TRANSFORMING RELATIONSHIPS FOR HIGH PERFORMANCE

The Power of Relational Coordination

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12 WORK PROCESS INTERVENTIONS TO CREATE NEW WAYS OF WORKING

On the face of it, work process interventions appear to be the polar opposite of relational interventions. While relational interventions are focused on transforming relationships among the people who doing the work, work process interventions are focused on transforming the work itself. Process improvement and relational coordination come from distinct silos of expertise. They have distinct languages and distinct methodologies, driven by distinct "inquiry preferences"—in particular, one appears to be more technical and measurement driven, while the other appears to be softer and more relationally driven.[1] At times, they are seen as competing paradigms. People who identify with one of these paradigms can feel threatened when confronted with the other one.

One day, I was out walking with a colleague who is an organizational development practitioner skilled in relational interventions. We ran into a leader of one of the local hospitals that she works with. Tension emerged as they discussed the design of an upcoming meeting and whether to include an internal consultant who uses lean tools to improve performance. "Are we going to bring him to that meeting? If we do, then it's going to be defined as an OE [operational excellence] problem." For them, it seemed to be an either/or choice about which approach would be used to define the problem and therefore the solution. It did not seem realistic that the two approaches could be used in a complementary and synergistic way. The very silos that we are working to overcome in organizations can also limit our collective impact as change agents.

This competition between social and technical approaches to organizational change is not simply a US phenomenon. For the first couple of years that I was invited to Denmark, it seemed that the organizational development practitioners did not talk to the lean practitioners, and vice versa. Now, more and more, they are talking. Still, of the twenty-five change projects we identified and analyzed in "The Interventional Uses of Relational Coordination: Early Evidence from Four Countries," we found that while all used relational interventions, such as creating a safe space, feeding back relational coordination data to participants, and engaging in coaching and role modeling, only 44 percent used work process interventions. One possible explanation for this finding is that many of the practitioners and change agents who were initially drawn to the relational coordination framework had training that was conducive to relational interventions—such as organizational development—and few had been trained in work process interventions.[2]

For decades, sociotechnical systems designers have seen relational and work process interventions as complementary approaches to organizational change.[3] In this chapter, I introduce tools for carrying out work process interventions, showing how they can be informed by the principles of relational coordination. Once change agents have used relational interventions to begin changing the way participants communicate with and relate to one another, they can use work process interventions more effectively to transform the work itself.

PROCESS IMPROVEMENT AND RELATIONAL COORDINATION AS COMPETING PARADIGMS?

The benefits of integrating process improvement and relational coordination first arose for me in conversations with colleagues Ed Schein and Amy Edmondson. We were meeting regularly to develop what became the Relational Model of Organizational Change. At the time, Schein was in conversations with the CEO of Virginia Mason, a health system in Seattle, Washington, known for its deep implementation of lean methods.[4] He had been influenced by those conversations to see process improvement as far more central to organizational change than he had previously thought.

It was Earl Murman, astronautics and aeronautics physicist at the MIT Lean Advancement Initiative, who first referred to relational coordination as "the soft side of lean." In Murman's experience, shared goals, shared knowledge, and mutual respect, as well as timely, accurate, problem-solving communication, helped to drive effective process improvement. Some observers object to calling relational coordination "the soft side of lean," seeing the label as somehow minimizing the real challenges of building high-functioning relationships and the importance of these relationships for successful change efforts. Both Dale Collins Vidal, surgeon leader at Dartmouth-Hitchcock, and Marjorie Godfrey, co-director of the Dartmouth Institute Microsystem Academy, have pointed out that relational coordination is actually quite hard in the sense of being both measurable and challenging to achieve.

Regardless of the term we choose, the relational side of lean may indeed be important to its success. One central finding of Godfrey's research was that in the absence of skilled coaching with attention to relational as well as technical dimensions, lean does not work well.[5] Another study found that process improvement in hospitals was associated with an *increase* in clinical quality but a *decrease* in the quality of the patient experience.[6] This outcome seems likely when work process improvement is carried out using technical tools with little attention to the relationships with the customer or between the roles that work with the customer.

Indeed, process improvement is about connecting across silos. To drive out waste and engage in just-in-time production, people must connect with each other horizontally instead of referring all problems up the chain of command to be resolved at a higher level. In the traditional bureaucratic model, buffers in the form of excess inventory or wait time for customers exist between the steps in the process, minimizing the need for workers to communicate directly with each other. However, excess inventory is wasteful because of storage and inventory costs, and negatively impacts quality by increasing customer wait times. More fundamentally, inventory reduces transparency and, therefore, the ability to identify and address performance issues in a timely way. A negative feedback loop is set up that demoralizes staff and frustrates managers. In sum, lean is all about seeking to deliver products and services just in time, in

response to customer demand. To do so requires communicating on the fly in a timely, problem-solving way with each other and with the customer.

