TRANSFORMING RELATIONSHIPS FOR HIGH PERFORMANCE

The Power of Relational Coordination

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13 STRUCTURAL INTERVENTIONS TO SUPPORT AND SUSTAIN THE NEW DYNAMICS

Structural interventions are the third type of intervention in the Relational Model of Organizational Change. These are new structures introduced to support and sustain shared goals, shared knowledge, and mutual respect among co-workers, clients, and leaders. Some structural interventions can be introduced locally with the support of frontline leaders, such as new types of team meetings, new protocols to clarify roles and the connections between them, or boundary spanners whose role is to coordinate the work of others. Other structural interventions can be introduced by middle managers in HR or IT, such as hiring and training for teamwork; revising accountability and reward structures; or designing new supervisory roles, shared conflict-resolution practices, and shared information systems. Each intervention may be supported, or even mandated, by internal stakeholders, such as top management or the board of directors, or by external stakeholders, such as suppliers, investors, customers, industry associations, regulators, or policy makers. An intervention may also be *undermined* by internal or external stakeholders if it is seen as threatening or is simply misunderstood.

Some of these structures are familiar from Chapter 5, where they were first introduced. We saw how structures can be designed to support new relational dynamics and key performance outcomes, but we did not explore how they were implemented. It was as though a magic wand had simply called them into existence. We know from the Relational Model of Organizational Change that although these structures can *support* new relational dynamics, they cannot, by themselves, *create* new relational dynamics. When participants' sense of self is defined by the old relational dynamics, new structures will feel unfamiliar,

unwelcome, and awkward. These new structures will often "fall flat" or be rejected, like new shoes that do not fit, and are likely to add problems rather than resolve them. These new structures can be implemented successfully only when participants themselves see the need for them and participate in their design and implementation, having understood the principles of relational coordination, relational coproduction, and relational leadership through their own direct experience.

In this chapter, we explore five structural interventions—shared accountability and rewards, relational job design for boundary spanners, inclusive team meetings, shared protocols, and shared information systems—paying particular attention to how they are designed and implemented by participants who have already begun building shared goals, shared knowledge, and mutual respect among themselves and with their customers and leaders using the relational and work process interventions we learned about in the previous two chapters, thus avoiding the top-down phenomenon of forcing the adoption of new structures that do not fit.

SHARED ACCOUNTABILITY AND REWARDS

One of the most powerful structural interventions in the Relational Model of Organizational Change is shared accountability and rewards. In many industries, accountability and reward structures were traditionally designed to achieve command and control, reinforcing silos by holding managers accountable for key performance indicators specific to their functions, and by failing to counterbalance these functional forms of accountability with broader forms of shared accountability and rewards. Siloed accountability and reward structures have the advantage of enabling top leaders to control subordinates by asking, in effect, "Who's the best here?" People in different parts of the same organization can make each other look good or bad, and siloed accountability and reward structures favor making each other look bad.

As organizations face increasingly complex environments, it has become clear that workers and leaders need to cross internal organizational boundaries to achieve the desired outcomes for customers. But when workers' accountability is to their own functional leaders, they may not feel safe going

beyond their silos. Doing so might jeopardize their careers by making a leader who is in competition with their leader "look good" and their own leader "look bad." I have heard co-workers from United States to Denmark to Japan discuss this challenge and conclude that, to achieve relational coordination, "We need to have the courage to do the right thing," clearly recognizing the risks for their careers. When existing structures of accountability and rewards are siloed, they must be redesigned so that it is not only permissible to connect directly with colleagues in other departments—it's actually valued and rewarded.

In our Part II stories of change, we saw that shared rewards can support efforts to change behaviors. For example, we saw our colleagues in Varde Municipality respond to a new national payment model in which they would be responsible for paying 20 percent of the costs of hospital or physician visits for their citizens. This new reward structure, stemming from the Danish healthcare revolution, was intended to motivate municipalities across Denmark to engage in more proactive efforts to achieve health and wellness in their communities. It worked. But one of the most important steps Varde and other municipalities took was to address fragmented relational dynamics across their agencies. Without those relational interventions, the new reward structure mandated by national policy makers would have been highly divisive, giving rise to blame rather than problem solving.

