                                     | 1                               | 2                           | 3                           | 4                           | 5                           |
## Shared goals

**Do people in these groups *share your goals* for ...?**

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</table>
## Shared knowledge

**Do people in these groups *know* about the work you do with ...?**

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</table>
## Mutual respect

Do people in these groups *respect* the work you do with ...?

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<tr>
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</table>
### Response to RC survey

<table>
<thead>
<tr>
<th>Workgroup Name</th>
<th>Abbreviation</th>
<th>Percent of Respondents</th>
<th>%</th>
<th>Comp</th>
<th>Invt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>MDs</td>
<td>85%</td>
<td>11</td>
<td>13</td>
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<tr>
<td>Registered Nurses--5C</td>
<td>RN/5C</td>
<td>80%</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Administrative Support--5C</td>
<td>AS5C</td>
<td>33%</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Surgical Technicians--5C</td>
<td>ST/5C</td>
<td>50%</td>
<td>1</td>
<td>2</td>
<td></td>
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<tr>
<td>Registered Nurses--CIRS</td>
<td>RNCIR</td>
<td>89%</td>
<td>8</td>
<td>9</td>
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<tr>
<td>Directors, Medical and Nurses...</td>
<td>DMDRN</td>
<td>100%</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Directors, Embryology (Assi...)</td>
<td>D.Emb</td>
<td>50%</td>
<td>1</td>
<td>2</td>
<td></td>
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<tr>
<td>Embryologists</td>
<td>Embry</td>
<td>55%</td>
<td>6</td>
<td>11</td>
<td></td>
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<tr>
<td>Medical Assistants</td>
<td>MAs</td>
<td>100%</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Practice Assistants and Coo...</td>
<td>PA&amp;C</td>
<td>67%</td>
<td>4</td>
<td>6</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td>74%</td>
<td>42</td>
<td>57</td>
<td></td>
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</tbody>
</table>
Seven dimensions of RC

Between Workgroups

- Relational Coordination: Mean 3.68, Min 3.48, Max 3.82
- Frequent Communication: Mean 4.24, Min 3.84, Max 4.71
- Timely Communication: Mean 3.69, Min 3.46, Max 3.87
- Accurate Communication: Mean 3.92, Min 3.78, Max 4.08
- Problem-Solving Communication: Mean 3.38, Min 3.06, Max 3.71
- Shared Goals: Mean 3.78, Min 3.49, Max 3.98
- Shared Knowledge: Mean 3.16, Min 2.74, Max 3.68
- Mutual Respect: Mean 3.58, Min 3.29, Max 3.80

Weak | Moderate | Strong
--- | --- | ---
<4.0 | 4.0-4.5 | >4.5
<3.5 | 3.5-4.0 | >4.0
<3.0 | 3.0-3.5 | >3.5
Overall RC ratings for each workgroup
Problem-solving vs. blaming

### Problem-Solving Communication

<table>
<thead>
<tr>
<th>Between Workgroups</th>
<th>Mean</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Workgroups</td>
<td>3.38</td>
<td>3.06</td>
<td>3.71</td>
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<td>3.06</td>
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<td>3.34</td>
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<td>Administrative Support--5C ...</td>
<td>3.29</td>
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<td>5.00</td>
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<td>5.00</td>
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<td>Registered Nurses--CIRS</td>
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<td>3.71</td>
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<td>Embryologists</td>
<td>3.61</td>
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<td>Medical Assistants</td>
<td>3.39</td>
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<td>5.00</td>
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<tr>
<td>Practice Assistants and Coo...</td>
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#### Within Workgroup

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<th>Strong</th>
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<tbody>
<tr>
<td>&lt;4.0</td>
<td>4.0-4.5</td>
<td>&gt;4.5</td>
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#### Between Workgroups

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<th>Moderate</th>
<th>Strong</th>
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<tbody>
<tr>
<td>&lt;3.5</td>
<td>3.5-4.0</td>
<td>&gt;4.0</td>
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#### Between Organizations

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<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3.0</td>
<td>3.0-3.5</td>
<td>&gt;3.5</td>
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Shared knowledge
Map for overall RC
Matrix for overall RC