Microsystems is another approach to process improvement that addresses both relational and technical aspects of systems. Defined as "the smallest replicable units" of production or value creation, microsystems are the places where workers meet each other, and where workers meet their customers. According to Godfrey and her colleagues Paul Batalden and Eugene Nelson, microsystems are effective or ineffective, producing high or low levels of performance, depending on their design. As Batalden famously said, "Every system is perfectly designed to produce the outcomes it produces." One of the distinguishing factors is the quality of interrelating among workers who carry out interdependent tasks. "Microsystems that work as high reliability organizations, similar to those described by Weick and colleagues, are [those in which participants are] 'mindful' of their interdependent interactions."[7]

TOOLS FOR CHANGE AT THREE STAGES OF WORK PROCESS IMPROVEMENT

Now let's consider tools for change at three stages of work process improvement: (1) *assess the current state,* (2) *envision the desired state,* and (3) *experiment to close the gap.*

Assess the Current State

Work process improvement typically starts with an assessment of the current state. One tool for assessing the current state is simply "going and seeing." There is no substitute for observing the work itself, in real time. In lean parlance, this is known as "going to the *gemba* (a Japanese term meaning "the real place"). Practitioners have discovered that it is extremely useful for participants to then step back from immediate observation and visualize the "system" or the "process" they are part of. In a sense, they are creating a boundary object that represents the system. Tools for developing a visual representation of the current state include process mapping, value stream mapping, or flow charts that trace the customer journey. These tools produce insights into the current state that are not available from the perspective of any one workgroup, given

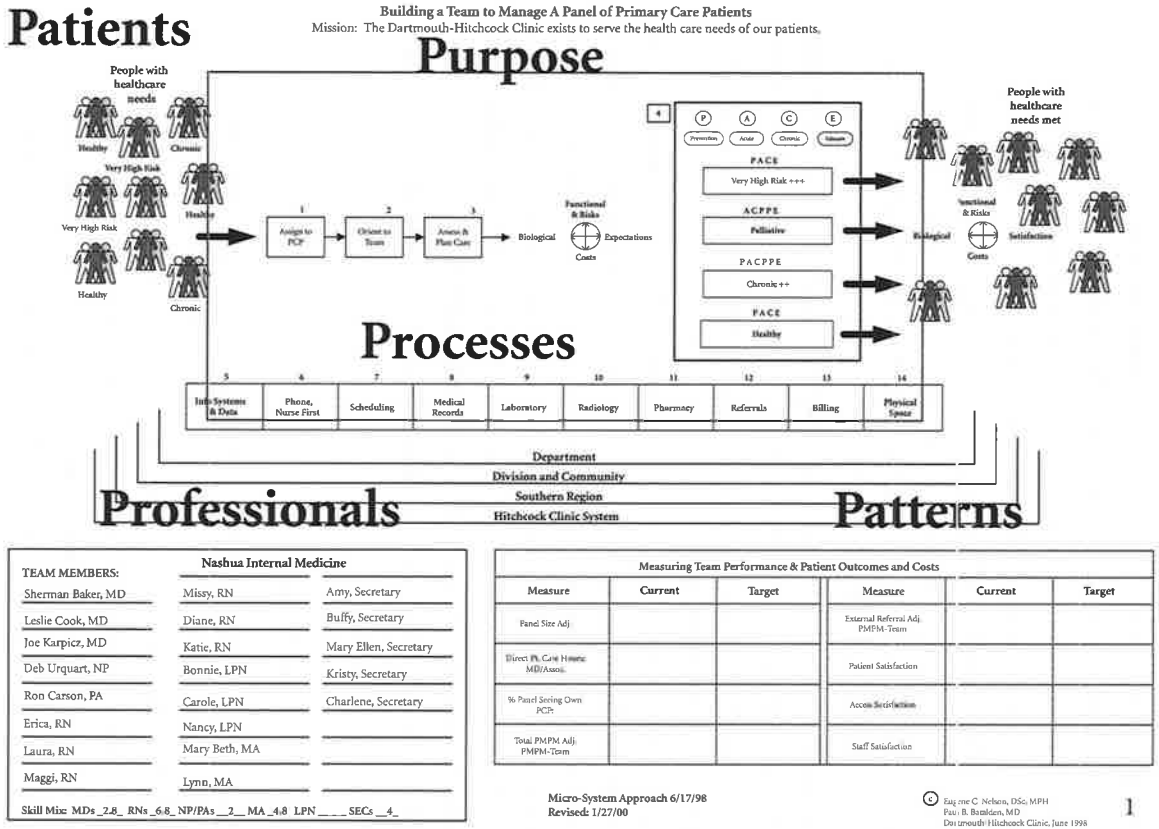
each workgroup's unique line of sight. They can therefore be used to highlight connections between the tasks carried out by the different workgroups, including customers, making interdependencies more evident.