We saw participants at Dartmouth-Hitchcock and Billings Clinic working to create accountable care organizations in response to a new payment model that stemmed from the Affordable Care Act—a reward structure in which organizations assume responsibility for the cost and quality of care for patient populations in place of the traditional piece-rate payment model. This new shared reward structure was one of the key motivations for the change efforts we observed in Dartmouth's surgical units (Chapter 9). As one of the surgical leaders pointed out, the new reward structure initially created something of an identity crisis for surgeons: "Within surgery, some of the sections are particularly troubled because for the first time ever they're having trouble making budgets. Normally, surgeons are the ones who bring in the bulk of the money for institutions—sort of prized and highly valued and right now they're just expensive." To respond successfully required them to engage in interventions

to begin changing surgeons' relational dynamics with their colleagues, patients and leaders.

I observed the same tension at the University of Washington Regional Heart Center as its leaders began to implement an at-risk contract with the Boeing Company for the heart care needs of Boeing employees and their families. Surgeons who had learned to work successfully within the previous piece-rate reward structure by keeping the operating rooms at full capacity and building new ones when needed, were now hearing about the need to promote population health upstream and prevent readmissions downstream. Some were frustrated with the mixed messages they were receiving during this historic transition to accountable care, and understandably so. Within a relatively short period, however, they transitioned from arguing that there was no point in learning to coordinate better—what they really needed was additional operating-room capacity—to expressing interest in the process of building shared goals and shared knowledge across their healthcare system to respond more effectively to the new reward structure.

At Billings, the orthopedic surgery department had negotiated a payment contract under which they would be paid a "flat fee" by the federal government for the overall care of each patient receiving a joint replacement, covering both hospital and post-hospital costs. The arrangement would reward them for achieving greater coordination not only internally, within the clinic, but also externally, with rehabilitation and home care providers and with patients and their families as well. Surgeons at Billings understood that going forward, they could succeed only by achieving better quality outcomes for the overall patient recovery, at lower costs. They had already streamlined and standardized their internal workflows through a work process intervention based on lean principles, and had already begun to build a relationship with a home care agency that was eager and willing to partner with them. However, they had not yet adequately transformed their internal working relationships, according to orthopedics staff; nor had they fully developed the partnership with the new home care agency or with other external providers. Frontline workers in orthopedics, including nurses, physical therapists, and case managers, then began launching a relational intervention, receiving advice from their

colleagues in the Billings intensive care unit—hoping to bring the orthopedic surgeons on board.

As health systems like Dartmouth-Hitchcock, University of Washington, and Billings moved to adopt shared reward structures, other health systems, such as Group Health and Kaiser Permanente, were already organized around shared rewards. Like all vertically integrated companies, however, these integrated health systems still suffered from some fragmentation among their different components. Kaiser Permanente, for example, was organized regionally, and each region—Southern California, Northern California, Hawaii, the Northwest, Colorado, Georgia, and the Mid-Atlantic states—was responsible for optimizing the quality and minimizing the cost of care for its own members. Relative to other organizations, Kaiser Permanente had achieved a high level of shared accountability and rewards, but the leadership felt they could do better. One frontline leader reported, "At the level of the regions, there was this sense that, 'Well, as long as I make my numbers, I will get my performance bonuses or recognition or whatever.' Then our new CEO determined that 'each of the regional leaders is not going to get his or her rewards unless every region achieves its targets.'" The new shared reward structure was intended to reinforce shared accountability across the regions: "They wanted to promote the notion that we're all here to help each other and not just feel good because we made our own targets." The CEO of Kaiser Permanente was clearly willing to give up the traditional divide and conquer model in favor of shared accountability and shared rewards across the regions in order to meet the demands of the environment.

But some traditional accountability and reward structures still remained in place *within* the Kaiser regions. Ellie Godfrey, a vice president in the Northwest region, realized that the old structures were still influencing the behavior of frontline workers when she began leading efforts to improve the coordination between inpatient and outpatient care.

> When I realized that we had a problem, it was when I was trying to explain to employees why they need to talk each other when they're taking care of the same patient, and one of them said, "But why would I talk to them? They report to a completely different person." So their idea was, given the way the organization

> chart is, Why would you talk to somebody who has a different leader? People are thinking, "I'm accountable for what happens within the purview of my leader." And they are not making this up—they are getting these signals from us as leaders. It's not good for the organization or the patient, but we have to realize we are responsible.

The good news was that through efforts to build relational coordination at the frontline, leaders like Godfrey became aware of the impediments that the existing accountability structures created for coordinated care, and were ready to take responsibility for making the needed changes. According to Godfrey, "We now have staff and physicians from different parts of the delivery system working together and with patients to develop patient centered care plans, agree to main point of contact for the patients, and clarify roles and responsibilities across the system as it relates to coordinated care."