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Non-reciprocal ties
Matrix for problem solving vs. blaming

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**Weak**
- Within Workgroup: <4.0
- Between Workgroups: <3.5
- Between Organizations: <3.0

**Moderate**
- Within Workgroup: 4.0-4.5
- Between Workgroups: 3.5-4.0
- Between Organizations: 3.0-3.5

**Strong**
- Within Workgroup: >4.5
- Between Workgroups: >4.0
- Between Organizations: >3.5
### Matrix for shared knowledge

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### Rating Scale

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How do organizations support relational coordination - or undermine it?
Organizational structures that support relational coordination

- Select for Teamwork
- Invest in Frontline Leadership
- Create Shared Accountability
- Share Costs and Rewards
- Resolve Conflicts Proactively
- Make Job Boundaries Flexible
- Create Boundary Spanners
- Develop Shared Protocols
- Broaden Participation in Team Meetings
- Develop Shared Info Systems
- Partner with Suppliers

Relational Coordination
- Frequent
- Timely
- Accurate
- Problem Solving
- Communication

Shared Goals
Shared Knowledge
Mutual Respect

Performance Outcomes
- Quality
- Efficiency
- Citizen Engagement
- Worker Well-being
“Here technical expertise exceeds teamwork ability as a criterion; doctors expect teamwork of others simply by virtue of the fact that they are doctors, after all.”
“You’ve got to be a nice person to work here…We pick it up through their references. The doctors here are also sure to know someone who knows that doctor... . . . Nurses like it here because physicians respect their input.”
“Teamwork with nurses is always important—we’re always dealing with them. So is teamwork with physicians. We need to know if the physical therapist has an attitude toward physicians because it is so important to communicate with the doctors.”
“You can be the best social worker in the world, but if you can’t work with the other disciplines, then you can’t work here. Some are very good diagnostically. But it’s the communication skills [we are looking for].”
“The quality assurance committee is strictly departmental and it’s strictly reactive. Everybody is giving reports to QA but nobody is listening or learning. The QA committee satisfies hospital-wide reporting requirements. But it’s not effective. We have board members on that committee, but we still can’t get it to work. People have a bad attitude when they go. It’s a lengthy, cumbersome meeting.”
“Quality assurance used to be completely reactive here, with incident reports. There would be a review to determine injury or no injury. QA is more real-time now, not so reactive.”