The "5 Ps" tool is used to assess the current state of the microsystem. What is the *purpose* of the microsystem? Who are the *patients* or the *customers*, and what are their characteristics? Who are the *professionals* or *workers*, and what are their distinct roles? What are the *processes* through which work is carried out? And what are the *patterns* of interrelating through which these processes are carried out? The microsystem and the larger system in which it is embedded is seen as a complex adaptive system that evolves over time. In particular, the fifth P—patterns—is key to the adaptive capacity of the microsystem. "Patterns are the consistent behaviors, sentiments and results that emerge from the relationships of the parts involved in a complex adaptive system."[8] The 5 Ps tool is illustrated in Figure 12.1.

To assess the current state, participants must go beyond the microsystem to understand the broader context. This broader context is made up of the *mesosystem*, which is simply a set of interdependent microsystems, and the *macrosystem*, which is the regulatory, cultural, social and political environment within which the microsystem is situated. These "3 Ms" help participants to assess the current state more broadly by helping them to see the system at multiple levels. Context diagrams are a tool for mapping and assessing this broader context.

Identify the Desired State

Attention to the current state is a powerful way to begin a journey of improvement. Whenever we represent the current state visually and analyze it, it becomes clear that there are flaws in it. But identifying flaws is not sufficient. Rather, we must identify a desired state. The second core element of work process interventions, therefore, is envisioning the desired state. The desired state is perhaps the least-well-developed stage of work process improvement. Some argue that practitioners tend to focus instead on identifying the flaws in the current state, and then allow those flaws to drive the improvement process. Recall system thinker Ackoff's critique in Chapter 6: "Most applications of



TEAM MEMBERS:	Nashua Internal Medicine	
Sherman Baker, MD	Missy, RN	Amy, Secretary
Leslie Cook, MD	Diane, RN	Buffy, Secretary
Joe Karpicz, MD	Katie, RN	Mary Ellen, Secretary
Deb Urquart, NP	Bonnie, LPN	Kristy, Secretary
Ron Carson, PA	Carole, LPN	Charlene, Secretary
Erica, RN	Nancy, LPN	
Laura, RN	Mary Beth, MA	
Maggi, RN	Lynn, MA	

Skill Mix: MDs _2.8_ RNs _6.8_ NP/PAs __2__ MA _4.8 LPN ____ SECs __4_

Measuring Team Performance & Patient Outcomes and Costs					
Measure	Current	Target	Measure	Current	Target
Panel Size Adj.			External Referral Adj. PMPM-Team		
Direct Pt. Care Hours: MD/Assoc.			Patient Satisfaction		
% Panel Seeing Own PCP:			Access Satisfaction		
Total PMPM Adj. PMPM-Team			Staff Satisfaction		

Micro-System Approach 6/17/98
Revised: 1/27/00

1

FIGURE 12.1 The 5 Ps template for assessing the current state

SOURCE: E. C. Nelson, P. B. Batalden, and M. M. Godfrey, *Quality by Design: A Clinical Microsystems Approach* (San Francisco: Jossey-Bass, 2007).

improvement science are directed at improving the parts, but not at improving the whole . . . [As a result] the parts don't form a system because they don't fit together."[9] To improve the whole rather than simply the parts, Ackoff noted, "improvement programs have to be directed at what you want—not at what you don't want."

This means that a fundamental step in work process improvement is achieving clarity about the shared purpose or shared goal, and to get relevant stakeholders together in the room to envision the desired state. Attention to this step can prevent wasteful solutions, such as building emergency department capacity when the real need is for primary care capacity to keep people *out* of the emergency department, or even overbuilding primary care capacity when the real need may be public investment in healthy communities, including in childcare, sidewalks, bike lanes, safe neighborhoods, healthy food, job placement, or a cleaner environment.

The lean approach to identifying the desired state is to identify the *customers* and find out what they value. After all, it is the customers—not the workers—who ultimately define what is value added and what is not value added. A tool for identifying customers and hearing their voices is the customer stakeholder analysis. "Taking a customer perspective, lean determines the value of any given process by distinguishing value adding activities from non-value adding activities."[10] The microsystems methodology further envisions the desired state by articulating the purpose of the microsystem and identifying its desired outcomes, using the 5 Ps template (see Figure 12.1).