In Varde Municipality (Chapter 8) we heard similar conversations. As municipal leaders reviewed baseline relational coordination survey results in the form of a network map that showed weak ties among many of the workgroups serving the citizens of Varde, the CEO of the municipality reflected:

> This map and the weak ties we see here just reflect the way we have told our employees to work. We are telling them, "You have to go and work and do your job." We think we have told them they should work together, and we think it's the way we do our work as leaders, but if those employees closest to the citizens are still asking, "Does that mean we can call for help from somebody else if we need it?" then we haven't said it enough.

Changing accountability and reward structures feels risky. But it is fairly straightforward. In Varde, leaders began to create shared budgets to strengthen shared goals between areas that needed to coordinate better. At Blue Shield California, chief health officer Marcus Thygeson began to hold his leaders accountable for the level of relational coordination in their teams, in addition to other key outcomes. According to director of training and support Steve Freund, "Leaders used to see relationships as a positive spillover. Now they are starting to see relationships as having positive spillovers." Note, however, that the new accountability structures were not implemented on their own—they were preceded by relational interventions that changed the way leaders understood the work and their role in supporting it.

RELATIONAL JOB DESIGN FOR BOUNDARY SPANNERS

Boundary spanners can also support the three dynamics of relational coordination, coproduction, and leadership. Boundary spanners have the task of creating relational coordination among professionals and at the same time creating relational coproduction with clients—pulling the whole team together to solve the needs of a particular client population and engaging clients as members of the team. We find this boundary spanner role in airlines, in the form of operations agents; in banking, in the form of customer service managers; and in hospitals, in the form of case managers.

In the Windsor Regional Health System, case manager and clinical nurse specialist Alissa Howe Poisson serves as boundary spanner to bring the professions together and ensure that they are "on the same page" regarding the patient's path of care, to avoid confusion and missed signals. One of her key roles is to engage in conflict resolution.

> People do consult with me a lot about conflicts on the unit. Sometimes I coach. And often I will say, "Have you called so-and-so? Have you asked him to help you understand?" I get called several times a day for stuff like that. I think it's about talking to each other in a respectful way. I mean nobody really likes to be questioned about why they're doing the things that they are doing. But when it involves a team, we need to know so that we're on that same page. I can help people solve these conflicts by giving them some resources, but I can't come and solve every problem. When all else fails, then I need to intervene, but I don't need to have those conversations for you. I need to help you learn how to have those conversations.

Going beyond airlines, banks, and hospitals, boundary spanners have been emerging as a critical component in initiatives to build health and wellness in the community, where they are sometimes called "wellness coaches," "health coaches," or "navigators." Our colleagues at Partners Healthcare in Boston, for example, created a new boundary spanner role as a key component of their community-based health and wellness model. "It was incredibly important to convert to a team-based care model," physician leader Sree Chaguturu explained. "[To do this,] we were simultaneously implementing lean operations and cultural transformation."[1] Thus the new boundary

spanner role was created in the context of lean and culture change efforts. In the primary care clinics, experienced nurses were hired and deployed as care managers to work side by side with other primary care professionals and to lead team-based coordination. Each care manager's principal task was to develop a one-on-one relationship with 180 to 200 high-risk patients. They worked with each patient to develop a customized treatment plan and then coordinated the patient's care team. The care team included traditional care providers, such as the primary care provider and the pharmacist. To go upstream and influence the social determinants of health, the team also included nontraditional service providers, such as a mental-health service provider, a social worker, a financial counselor, and a community resource specialist to assist with housing and other social issues. Care managers conducted both home and office visits, educated patients about their treatment and service options, facilitated patient access to services, and helped to train patients in self-management.

At Group Health (Chapter 7) we found medical assistants who were training to become health coaches for patients with obesity. We also saw this role emerging in Varde Municipality as part of an effort to keep citizens healthy and out of the hospital. For these new boundary spanner roles, motivational interviewing has become a critical tool for engaging customers or citizens in the change toward healthier behaviors. As Varde health director Margit Thomsen explained, "It's not enough to say 'do it because I'm a nurse.' It has to connect to something the citizen cares about."