“But we don’t have a full system in place. It’s evolving… It’s not cross-functional yet. Usually I take the nurses and the chief of the service takes the physicians. There is finger-pointing.”
“We have a history of punitive measures. Now it’s ‘what makes competent people fail? What in the system failed? What piece of information was missing?’ We are looking at a learning perspective now. It’s still a QA function. But now it’s more like quality improvement.”
“We have a Bone Team which includes the service line director, the case management supervisor, the head of rehab, the VP for nursing, the nurse manager, the clinical specialist, three social workers and three case managers. We generally look at system problems.”
“I would say that for any non-physician to challenge a physician has the whole episode laced with pitfalls. For a nurse, a therapist, a pharmacist, a social worker, a nutritionist, an occupational therapist to challenge a physician is up there with losing a job or getting a divorce—very stressful. And I can say personally as a nurse that in my more formative years that was something that you would try to avoid at all costs.”
“The kinds of conflicts we often have are disagreements about the patient’s treatment plan: what it should be. It can go across all of the groups. The other big thing is getting a physician to come up to the unit, to be available. . . . We have a formal grievance process if you’re fired, but not for conflicts among clinicians. . . . There are no particular processes. We just hope people use common sense and talk to each other.”
We have a staff council that’s largely responsible for information sharing among the departments. The staff council deals with medical policy and conflict resolution. . . . It’s an informal body to air differences. It’s more for problem solving. We have monthly meetings that are attended by all medical staff, including physicians, nursing, and social work.”
“We implemented training classes for all employees that teach employees how to deal with conflict resolution, including adopting appropriate behaviors. There is a Pledge to My Peers, which is a structured format for resolving conflicts in a peer-to-peer fashion. Aggrieved employees are encouraged to approach the coworker or supervisor or whoever and say, ‘I would like to speak with you regarding the pledge.’ ”
There are certain cultural tendencies that inhibit others from doing their work. Therapists train nurses in mobility, but still nurses are often reluctant to deal with moving the patient, getting the patient out of bed, etc. It’s partly because they feel they aren’t qualified, and partly because that’s just considered a PT thing.”
“There are customs – like the fact that a physical therapist will never deal with bedpans and such – that go above and beyond licensing. These customs have a negative effect, like when a physical therapist will go get a nurse just to deal with the bedpan, making things difficult.”
“[Here] physical therapists definitely do the bedpans. You see, length of stay is so compressed and time is so valuable. You’ll only delay yourself if you try to hunt down the nurse’s aide.”
“It’s a question of what you’d rather defend. That you did nothing, or that you tried to help, even if you may have gone beyond your licensing. I tell my staff I’d rather defend them doing too much than not enough.”
"I have about 30 patients – with that number I pretty much just go down the list and see who is ready for discharge.”
“Our case managers do the discharge planning, utilization review and social work all rolled into one. The case manager discusses the patient with physical therapy and nursing and with the physician. He or she keeps everyone on track. The case manager has a key pivotal role – he or she coordinates the whole case.”
“Case managers have to be very very very good communicators and negotiators and very assertive but also have a good sense of timing …. Willing to be a patient advocate but also be able to balance the financial parameters and think ‘out of the box’ and have a system perspective.”
“It’s often the person who is closest to the patient who knows where the patient and the family are at. In our huddles doctors are learning to listen and not feel like they have to know everything. Everybody has a different piece of the puzzle to contribute.”
“I can spend half of my day tracking down patients. I will hear somebody mention somewhere in the hallway about a patient with this condition, and they’re not on my printout, so I’ve got to walk on every floor and say, ‘Do you have this patient?’ And they go: ‘Oh that patient’s on the vascular service, but yeah, I think Dr. So and So already operated on him.’ It’s ridiculous.”
“You can’t track down all of the physicians here because some of the physicians have their own system. That’s a problem – they don’t talk. Independent physicians have their own independent systems, and they only talk to themselves. I mean, so there’s a big problem. Some of them are on the email system, and some of them aren’t.”
"Information systems are important for coordination, I think, but right now they are more a hope than a reality. Our chief information officer is building a clinical and administration information system allowing patients to receive care anywhere across the continuum...For automation to work, it's important to get a format that's understood across specialists."
“In some cases, it’s added time for order entry, but the additional time has been outweighed by far less aggravation in trying to locate a record….People recognize the power of having a system like provider order entry because you can do incredible medical management just by providing information at the point of care.”
“We’ve been so successful with order entry that we can’t keep up the demand from our providers. There are probably about 55 things that people currently want to change to our current application. We put together an order entry advisory committee, a group of physicians and nurses that come together on a monthly basis, and they prioritize what’s the most important thing on the list now that we need to do.”
Organizational structures that support relational coordination

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- Partner with Suppliers

Relational Coordination
- Shared Goals
- Shared Knowledge
- Mutual Respect
- Frequent
- Timely
- Accurate
- Problem Solving
- Communication

Performance Outcomes
- Quality
- Efficiency
- Citizen Engagement
- Worker Well-being
Leaders have a role in designing and implementing ALL of these structures. They can be designed to WEAKEN relational coordination or SUPPORT relational coordination.
Invest in Frontline Leadership

Resolve Conflicts Proactively

Share Costs and Rewards

Select for Teamwork

Create Boundary Spanners

Develop Shared Protocols

Broaden Participation in Team Meetings

Create Shared Accountability

Make Job Boundaries Flexible

Develop Shared Info Systems

Partner with Suppliers

Relational Coordination

Frequent

Timely

Accurate

Problem Solving

Communication

Shared Goals

Shared Knowledge

Mutual Respect

Performance Outcomes

Quality

Efficiency

Citizen Engagement

Worker Well-being

But where would you start?
What is the path for moving from low to moderate to high RC?

- Quality/efficiency performance index
- Relational coordination

Diagram showing hospitals (Hosp1 to Hosp9) on a graph with Relational coordination on the x-axis and Quality/efficiency performance index on the y-axis.
How do organizations learn new ways to coordinate?