Positive deviance offers a unique approach to identifying the desired state. Positive deviance starts by inviting participants to notice when things work particularly well, to recognize that success, and to use that success as a way to build an understanding of the desired state and how to get there. In effect, positive deviance meets Ackoff's criteria for an improvement program that is "directed at what you want—not at what you don't want." Although we saw positive deviance and appreciative inquiry in Chapter 11 as tools for relational interventions, both also have the potential to be used for work process interventions. Indeed, organizational scholars Marguerite Schneider and Curt Lindberg argue that positive deviance is an alternative improvement methodology that avoids a focus on gaps and deficits, providing instead a

strength-based approach with the potential to build high-functioning relationships and unleash creative energy.[11] One study found that high-quality working relationships enabled the success of work process improvement efforts by providing participants with the "psychological capital" to frame resource constraints as a positive challenge rather than a deficit, in effect supporting the positive deviance approach.[12]

Experiment to Close the Gap

Once the current state and the desired state are identified, it is then possible to identify the gap between them, identify solutions or "countermeasures" that might close the gap, and to test those countermeasures to discover their effectiveness. One tool for pulling together these pieces into a single coherent picture to inform the experimental process is the A3. The A3 is a standardized communication tool intended to make it easier for participants in improvement efforts to understand each other. What is important is not the format itself, but rather the process and thinking behind it and the conversations it facilitates. It is intended to foster effective and efficient dialogue among participants, to foster problem-solving communication, encourage frontline initiative, and clarify who is responsible for problems or solutions. A3 helps participants to clarify links between problems, their root causes, and proposed countermeasures.[13]

The A3 asks developers to articulate why a problem they have identified is important to the organization and how it impacts the customer in a negative way. There is relatively brief attention given to envisioning the desired state, in the form of articulating goals. Finally, the A3 asks developers to propose solutions to the deficits that have been identified. Ground rules for presenting an A3 aim at creating a respectful environment for communication—with no interruptions, only clarifying questions permitted, and plenty of time allowed for postpresentation feedback; any needed refinements to be made on the spot. After an A3 has been developed, the experimental cycle Plan/Do/Check/Adjust is used to test and continuously refine the proposed solutions, assessing their impact on closing the gap between the current state and the desired state.

COMBINING WORK PROCESS INTERVENTIONS WITH RELATIONAL INTERVENTIONS

As we review these tools for work process interventions, it is apparent that relational interventions play a critical role in their effective use. Relational interventions can help participants to develop *shared knowledge* or systems thinking, enabling them to better assess the *current state* and even helping them to know who should be involved in assessing the current state. Relational interventions can help to develop *shared goals* among multiple participants including both workers and clients, enabling them to better identify the *desired state.* Relational interventions can also help participants to develop *mutual respect* and *problem-solving communication,* enabling them to identify and test potential solutions through experimentation, to close the gap between the current state and the desired state.

Let's take a closer look at how some change agents have innovated to combine relational and work process interventions in a synergistic way.

Combining Work Process and Relational Interventions at Salus Global

One of the earliest attempts I observed to combine relational and work process interventions emerged in obstetrics. An obstetrician and an obstetrics nurse in Canada—Ken Milne and Nancy Whitelaw—discovered through their work together that relational approaches between care providers and with patients seemed to result in fewer errors, better quality outcomes, less waste, and fewer liability claims. With support from a Canadian insurance association, they formed a consulting practice, called Salus Global, to teach their methods to obstetrics staff throughout Canada. Together with their colleague Margaret Nish, Milne and Whitelaw designed a process to facilitate experimentation and learning by organizations that were seeking to change their dynamics and improve their performance. Milne explained, "At the beginning we didn't know what to call what we were doing, but after reading organizational theory in the late 1990s, I realized we were doing relational coordination."

In the change process they designed, interprofessional improvement teams are formed at the start to take stock and gain insight into how their

relationships and communication impact their performance. Participants identify common themes of shared experiences through narrative, then they use the RC survey to measure their relational coordination. Once they understand the current state of relational and communication dynamics across roles, they set goals and strategize ways to improve their performance that can be tested through a rapid-cycle improvement process in the work place. Next, the successfully tested strategies are implemented by the interprofessional improvement team, and their impact is assessed by re-measuring relational coordination and evaluating the achievement of performance goals. Finally, performance goals at the unit level are linked back to organizational goals.