Regardless of the industry, boundary spanner roles tend to be counterproductive when they are added as new structure in a context that lacks the basic relational coordination dynamics. According to Carsten Hornstrup:

> What they do now, when relational coordination is lacking, a lot of organizations put in what we would call boundary spanners, but to me it seems like that just becomes yet another unit. What I find is if relational coordination already works relatively well, boundary spanners can do boundary spanning, but if relational coordination is poor, the others say, "Okay, it's a boundary spanner. Hand off." So you have six of them involved, but only one is taking actual responsibility. The other five take less responsibility. So at a system level, responsibility for boundary spanning deteriorates.

Indeed, we have seen mixed findings in the research on boundary spanning.[2] If relational coordination is at least moderately strong, participants can make good use of boundary spanners who are well-staffed and skilled to facilitate conversations and shared understandings. If relational coordination is too weak, adding boundary spanners can make it worse because participants may use it as a crutch. Starting with relational and work process interventions enables participants to develop a basic level of shared goals and shared knowledge so that they can make effective use of the new boundary spanner role.

INCLUSIVE TEAM MEETINGS

Although team meetings seem to be a relatively straightforward intervention, they are often challenging to implement and sustain. The initial enthusiasm can fade, leaving participants cynical and resistant to further change efforts. According to a physician leader in an East Coast health system, "We implemented bedside rounds, we came up with clear protocols and roles. When everyone was there, it worked well. The issue is getting everyone there at same time. You can't really schedule it. It's been hard to sustain—now it's falling apart and people are feeling cynical."

Why did this effort fail? It appeared that the meetings were introduced in a context that suffered from low levels of relational coordination. The meetings on their own were not capable of creating new relational dynamics. There had been no relational interventions preparing the way to enable participants to use this new structure effectively.

At Windsor Regional Medical Center, by contrast, team meetings were initiated by frontline staff as part of their efforts to improve relational coordination and their work processes, facilitated by Ken Milne and Nancy Whitelaw of Salus Global. Poisson, a case manager and clinical nurse specialist, explained how the team meetings worked:

> Say we have a high-risk patient, where there's a number of specialists involved in their care, and not everybody is communicating as well as they should. We're not really sure initially which direction we are all headed with this patient and what the plan of care should be. It's very upsetting to the patient when their care team

is giving different messages. What are our priorities and which way are we going with this patient because there seems to be a difference of opinion at that time.

I'll usually talk to the physicians and ask, "Can we get a team meeting together?" We then plan a date and time as soon as possible to have a discussion about the care of the patient and get everyone on the same page. Most of the time, nobody is wrong in their ideas for the patient, but they're all coming from a different specialty. It's important to bring all required specialties to the table so they can share their expertise and plan the safest possible care for the patient. So we say, "Everybody, let's bring all of your expertise to the table."

And we have that conversation so that we are giving the same message and not confusing the patient by having different ideas, but we're also providing the best care because we know what each of your perspectives is and why we're moving in that direction, why she's on this medication, why she needs this test.

Although it was part of her role as a boundary spanner to convene and facilitate team meetings, Poisson's strategy suggested that some traditional power dynamics remained. She noted, "I typically like to get the most responsible physician to facilitate that meeting. They're the experts. And to be honest with you, the physicians often take some of those questions and discussions better from one of their physician colleagues than from a nurse colleague."

Nurses typically had valuable input to offer, so a key role for Poisson as boundary spanner was to work through the existing relational dynamics to get the right people to the table and to ensure they understood the value of their contribution. As she explained:

Sometimes the charge nurse is a great resource because she'll ask, "How is this actually going to work on the floor? It sounds like a good idea, but how are we going to make this work?" Sometimes other clinical practice managers will come when the care of the patient crosses their specialty—it's another set of ears, another brain to brainstorm.

So it's just trying to get everybody's expertise to the table to provide the best care for the patient. Sometimes, maybe some of the specialists don't always want to come. I'll just say, "This is what you're doing for the patient. Surely you have some expertise that you can bring to the table because we'd really like to hear it." If that doesn't work I just say, "Look, you do have expertise and we do need you." After that, they don't usually refuse.

It was soon understood that anyone who identified the need for a team meeting could call one. As Poisson's colleagues began to see the usefulness of the meetings, they were more likely to initiate them on their own:

> Sometimes it's the physician who will call and say, "Can you set up this team meeting for this case?" Sometimes it's been one of our charge nurses that says, "Hey, look, this is the situation. Here is what everybody is saying. There seems to be a difference of opinion. Maybe we need to have one of those team meetings again." So the more we have them, the more that kind of happens. People are starting to see that they're useful.