- Most organizations are still traditional bureaucracies with workers in their silos.
- Relationship patterns are deeply engrained in our organizational cultures, professional identities – and even personal identities.
- Our model doesn’t tell us where or how to start.
Cultural learning, unlearning and transformative change

- **Stage 1 – Unfreezing**
  - creating the motivation and openness to change

- **Stage 2 – Learning**
  - learning new concepts, new meaning for old concepts, new standards for judgment

- **Stage 3 – Refreezing**
  - internalizing new concepts, meanings, standards
Stage 1 – Unfreezing, creating motivation and openness to change

- Disconfirmation
  - a perceived threat to survival or failure to meet one’s goals or ideals
  - may require an educational intervention for frontline employees regarding the economic context, or for top management regarding the realities of frontline work
Stage 1 – Unfreezing, creating motivation and openness to change

- Survival anxiety
  - “You begin to recognize the need to change, the need to give up old habits and ways of thinking and the necessity of learning new habits and ways of thinking.”
Stage 1 – Unfreezing, creating motivation and openness to change

- Learning anxiety
  - Fear of loss of power or position
  - Fear of temporary incompetence
  - Fear of punishment for incompetence
  - Fear of loss of personal identity
  - Fear of loss of group membership

- Defensive responses
  - Denial
  - Scapegoating, passing the buck, dodging
  - Maneuvering, bargaining
Complex dynamics of change

- Survival anxiety
- Learning anxiety
Compelling positive vision
- The vision must be articulated and widely held by senior management – most importantly, it must articulate the desired “new way of working”

Formal training
- If the new way of working requires teamwork, formal training on team building and maintenance must be provided
- Involve learners in designing their own optimal learning process

Create psychological safety to reduce learning anxiety
Informal training of relevant groups and teams

Because resistance to change is often embedded in group norms, informal training and practice must be provided to whole groups so that new norms and assumptions can be built jointly.

Practice fields, coaching and feedback

Need to be able to make mistakes and learn from them without disrupting the organization.

Create psychological safety to reduce learning anxiety
Three key elements that support relational coordination:

- **Relational Coordination**
  - Communicating
    - Frequent
    - Timely
    - Accurate
  - Problem-Solving
    - Relating
    - Shared Goals
    - Shared Knowledge
    - Mutual Respect

- **Structural/Systemic Interventions**
  - Select/Train for Teamwork
  - Shared Accountability
  - Shared Costs/Rewards
  - Conflict Resolution Practices
  - Meetings/Huddles
  - Job Design
  - Boundary Spanner Roles
  - Shared Protocols
  - Shared Info Systems
  - Spatial Design

- **Relational Interventions**
  - Foster Psychological Safety
  - Feedback RC Metrics
  - Coaching/Humble Inquiry

- **Work Process Interventions**
  - Plan/Do/Study/Act
  - Lean/Six Sigma
  - Positive Deviance

- **Performance Outcomes**
  - Quality
  - Efficiency
  - Patient Engagement
  - Worker Well-Being
Four case studies in change

- Dartmouth-Hitchcock
- Group Health Cooperative
- Billings Clinic
- Varde Municipality
Dartmouth-Hitchcock
Dartmouth-Hitchcock

- Well-known medical center in New England with long history of clinical excellence and organizational innovation
- At the cutting edge of accountable care, process improvement, microsystems, and shared decision-making with patients
“Imagine a health system that focuses on health, not just health care. Our solution to the current health care model is to eliminate fee-for-service and provide service that is rewarded for quality and results, rather than volume.”

-- CEO James Weinstein
In 2013 Rich Freeman, Chair of Surgery, launched a transformation effort. From traditional silos of expertise toward a team-based model of care. Payment reform was creating pressure to achieve greater efficiencies. Also, quality concerns and low worker morale.
“There were a few wrong site surgeries and near misses [which] happened despite compliance with the checklist and timeout. The issue was rote completion of the checklist, and there wasn’t any communication and feedback.”