In one recent engagement, the identified goals for improvement were to establish effective problem-solving communication; to value, understand, and respect each other's role and scope of practice; and to improve the patient-flow process for elective cesarean sections. Multiple strategies were developed by participants, with positive outcomes. Delays in elective cesarean sections were dramatically reduced, and on-time starts improved from 28 percent to 89 percent for obstetricians, from 66 percent to 75 percent for anesthesiologists, and from 38 percent to 75 percent for nurses. Results from a standardized patient satisfaction survey showed an increase in patient satisfaction from 46 percent to 67 percent; and overall RC scores improved on all seven dimensions of relational coordination. Consistent with the Salus approach, senior leadership support had been negotiated as a precondition for this engagement, and the program director was able to lend her credibility, integrity, and mentoring leadership to the process.[14]

Introducing RC as the Soft Side of Lean in the Maine State Government

Another early effort I observed was in the Maine Department of Health and Human Services, where pioneering work was carried out by Walter Lowell and Kelly Grenier through the Office of Lean. Their job was to respond to the many requests for help from employees throughout the department to improve the quality and efficiency of service delivery. According to Lowell, "It was a blame/shame environment when we started. During the training, we started to see the goal alignment, the shared knowledge, and the respect they were developing

for each other. We saw it but didn't know what it was. We realized that when the lean training works, it's because they are changing their relationships in really important ways."

Given its importance to the success of their efforts, Lowell and Grenier wanted to ensure that this relational transformation would happen on a regular basis. They looked to others for insights and, in the summer of 2011, found material that Earl Murman had posted online referring to relational coordination as "the soft side of lean." They learned more by reading *The Southwest Airlines Way*.[15] According to Lowell, "Once we saw relational coordination, we realized it was an integral part of organizational transformation and the lean work we were doing." Figure 12.2 shows how these principles were adapted for Maine state government.

Grenier led the development of a training program for coaches. Coaches learned to use value stream mapping to help participants create shared knowledge, gaining insight into each other's tasks and how those tasks intersected with each other's in the work process. Coaches learned to help participants

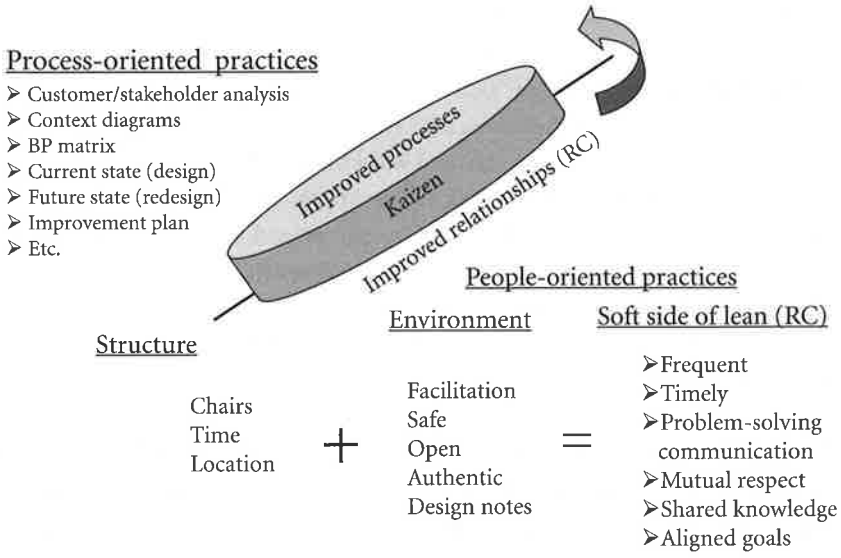


FIGURE 12.2 Introducing relational coordination as the soft side of lean in Maine state government
SOURCE: Walter Lowell.

identify shared goals by asking, "What are we really trying to accomplish here?" Coaches learned how to create a safe space in which respectful interaction and problem-solving communication could occur, without fear of blame or shame. Lowell explained the Office of Lean's overall improvement approach:

> We start all our improvement work with a charter which is developed with the sponsor of the improvement work. The charter is very specific about intent and purpose for the improvement work to be done along with establishing boundaries for the work and targeted outcomes. This is designed to ensure the improvement team has consensus on what the problem is. From an RC perspective, the intent is to establish shared knowledge of the current situation.
>
> The team is then brought together to work on establishing a consensus on the current state of the process we are working on. This usually is the first time an intact work team has ever been ask to document what they actually do. It is during these sessions [that] we see all the RC unfolding—what we called the "soft side of lean." The focal point for the improvement session includes developing the value stream map and teaching the team some new concepts about how work works (i.e., process, flow, waste, value added time, etc.). We use a whole day to develop a value stream map because we want to give the participants tools to be able continue the work once the event is completed.
>
> The RC dynamics are quite obvious during these sessions. It is common for [participants] to say things like "now I know why we can't get things done" or "all this time I thought the problem was me." We emphasize throughout the session that they work in systems/processes, and when these are broken no one can be successful. We want to fix the process, not the people. This is very comforting thought for many because few have ever thought of work from this perspective.
>
> Our lean lab provided a safe place for these discussions, since it was not at their work site. We had them sit in a semicircle so there were no barriers between them, a very deliberate strategy that some initially find uncomfortable but they get over this pretty quickly.