Our colleagues in Varde Municipality described a similar experience. Karin Viuff's job was to initiate and host team meetings when a patient's situation was sufficiently complex that the most efficient solution was to get family members, the citizen, and members of the care team around the same table to share their multiple perspectives—so necessary in order to identify and effectively implement creative solutions. When I first met Viuff, she described the difficulty of persuading colleagues to participate in the meetings. Once baseline relational coordination data had been shared, however, and frontline leaders began engaging in relational coordination and relational leadership training, Viuff observed a change in her colleagues' attitudes. "Now people are calling me up and saying 'we need to meet about Mrs. So-and-So—can you help us to set it up?' Now I can respond to the needs that they see for themselves, and I'm not dragging them to the table so much anymore."

Likewise, at Billings Clinic (Chapter 10), we observed the spread of daily rounds in the intensive care unit. Not all physicians had been holding rounds, and not all physicians who had been holding rounds were leading them effectively from the standpoint of other team members. And yet there was no real avenue for addressing the inadequacy of this structure. Mandates were not believed to be the answer, based on a widespread understanding of the limitations of mandates. Certainly, people might comply and "go through the motions," but that was not seen as sufficient.

Once relational interventions to measure and assess baseline RC data were launched, with conversations about these data in a space that felt safe for learn-

ing and experimentation, participants soon began to address daily rounds. In Chapter 10 we saw physicians asking nurses and other colleagues, "How are my rounds?" and how sometimes the responses were, "Well, not great—they are pretty bad." Recall that the ICU Connections steering committee sponsored an ICU Summit meeting including a fishbowl featuring the physicians who had received the highest ratings from colleagues on the baseline RC survey, who were interviewed publicly about how they conducted their rounds. Recall that physicians who had not previously conducted rounds were able to see the value of rounds from the perspective of their nonphysician colleagues. The relational interventions leveled the playing field and opened up conversations for learning and improvement that had not existed previously, despite the ICU having already been "pretty good at teamwork." And recall the use of positive deviance and contagion rather than top-down authority to foster the redesign of team meetings. As a result of relational interventions that laid the groundwork, participants at Billings redesigned their team meetings, not driven by compliance or fear of reprisal, but driven instead by shared goals, shared knowledge, and mutual respect.

SHARED PROTOCOLS AND ROUTINES

Shared protocols take many forms. At their most effective, they are ways to visualize how the tasks or perspectives or insights of multiple participants are interconnected. At their most effective, they include clear roles for customers as well as workers, and they are used by leaders to support and coach participants in carrying out their interdependent roles.

As we saw at Billings, shared protocols can be useful to guide team meetings and to help ensure that distinct perspectives are heard and incorporated into action. Particularly when traditional patterns of interaction have been dominated by one or two groups, shared protocols can help to reinforce new patterns of interaction. As part of the effort to improve the use of family-centered rounds in the Billings intensive care unit, care manager Sandra Gritz designed the protocol shown in Table 13.1. To welcome continuous feedback and input from users of the protocol, she included a column to the right to invite feedback and suggestions for refinement. Inviting constant input

TABLE 13.1 New protocol for interdisciplinary rounds

ICU Connections

Billings Clinic Intensive Care Unit
Multidisciplinary Rounds Checklist

	Item	Comments	Orders/Plans
MD	Patient's Daily Goal(s) Plan of Care Disposition/Code Status Specific MD Concerns		
RN	Patient's Daily Goal(s) Specific Concerns Quality & Safety: Foley Central Line DVT Prophylaxis Skin Integrity Delirium Pain Control Sedation Holiday		
RT	Ventilator Vent Settings HOB ≥ 30 VAE Prevention Weaning Protocol O2 Needs (NRB/NC/SM) Breathing Treatments Specific RT Concerns		
PT/OT/SLP	Patient's Daily Goal(s) Orders Activity Level Anticipated Discharge Needs Specific Therapy Concerns		
Dietician	Diet Ordered TF Access/Type of TF Residuals TPN Specific Dietary Concerns Nutrition/Diet Education Needs		
Pharmacy	Electrolyte Management Glucose Control IVABX Appropriate Sedation/Analgesia/Paralytics Transition to PO Meds Specific Pharmacy Concerns		
Case Mgt.	Ready for Transfer out of ICU Anticipated Discharge Needs Barriers to Discharge Plans Specific Case Mgt. Concerns		
Family Issues	Family Up to Date Family Conference Social Issues Pastoral Care Palliative Care/Comfort Care Specific Family Concerns Family Journal		

SOURCE: Billings Clinic.

makes the protocol a "living document" and avoids what is often the downfall of protocols—that they are used mindlessly and robotically, rather than as a guide and "jumping off point" for mindful improvisation as the situation emerges.