-Giri Venkatramen, Associate Quality Officer
“Recent employee surveys show that we have a real problem with employee morale.”
- Rich Freeman, Chair of Surgery

“I’ve done well but it’s a tough culture here and many women don’t experience equal treatment.”
- Dale Collins Vidal, Surgeon and Unit Chief
Change effort in 11 units using two approaches - relational coordination and leadership coaching

Led by Freeman and fellow surgeon Jack Cronenwett

Change agents are Margie Godfrey and Tina Foster (relational coordination coaches) and Eddie Erlandson (leadership coach)

Dale Collins Vidal, high performing surgeon and unit chief, was early adopter of RC
"Relational coordination just makes so much sense to me as a leader. Ever since learning about the concept I have used it to run meetings in my unit. I ask everyone to consider how we are doing on shared goals, shared knowledge and mutual respect, and I put it on the board to keep these questions in focus."

-Dale Collins Vidal, Surgeon and Unit Chief
Group Health Cooperative
Group Health Cooperative

- Well known integrated health system in the Pacific Northwest
- Grew out of the post-WWII cooperative movement to provide care for fixed price
- Historic strength in primary care
- Significant financial/management/workforce challenges in early 2000s
Group Health Cooperative

- Seeking to strengthen primary care base
- Implemented lean and shared decision-making successfully in their 26 clinics
- Lean methods used to standardize work and eliminate waste
- Quality, efficiency and workforce outcomes improved – but some limitations were observed
“People got better at performing their own standard work, but when they had to go beyond and connect with each other in response to a patient need, it was not consistent.”

-Rob Reid, Group Health Research Institute
Decided to use relational coordination measures to guide insight and intervention

Change process to be led by two change agents – Kim Demacedo (lean coach) and Diane Rawlins (relational coordination coach)

This lean/RC team is developing an integrated model with integrated language and tools

But they first started with primary care leadership team
Group Health Cooperative

For their Medical Home 2.0, decided to integrate lean tools with relational coordination measures and tools

Led by Claire Trescott (Medical Director) and Barbara Trehearne (Chief Nurse) along with Primary Care Leadership Team

Change agents are Kim Demacedo (lean consultant) and Diane Rawlins (relational coordination consultant)
"It’s all about the relationships. We’ve been focusing on teamwork for a while, and now it’s time to take it to the next level. Barbara and I spend time in the clinics promoting teamwork. Before asking our clinics to do RC, we did it first as a leadership team."

-Claire Trescott, Medical Director, Primary Care
"It didn't make sense for the Leadership Team to drive change in our primary care clinics using relational coordination until they really understood it themselves. The best way to do that, we decided, was to invite the Leadership Team to take the RC survey, and then learn about and reflect on their results."

-Michael Parchman, Director, McColl Research Institute
"We are thinking the first intervention will be more focused on the relational aspects, emphasizing respect (and trust, safety), and shared knowledge, which could begin to touch on process improvement. The team members will also get a good chunk of time to make sense of their data and – hopefully -- "own" their improvement ideas and questions."

-Diane Rawlins, RC Consultant
"In the second session we will then focus more on process improvement--based on their ideas from the first session. At this point I see the relational interventions creating the container for the lean tools to be even more effective and sustainable. Likewise, I think the process improvement work will reinforce and strengthen the relational dimensions."

-Diane Rawlins, RC Consultant
Billings Clinic
Billings Clinic

- Innovative community owned healthcare system in Montana, Wyoming, North and South Dakota
- Organized as a multi-specialty physician group practice with hospitals, clinics and long term care
- Seeking to become an accountable care organization with bundled payments and patient-centered medical homes
CEO Nick Wolter wanted to meet these challenges by fostering teamwork throughout Billings Clinic.

Billings had been working for years with complexity science and positive deviance guided by internal consultant Curt Lindberg.

Positive deviance is an improvement methodology based on identifying high performance - then learning from those strengths.
“We started our change efforts in the Intensive Care Unit because the leaders there were highly respected – and they were already pretty good at teamwork. Introducing relational coordination was easy – they grabbed onto it very quickly. The ICU docs and the whole team have been using it to improve their work.”