Lowell and Grenier observed transformations in the interactions of those who went through lean training in conjunction with relational coordination training. The combination of relational and work process interventions appeared to be a powerful way to achieve improvements in the work as well as improvement in the ongoing work relationships. Despite the thoughtfulness

of their integrated approach and their attentiveness to creating a safe space, however, Lowell and Grenier did not measure relational coordination or do relational mapping or use other tools to "make visible" the current patterns in a way that could help participants to understand and take responsibility for those patterns. Of greater concern, Lowell and Grenier were not able to engage the leadership of state government in a meaningful way. These challenges ultimately limited the impact and sustainability of their work. Grenier explained, "People can get really discouraged when they go back to work—some say, 'It was a great training'; but within a couple of months, they are back in their old boxes. Nothing has changed to support their new ways of working together."

The major flaw appeared to be quite simple. In addition to lacking some aspects of the relational interventions we learned about in the previous chapter, the change strategy designed by Lowell and Grenier also lacked the structural interventions needed to support sustainability. The structures for how people were hired, trained, rewarded, and measured, and even local structures, such as meetings, conflict resolution, and so on, continued to reinforce the old silos.

For these structural transformations to be possible in the broader context of the Maine state government would ultimately require the support of state leadership. Lowell scheduled meetings with key officials from the governor's office and, at certain points, was optimistic about the potential to win that support. Yet the governor, who had originally supported the Office of Lean, lost an election against a tough and ultimately successful challenger, whose platform called for deep cuts in state government without any investments in process improvement. As Lowell moved on to build similar training programs elsewhere, he reflected on how the early efforts in Maine had fallen short:

> We were never able to engage our senior leaders in this work. Even though they did see us as a useful tool to solve some of their problems, we could not communicate to them the potential larger cultural change that we were seeing in the small groups we worked with. Art Byrne in his recent book *The Lean Turnaround* advocates including the CEO in as many of these improvement events as possible, which I think is the right idea given all the RC dynamics that are taking place and quite visible for them to see. Despite what senior leaders say, most are clueless about what lean means, and RC really does have to be seen to be believed.[16]

Integrating Relational Coordination and Lean at Group Health Cooperative

Now let's consider Group Health's efforts to integrate work process and relational interventions. As we know from Chapter 7, Group Health decided to combine relational coordination with the lean methods they had already introduced. Despite the clear successes Group Health had with lean, its leaders came to see the lack of attention to relationships, including insufficient development of shared knowledge, shared goals, and mutual respect across roles, as limiting lean's impact. They decided to "layer RC on top of lean" by introducing relational coordination methodologies to teams that were already well-trained and experienced in lean methodologies. As they ventured into this experiment, the Group Health leaders thought deeply about and debated and how the primary care teams could use RC and lean together. Internal lean consultant Lindsay Pappas explained:

> One of the things that we've been pondering and thinking about is about the Relational Model of Organizational Change, and what comes first, and how everything's weighted in terms of focusing on relational skill development, or on process development and improving process. And how to fit all those things in. I don't know that they're untangle-able. We've been talking about relational and process interventions in terms of foreground and background, and asking what comes to the foreground at different points and what goes to the background.

To generate ideas, Group Health leaders conducted a brainstorming session to determine how to link the new relational tools to the more familiar lean tools. A broad and diverse group spent two days building an integrated RC/lean toolkit. The leaders who participated represented a spectrum, including clinical leaders, administrative leaders, human resource management leaders, and research leaders from the Group Health Research Institute. Nearly all had participated in the Relational Coordination Intervention Training in the previous two months, and about half had participated in the Relational Coordination Research Roundtable at University of California, Berkeley.

The two-day workshop was led by Pappas and Diane Rawlins, an external organizational development consultant who had worked with Group Health for many years. Unlike the arm's length, quasi-suspicious relationship that

was often observed at the time between organizational development and lean practitioners both in the United States and Europe, Pappas and Rawlins from the start articulated a desire to establish a respectful collaborative relationship. Day One of the RC/Lean Brainstorming Workshop was aimed at building a shared knowledge base within the group. According to Claire Trescott, then the director of primary care, Day One resulted in "more clarity on the common underlying principles of relational coordination and lean—for example, systems thinking and problem-solving rather than blaming communication—and respect for people."