The Billings Clinic's shared protocol for daily rounds has many features in common with surgical checklists and clinical pathways, including the goal of ensuring that multiple voices have the opportunity to speak up and offer input, and to ensure that key issues are addressed. However, researchers have found contradictory evidence regarding the usefulness of surgical checklists and clinical pathways in fostering relational coordination and improving performance.[3] Why? As we learned at Dartmouth-Hitchcock, some errors, including wrong-site surgeries, had occurred "despite compliance with the checklist and timeout. The issue was a rote completion of the checklist, and there wasn't any communication and feedback." These examples—and the research evidence—suggest that checklists, clinical pathways, and other shared protocols are more effective when there is a baseline level of relational coordination to support their effective use. Just mandating their adoption without first developing new relational dynamics to support their use is a recipe for disappointment.

SHARED INFORMATION SYSTEMS

Finally, information systems are another structure that can be designed to support relational coordination—but often are not. As a physician leader at Indiana University Health noted:

> Our new information systems have made coordination worse, not better. In the past at least we had to wait around for someone to hand us the paper chart, so we might have a little conversation about the patient. Now we're all sitting in front of our screens and we are not talking. And the way it's set up, it's reinforcing our silos, not breaking them down.

Similarly, a leader at Dartmouth-Hitchcock recalled a time when her colleagues were carrying out conflicts via the electronic health record—one would comment negatively on the orders entered by the other, and sometimes reverse

them. "After a while I said, 'You need to talk to each other. Just walk down the hall and have a conversation!'"

Just as we saw with other structural interventions, information systems cannot create positive relational dynamics from scratch. Ann O'Brien, national director for clinical informatics at Kaiser Permanente, pointed out that, in her experience, "Information systems cannot create relational coordination. If you don't have relational coordination, a good information system will not create it. It could make it worse." Emily Barey, director of nursing informatics for Epic Systems, agreed and pointed out that in her experience information systems work better when they are implemented in organizations that have already begun to achieve a level of relational coordination.

In other words, there is a bootstrapping dynamic. You need to be already engaged in building relational coordination in order to know *how* to use a shared information system well. If your relational dynamics are weak, even a well-designed system will likely make them worse, becoming a weapon in the local turf wars rather than a tool for achieving high performance. Moreover, the system is unlikely to be well-designed if it has not been informed by the shared knowledge and shared goals of the participants.

For example, we learned about a workshop that the ICU clinical staff at Billings had organized with their internal information systems experts and an external IT vendor, after working on relational coordination for about a year. According to Curt Lindberg:

> The folks from Cerner [IT vendor] and the IS department at Billings who were there, all told me afterward, "Boy, it's so refreshing to be in a meeting like this when people are actually talking about how we can advance the capabilities for the benefit of patients." Because many times, of course, they're at odds. And sometimes IT and IS are trying to push something that people don't understand. There are some real battles fought out on this turf.

Chief learning officer Carlos Arce noted:

> The ICU staff have done all the work amongst themselves to understand the relational coordination concepts, but that's not what this was about. The workshop was about the electronic medical record. A very practical, real issue. So they were able to not only appreciate the fact that they were meeting with a key

> partner, but their interactions were all done with that sense of appreciation for the timeliness of their communication. The frequency of that communication. How they respect what each other does. All those pieces were in there, but it was all applied and very specific to a real tangible need.

Also key to this change process was the inclusiveness of the workshop and its careful design. The bottom line was that the desired changes were identified with relative ease—as shown in Table 13.2—and largely implemented within a month.

Leadership at the top management level was essential as well. In order to invest time and effort in working with frontline workers, given the constant demands for their time, IT people need to know that coordination and co-production is a strategic priority for the organization and that information-system redesigns will be supported by the accountability structure. As Fred Brodsky at Group Health pointed out in Chapter 7, efforts that lack this clear leadership support end up being wasted investments, in his experience.

> "Garbage in, garbage out" is a common saying about information systems, meaning that the system is only as valuable as the data that people put into it. What we are seeing here is that this is also true from a relational perspective. The relationships that underlie the information that is entered will drive its usefulness. So we need to ask not only whether people understand what is in the information system, but how do they make sense of what's in there and how do they see the value of what's in there? If nurses don't value what physical therapists have to say, or if doctors don't value what nurses have to say, it doesn't matter how well those data are captured or presented in the information system.