-Curt Lindberg, Internal Consultant
ICU improvement team meets to review RC scores and find new ways to work together

One initiative is a new game

“We encourage ICU healthcare team members to submit cards for examples of behaviors we want to encourage in the ICU – shared goals, shared knowledge, mutual respect, communication that’s timely, frequent, accurate and focused on problem-solving.” - ICU Connections Newsletter
Recent submissions:

- Jen Potts, Occupational Therapist, recognized Ted, ICU Nurse, for Shared Goals, Mutual Respect, Problem Solving Communication
- Dr. Davis recognized Andy and Troy from Radiology for Mutual Respect, Shared Goals and Timely Communication
- Jamie Humphrey, ICU Nurse, recognized Reina, Respiratory Therapist, for Shared Goals and Problem Solving Communication
Billings Clinic

Recent submissions:

- Amber Hellekson, ICU Nurse, recognized Dr. Randall, Cardiovascular Specialist, for Shared Knowledge
- Jen Potts, Occupational Therapist, recognized Kristi Nelson, Dietician, for Timely and Accurate Communication
- Dr. Davis recognized Chaplain Doug Johnson for Shared Goals, Mutual Respect and Timely Communication
For each submission, a story is shared:

“When Dr. Yandell (cardiovascular specialist) overheard nursing staff discussing a procedure a patient had, he took the time to find an anatomical picture and explain, in depth, what took place. Amber Hellekson (nurse) wrote – ‘This was not even his patient or his service... he just took the time to offer his knowledge.’”
Story from Jen:

“In making discharge recommendations, Jen (occupational therapist) needs as much information as possible about any changes in routines the patient will experience and new knowledge the patient must take in. Kristi (dietician) discussed the new knowledge the patient had to acquire as well as changes in diet and how that would alter the patient’s daily routine. Kristi sharing her expertise helped Jen make a safe discharge recommendation.”
Story from Dr. Davis:

“When a patient is in a code situation, doctors, nurses, pharmacists and other team members are focused on working with the patient. Fortunately we have Pastoral Care to provide comfort and support to family members. Despite heroic efforts the patient died. Chaplain Doug was present and supportive to the family. Moreover he offered his compassionate support to the ICU staff, nurses and MDs.”
ICU Connections Bingo Game 1

On the Thursday before Christmas, there was a party in the ICU RN Break Room. Dozens of PT, OT, SLP and RNs were mingling and eating pizza.

The pizza party celebrated the ICU Connections BINGO game 1 winners—PT, OT, and SLP. The first ICU Connections BINGO game ended with their victory on December 1, 2013.

A Close Race

It was a close race, though. The winning card was placed on the BINGO board just minutes before the final card was placed for the ICU RNs.

A Shared Victory

That is why the victors decided to share their pizza party with the RNs. “It’s a gesture of good will,” said Jenn P., OT. “We want the ICU nurses to know we respect what they do and we know they almost won. The key word, though, is ALMOST,” she said, laughing.

Tawni R. RN shared some pizza, but was clear in her thoughts. “We’ll win next time. You can’t hold a good ICU RN down!”

The pizza was provided by Dr. Merchant, who is anxious to buy pizza for the winners of the next game.
I RESOLVE TO . . .

1. **Share My Goals** of patient care with other ICU health care team members. I will also learn about the patient care goals of other team members and contribute to development of shared goals.

2. **Share My Knowledge** about patient care with other ICU health care team members. I will also learn about the patient care responsibilities of other team members and draw on their expertise.

3. **Respect** the work, experience, knowledge, and patient care goals of other ICU health care team members. I will also expect that same respect from other team members.

4. **Communicate Frequently** with all ICU health care team members.

5. **Communicate** with all ICU health care team members in a **Timely** manner, providing information when needed.

6. **Communicate Accurate** information all ICU health care team members to ensure proper patient care.

7. **Make sure all my Communication** with all ICU health care team members **Solves Problems**. I will not pout, place blame, or complain.
Billings ICU held Relational Coordination Summit in Fall 2013 to celebrate their learning.

Now rolling out RC in primary care, for their patient centered medical homes.