On Day Two the task was to combine relational tools and lean tools. By the end of the day, the flip charts on the walls around the room were filled with multicolor Post-it notes indicating tools—both relational and technical—participants had used previously that had the potential to help interdependent teams build shared goals, shared knowledge, and mutual respect, as well as timely, accurate, and problem-solving communication. The resulting RC/lean toolkit was summarized as follows:

Shared Knowledge

- What it means: the degree to which participants perceive that their work in the focal work process is understood by other workgroups
- Methods:
  - Write and share your own job description with other team members.
    - Step 1: This is what I do.
    - Step 2: This is how what I do relates to what other team members do.
  - What does each person do?
    - Scope of practice
    - Core activities
    - Write down 3 things others don't know I do (invisible work).
  - Role play the work process. Physically simulate.
  - Role clarity. Use RACI (responsible, accountable, consulted, informed) diagrams. Conversation of interdependence. Create a conversation that

helps people know how they affect each other: What is it about how I do my work that helps you do yours? What about how I do my work gets in your way? How could I do my work differently that would help you more?

- Relational mapping
- Work process mapping
- Work shadowing. Go-see, work observation, gemba observation
- Multidisciplinary education events on specific new issues, e.g., opioid exchange
- Cross training. Flexibility to span across boundaries
- Group presentation about how group works as a unit. Act out
- Proof in the pudding. Engage in improvement/innovation work to solve shared problems
- Standard work. Simple, organic, around process, include all roles, don't functionally separate
- Epic electronic health record. Establish norms for interoffice communication, take a week "fast" from Epic communication, determine appropriate medium for different kinds of communication
- Regular measurement and feedback
- Task board in lunch room for people to list their tasks

Shared Goals

- What it means: the degree to which participants perceive that other workgroups share their goals for the focal work process
- Methods:
  - Process for team to establish goals together
    - Have dedicated time as a team to develop goals together
    - Be clear. What are we trying to achieve here? Is there one main goal? Subgoals underneath? Which of the subgoals are shared, and which are unique to certain groups?

  - Team discussion. What are the times when our goals are aligned? When do we seem to be working at cross-purposes?
  - Sticky notes. What are my top 3 goals? What is our team goal?
- Establish patient-centric goals.
  - Set long term goals, reflect on past long term goals
  - Visioning exercise
  - Start with already shared goals (e.g., patient safety) to build mutual respect and shared knowledge.
  - Link goals to triple aim: access/quality/affordability.
  - Time-based goals. Reduce lead time (time from scheduled to seen); reduce non-value-added time (wait time; time lost due to scrap, rework, errors).
  - Make goal/target explicit and visual.
  - Shadow patient through entire visit, spend time in the waiting room listening.
  - Interview patients by phone and in the waiting room.
  - Use existing data to understand patient experience: Yelp comments, Patient Experience Survey comments, Press Ganey
  - Find a way to remember or discover patient goals.
  - Develop common understanding of the patient/customer.
  - Focus groups with specific types of patients, to discover their needs—e.g., single moms or patients over age 75 living at home alone
  - Patient focus groups to identify areas for improvement, shared goals from patient perspective
  - Expanded huddle weekly to discuss complex patients.
  - Team-based patient care conference. Agree on patient goals.
  - Establish self-care/team wellness goals.
  - Design constructive conversations to make these goals explicit.

Mutual Respect

- What it means: the degree to which participants perceive that their work in the focal work process is respected by other workgroups
- Methods:
  - Establish a system of behavioral accountability. Team norms
    - What understandings do you need to have with each other to show up fully, to do your best work, to feel respected?
    - How do we speak up when we see each other violating one of our norms?
    - "Spirit of Improvement" guidelines from Lean
    - Ground Rules / Code of Conduct: What are the trust breakers?
    - "The Pledge"
    - Include participation and listening.
  - Recognize and reward
    - Kudos
    - Formal recognition at team meetings
  - Build on strengths
    - Stories about times when you have felt respected
    - Paint the picture: this is what respect looks and feels like to me.
  - Have interdisciplinary staff meetings.
    - Connect on a personal level.
- Share stories of personal life.
- Spend time together in a morale event.
- Understand each other's personal views.
- Hoopla—guided personal storytelling
- Storytelling, stepping stones
- Conversations about origins: motivators/passion/success
    - Highs/lows. What were the highs and lows for the day/week around patient care?

- Team-defined meeting format, good listening
- Role-specific storytelling, best practices

Timely Communication

- What it means: the degree to which participants perceive that other workgroups communicate in a timely way about the focal work process
- Methods:
  - Conversation of interdependence. What is timely to you? What do you need to know, and when?
  - Norming. What are our agreements about method and urgency of communication?