Ina Sebastian, of the MIT Center for Information Systems Research, analyzed the use of an information system in a Hawaiian health organization. She created a conceptual mapping between different aspects of the information system and the seven dimensions of relational coordination. She found that

> how people use information systems reflects and maybe even reinforces high or low levels of relationships. The information system I observed offered several potentials for coordination. But clinicians acted on these potentials differently, depending partly on their relationships. For example, the information system provides users with the potential for sharing information with others in a way

TABLE 13.2 Electronic medical record relational coordination workshop

Inputs to workshop

Participating

Chief learning officer	Hospitalist physician
Cerner information systems	Intensivist physician
Billings information systems	Emergency physician
RN, care manager	Pharmacist
RN, information systems	Occupational therapist
Nurse practitioner	Physical therapists
Human resources	Respiratory therapist
Partnership for complex systems	Speech and language therapist
Chaplain	Chief medical officer

Guiding questions

In pairs and then small groups, attendees asked:

- What information does each discipline need from other disciplines to provide superior care of ICU patients, that they are not routinely receiving in a timely manner?
- What information can my discipline offer to the other disciplines to enable them to provide superb care of ICU patients?
- When is this information needed?
- What vehicles can best support these information needs—EMR, personal interaction, or both?

Output of workshop

Unmet information needs	*When needed*	*EMR, personal interaction, or both*
Input on patients and plans from additional specialties (i.e., neurosurgery, cardiovascular surgery, neurology, hospitalists, trauma surgeons) during ICU rounds. It was noted that nurse practitioners and physician assistants could assist in meeting this need. It was also observed that for this to be practical, rounds would need to happen on a more consistent basis.	Daily at set time	Personal interaction
Awareness of each discipline's daily goals for each patient—so goals of all members of ICU team are readily available to everyone.	Every day—as early as possible	Both
Consistent nursing documentation of common elements—easily accessible by all ICU team members.	Daily	EMR
Information on timing of daily schedule of key activities (i.e., surgery, sedation holiday, colonoscopy) for each patient. Also, a process for working through conflicts in schedule.	Ongoing	Both
Order for speaking valve to be communicated to nursing, respiratory therapy, and speech therapy.	As order is placed	EMR

(*continued*)

TABLE 13.2 (*continued*)

Unmet information needs	*When needed*	*EMR, personal interaction, or both*
Clarify expectations about participation by various disciplines (core and optional) daily work rounds and interdisciplinary rounds and daily alerts when rounds are to start.		
Essential information about patients coming from the ED.	Upon transfer	EMR
Essential information from ICU about patients transferred to other units.	Upon transfer	EMR
Knowledge of when sedation holiday will take place and what happens during holiday.	In the morning	Both
Knowledge about when decision is made to move patient to comfort care status—communicated to all disciplines.	When decision is made	Both
Process for identifying and resolving conflicting activity orders (i.e., between nursing and rehab).	When apparent	Both
Accurate height and weight on patients. Is it possible to use standing scales instead of bed scales?	Admission and daily	EMR
Sharing information with patients and family members.	Daily	White board

SOURCE: Billings Clinic.
NOTE: ED, emergency department; EMR, electronic medical record; ICU, intensive care unit; RN, registered nurse.

> that is understandable and includes all necessary details through progress notes. If relationships are on a high level, team members will likely take advantage of these potentials and write a great note. They care if other team members understand how they arrived at their assessment or what exactly happened during the shift. If relationships are on a low level, clinicians may not care to elaborate and really communicate their thought processes to others in a note.[4]

In effect, existing relationships could either enhance or limit users' ability to make use of the information system. Shared goals played a role in how clearly and elaborately participants wrote progress notes. Shared knowledge enabled participants to communicate in a way that would make sense to other disciplines. With high mutual respect, the notes were more likely to be read.

Another colleague found that spatial redesign created conversations that facilitated the success of a new information system. In one unit of the health system, computer terminals were all placed in the same room.

> They're all sitting at different terminals, but they go into the same room to input their data, and so they would have conversations and say, "Well, what do you think about this?" and "What do you think about that?" So they'd be having a conversation as they input their data, and that really made a difference for the quality of what went in because they had already kind of figured out how to put it in.
>
> It helped them use a language in putting in the data that could be understood by others because they already—just by having that little back-and-forth conversation—figured out how to say it in a way that the person gets it. And then you can put it in the system that way rather than just using your own professional language and your own acronyms, all the little things that you do that are just for other physical therapists. If you don't have these conversations, you don't even know how to write it in a way that makes sense to the others. And just being in that same room gives you the feeling that, "Oh, that's a person who actually should be able to read what I'm doing right now, so I've probably not said that very clearly."