Also rolling out RC in orthopedic surgery to facilitate success of bundled payment contract for joint replacement surgeries.
Varde Municipality
Varde Municipality

- Danish municipalities responsible for elder care, care for children and youth, home care, drug abuse, homeless, handicapped, workforce development, cultural activities and infrastructure
- Consolidated from about 300 municipalities to 95 in 2007 to handle their responsibilities
- Now are accountable for 20% of healthcare costs if citizen is hospitalized or visits a doctor
“With the healthcare revolution in Denmark we set up a clear separation of duties between regions and municipalities. We formed 5 regions for health and psychiatric care and 95 municipalities who are responsible for before people get sick and after they are out of hospital. Because of the 20% and because of our citizens, we have incentives to take care of our duties.”

- Max Kruse, Municipal Director
“Varde Kommune was formed from five smaller municipalities in 2007 to become one municipality. We have a lot of consensus in what we do because we work together for the best of our people. We make a written plan for the coming year once a budget has been decided upon by our mayor and city council. We are close to the users and we are very practical.”

- Max Kruse, Municipal Director
“Local health issues are a priority for Varde Kommune. By far Varde sets the priority on local health. It started with an earlier leader Bent Pol – he set a high priority and a high ambition for local health. It’s our history. We are a healthy part of Denmark so it was easy to take this step – and we provide the resources to make it possible.”

- Erling Pedersen, Director of Health and Social Care
New efforts:

- Wellness visits to all citizens 75 and older
- Outreach to citizens with depression, joblessness, handicaps, drug abuse
- Transitional unit in elder center to reduce hospitalizations and readmits by providing intensive physical therapy to elders

“It doesn’t work to say do it because I am the nurse and I said so. It has to connect to something the citizen cares about.”
— Margit Thomsen, Director of Health Promotion
“We also do rehabilitation for those who are out of work. If you lose your work, you lose your connections with work. Within six months it is very tough to get you back into work. It’s our job to get them healthy and get them back to work again. This takes a lot of collaboration between different people.”

- Erling Pedersen, Director of Health and Social Care
“Now we have the challenge of working across sectors and we don’t know how to do it yet. These people have to get along and work together. Sometimes it works – especially at the beginning of the week [much laughter around the table]. They need to have a good relationship between each other and a good dialogue - they need to know what is going on in the other silos. Otherwise nothing works.”

- Erling Pedersen, Director of Health and Social Care
RC across sectors

- Relational coordination across sectors requires:
  - Patient - Family
  - Worker – Patient
  - Worker - Family
  - Worker - Worker
  - Worker - Leader
  - Leader - Leader
  - Acute – Post-Acute – Home Care
Relational coordination across sectors

Families as integrators of a highly fragmented “system”

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Beyond relational coordination

- Patients/families
- Workers
- Leaders

Relational coproduction

Relational coordination

Relational leadership
Three key elements that support relational coordination:

- **Relational Coherence**
  - Communicating
  - Frequent
  - Timely
  - Accurate
  - Problem-Solving

- **Relating**
  - Shared Goals
  - Shared Knowledge
  - Mutual Respect

- **Performance Outcomes**
  - Quality
  - Efficiency
  - Patient Engagement
  - Worker Well-Being

**Structural/Systemic Interventions**
- Select/Train for Teamwork
- Shared Accountability
- Shared Costs/Rewards
- Conflict Resolution Practices
- Meetings/Huddles
- Job Design
- Boundary Spanner Roles
- Shared Protocols
- Shared Info Systems
- Spatial Design

**Relational Interventions**
- Foster Psychological Safety
- Feedback RC Metrics
- Coaching/Humble Inquiry

**Work Process Interventions**
- Plan/Do/Study/Act
- Lean/Six Sigma
- Positive Deviance

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- Lean/Six Sigma
- Positive Deviance
RC Intervention Plan of Action

- Train local RC coaches
- Design intervention approach with coaches
- Establish psychological safety among participants
- Measure baseline RC, feedback data to participants
- Engage in coaching and humble inquiry
- Facilitate discussions, identify target opportunities
- Carry out interventions
  - identification of goals (shared goals)
  - conversations of interdependence (shared knowledge)
  - standards of behavior (mutual respect)
  - redesign structures and processes as needed
- Re-measure RC, continue feedback, reflection, intervention