Accurate Communication

- What it means: the degree to which participants perceive that other workgroups communicate in an accurate way about the focal work process
- Methods:
  - Templated documentation. After establishing what accurate means in a work process establish templated/standard.
  - Communication models:
    - Cone in the box
    - Ladder of inference
    - Heedful interrelating
    - Intention/impact
    - Humble inquiry

Problem-Solving Communication

- What it means: the degree to which participants perceive that other workgroups communicate in a problem-solving rather than a blaming way about the focal work process
- Methods:
  - Establish a method for delivering feedback.

- Agree upon and learn a conflict resolution method—then *use* it.
- End use of electronic health record for avoiding direct conflict
- Peer coaching
- Action/decision logs
- Idea boxes
- Structured team huddles
- Dedicated time for team problem solving
- Use language around RC communication dimensions/challenges in value stream mapping for continuous improvement
- Understand conflict behavior styles and strategies/tools for adapting to people with other styles
- Interest-based negotiation
- PDCA (Plan/Do/Study/Act) problem-solving methodology
- A3 problem-solving methodology

PUTTING THE TOOLS INTO ACTION

At Group Health, lean and RC were relatively easy to combine in practice. The teams in each clinic used lean tools to analyze and improve relational coordination, and then used their newly improved relational coordination to advance, extend, and deepen their process improvement efforts. As the coaches finished their training and took leadership of the improvement work, Pappas moved on to work with teams throughout Group Health and found herself using the lean/RC approach:

> I'm now very attentive to relational coordination when I work with a group where there's a basic lack of mutual respect, for example. But it can be helpful in any improvement project. Here's one example, from Urgent Care and the lab, where we used lean and RC together.
>
> The workshop participants represented frontline staff in Urgent Care as well as the lab. Local leaders of both departments attended as well as the lean coaches. What were our shared goals? Technically, it was "improve throughput" but we talked about it in terms of patient and staff experience and qualitatively

and quantitatively described both the current state—confusing, room for error, unpredictable—and the future state—simple, smooth, clear. To develop shared knowledge, we went to observe work at the frontline. The Urgent Care staff—RNs, unit clerks, techs—walked the lab staff through the Urgent Care department and their methods for sample collection and ordering through result retrieval and action. Then we went to the lab, and the techs walked the Urgent Care staff through their process.

Immediately, improvement ideas started flowing. "You mean if we send you a sample without an order it just sits here?" "Wow, you have to throw out how much blood at the end of the day because it hemolyzed or you never got an order?!" It was low hanging fruit!

We simulated their process using a pen as a stand-in for the sample and a sticky note as a stand in for an order, and used the lean concepts of pull, flow, and take time to question their process. We also brought in a discussion of reciprocity from relational coordination. It turns out this concept is very much in line with pull and flow. If the downstream process does not have what it needs to proceed when it is needed, or if a mistake has been passed on, the outcome of the process is not only at risk but relational aspects are as risk, as well (blaming, trust, lack of respect). After getting clear on the target (shared goals) and the current state (shared knowledge)—the group spent two days "try-storming" some countermeasures. The result was new agreements on standard work that ensured process quality.

At the end, I asked questions I don't typically ask related to sustainability: "Over the past three days, this group, who didn't know each other before, has formed a team and has come to understand each other's work, which set you up to improve your shared processes. The rest of your department did not have that opportunity. How will you bring this back to your teams?" Finally, I asked, "How do you sustain the improvements you just made? What can you do to keep Urgent Care and lab connected despite your departmental divide?" The result they came up with was to have a lab representative attend the Urgent Care huddles on a regular basis and have airtime to share information, give updates, and be seen as part of the team.

In effect, Pappas, Rawlins, and their colleagues had discovered how to combine work process and relational interventions in a fairly seamless way. But they took two additional steps to foster sustainability. First, they coached frontline participants to design and implement their own structural interventions to sustain the improvements they had made. Secondly, from the start,

they engaged frontline and mid-level leadership to gain their understanding and support. There was little mention of top leadership, however, creating concerns about sustainability.

SUMMING UP

These experiences help us to better understand the tools that are available to carry out work process interventions in the Relational Model of Organizational Change. In particular, we can see the potential synergies between relational and work process interventions, how one can support the other, and how one without the other could lead to an unbalanced approach that is either excessively relational (touchy-feely with inadequate connection to the work) or excessively technical (focused on the work but ignoring the relationships through which the work is carried out).

The stories from Maine state government and Group Health raise the issue of how to sustain these new patterns of interaction once they do take hold. In the following chapter, we will consider how structural interventions like shared accountability and rewards, shared protocols, team meetings, boundary spanners, and shared information technology can be used to support and sustain the new relational dynamics. But we will also see that implementing these structures is feasible only once the new relational dynamics have begun to emerge—perhaps the most fundamental insight suggested by the Relational Model of Organizational Change.