People often do not think of entering data in an information system as being an act of communication with other professions. They may think of it as communicating with themselves or with an administrator who has to track data for payment purposes. But they are not thinking, "I'm actually communicating with other professionals working with this client." Being in the same room with the other professionals to enter the data can change their frame of reference. Another way to create this reframing is requiring the notes entered into the information system to be captured as e-mails sent by professionals to one another, clarifying for themselves who is the recipient of their communication. However, these techniques are not likely to work if participants are connected by very low levels of relational coordination, with little sense of shared goals and little understanding of each other's work

Information systems can also transform the client/professional relationship, thus supporting relational coproduction. Client-centered IT solutions are

common in the aviation, banking, finance, and other service-sector industries. Efforts to create patient portals are now common, and there are high hopes for fostering relational coproduction between patients and care teams, as we saw at Group Health.[5] Structural solutions are insufficient to move this work forward. Even well-designed structural interventions are not likely to succeed until relational and work process interventions have built a baseline level of shared goals, shared knowledge, and mutual respect among participants.

SUMMING UP

In the structural interventions explored in this chapter—shared rewards and accountability, boundary spanner roles, team meetings, and shared information systems—we have seen an interesting bootstrapping phenomenon. It appears that these structural interventions can successfully support the new relational dynamics only when introduced into a context when these dynamics have already begun to emerge and take hold, transforming the way people see themselves and their role in the organization. It is not sufficient to create them by mandate. Participants need to have some experience of relational coordination in order to use the new structures effectively.

In order to get timely, accurate, problem-solving communication to occur in team meetings, for example, leaders can foster a relational climate of mutual respect and shared knowledge, while helping participants develop shared goals. When these conditions are not met, staff will not attend or will simply go through the motions. When these conditions are met, team meetings and other structural interventions help to support new relational patterns, changing roles and power relations in a way that lifts up the voice of the customer and distributes information and authority more evenly among the professionals who are there to meet their needs.

As I introduced relational coordination and coproduction to organizational leaders recently, one of them asked, "Doesn't this require not just new structures but also a different way of leading?" The answer is yes. If leaders are not connected among themselves, it is hard for them to role model the need to be bigger than one's own job and the need to think about the whole customer

experience. It is difficult to do cross-functional conflict resolution everyday if top leaders do not reinforce its importance, and if frontline leaders are not rewarded for bringing people together.

The message needed from leaders is that each participant has certain tasks to carry out and certain expertise to bring to bear, but that these tasks should be carried out, and expertise should be deployed in the context of shared goals. Each participant should be bigger than his or her own job. Participants are accountable for their own jobs, but their accountability is bigger than any one job. Leaders should ask themselves, "How can we support new structures that allow the necessary connections to happen on a regular basis, not just through heroic effort?" As Diane Rawlins pointed out in the context of her change work at Group Health, "Normal conversations go a long way—and also the structures that enable those normal conversations. Not just relying on heroism. It can be exhausting if you're trying to work against the structure every day. We're too busy to be asking people to be working uphill every day."

The Relational Model of Organizational Change shown in Figure 6.1 illustrates how the three types of interventions are expected to work together synergistically to support changes in relational dynamics. While the Relational Model of High Performance in Chapter 5 had a one-way arrow between structures and relational dynamics, the Relational Model of Organizational Change features arrows in both directions, showing that structural interventions do not *create* new relational dynamics, but rather are co-created *with* them, in a kind of bootstrapping process. While structural interventions are critical for embedding the new relational dynamics into the roles of co-workers, clients, and leaders, these structures cannot be expected to create the new relational dynamics from scratch.

The Relational Model of Organizational Change reflects a more nuanced, less linear understanding of the change process. Martha Feldman, Steve Barley, Wanda Orlikowski, Leslie Perlow, and other organizational theorists have explored the co-creation of structures and patterns of interrelating. They call this mutually reinforcing process "structuration." While structures are not capable of creating high-quality patterns of communicating and relating on

their own, these structures are needed to sustain those patterns over time by embedding them into our roles and our daily practice, thus preventing the need to continually reinvent the wheel.[6] The Relational Model of Organizational Change simply gives us a more complete picture of how this happens and the essential role that high-quality relationships play in the process.