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**Case Study:**

**Physician Leader Group's (PLG) Team Diagnostic and Performance Improvement Approach**

*Learn how a national provider of acute care medicine solutions transformed one of their Hospitalist Medicine teams through PLG's diagnostic, 5-step approach to improving team performance*

*Summary:*

PLG worked directly with a 26-person Hospitalist care team at a large regional medical center over the course of one year, with the goal of improving the team's working dynamics, performance metrics and rate of turnover. With a 5-Step process, including assessments, in-person working sessions and post-intervention follow-up, PLG was able to help this struggling team to align and recalibrate, and improve team leadership, engagement, communication, and overall dynamics. Improvements in two key performance metrics (patient length of stay and team HCAHP scores), as well as improvements in recruiting and a decrease in team turnover, demonstrated the sustainable impact of the intervention on the team's cohesion and overall performance.

## 1. Introduction:

PLG's client in this case study is a leading organization that partners with hospitals, health plans, physician groups, and post-acute providers for the management of acute episodes of care. They provide physician leadership, clinical process, technology, and analytics to manage clinical and financial performance, and provide services that span the acute care episode: Emergency Medicine, Hospital Medicine, Critical Care, Anesthesia, Physician Advisory Services and Telemedicine.

In this case study, the organization's health system partner was an award-winning 445-bed regional referral center offering a broad spectrum of services that includes diagnostic, medical, surgical and rehabilitative care in both inpatient and outpatient settings. The hospital is the only Level II Trauma Center in the region, and is an essential resource for more than 400,000 residents across two states. A Magnet-designated hospital, they are also an Advanced Primary Stroke Center, Chest Pain Center and Level 4 Epilepsy Center.

## 2. Problem / Challenge:

The client organization had a Hospitalist Medicine team on the ground that consisted of 24 full-time physicians, 2 Clinical Performance Nurses (CPNs) and 1 site coordinator. Organizational leadership recognized that the team was having challenges and decided to bring in PLG to coach the Chief (who

was also acting in a Regional Medical Director capacity) as part of their plan for improving his leadership competency.

What began on the ground as 360 interviews - an initial phase of the coaching engagement with the Chief - quickly became a recognition that the problem was larger and needed to be addressed with the entire Hospitalist team. Initial meetings showed that the team was in a fractured state with extremely limited trust. It was clear that the team was working with a large number of misinterpretations and negative inferences of each other in the group. Moreover, structures existed that further eroded trust, including the unnecessary division of the group into "Team A" and "Team B" (and where, not surprisingly, Team B was considered lower performing). Both groups had retreated into a state of apathy, not wanting to engage with any performance improvement efforts that the Chief was trying to implement. They were struggling to recruit new physicians to the team and relied heavily on locums to provide coverage. The team's lack of trust and negative state had devolved to the point of the team signing and presenting a letter of "no confidence" regarding the Chief to the organization and hospital executive leadership. Patient care was beginning to suffer as the team dynamics worsened and clinician turnover was increasing.

3. **The Solution:**

PLG raised their initial concerns to organizational leadership about the larger team issues, and in collaboration with the Regional Chief Medical Officer and health system executive leaders it was determined that the best course of action would be to work not only with the Chief, but to work with the entire Hospitalist team over a series of months. The client organization sought partnership with PLG in this effort in order to improve the team's performance metrics and rate of turnover by focusing on improving working relationships, building trust, and engaging the team in defining solutions to their unique patient-related and performance-based challenges. A one executive put it, we needed to "walk them back from the ledge".

**PLG's Five Step Approach to Improving Team Performance:**

Over the ensuing 6-months, PLG followed their Five Step Approach to helping the Hospitalist team improve and meet their performance goals. The Five Step is a phased approach, uniquely tailored to meet the needs of each particular team and customized in real-time. It is built on the following process:

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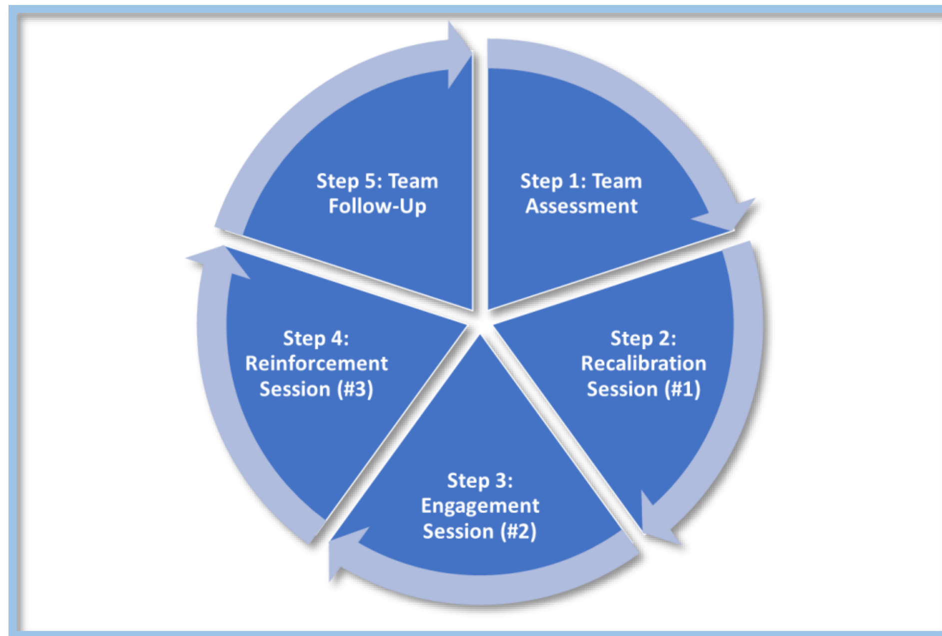
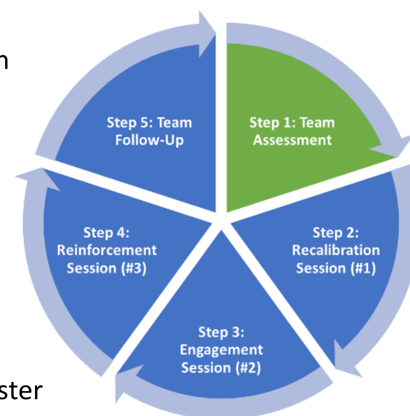



**Step 1: Team Assessment – April/May**




In order to get a comprehensive picture of the team dynamics and areas of particular need, a series of semi-structured interviews were conducted with the entire group. See *Exhibit 1* for samples of the questions asked.

The Assessment phase surfaced significant issues both within the team, and with the team's perception of the Chief's leadership. This was seen in the fact that the team rated the Chief's overall performance at a 4/10 while the Chief rated himself a 7/10, which demonstrated significant gaps in how the team saw him versus how he perceived his own leadership. The team raised specific concerns with the Chief's communication style and approach with different team members, and weaknesses in his ability to foster team cohesion or build and maintain trust on the team.

Conflict was seen as dysfunctional and unproductive on the team, with a lack of psychological safety and some team members fearing retribution for speaking up. There were many unresolved issues both with team leadership as well as among team members (e.g., with shift change punctuality, coverage, and what was seen as a culture of blame), that drove apathy and the feeling that people were "just showing up for a paycheck".

Further, team structures *themselves* created breakdowns in trust, with the unnecessary division between "Team A" and "Team B" stoking feelings of inequity.

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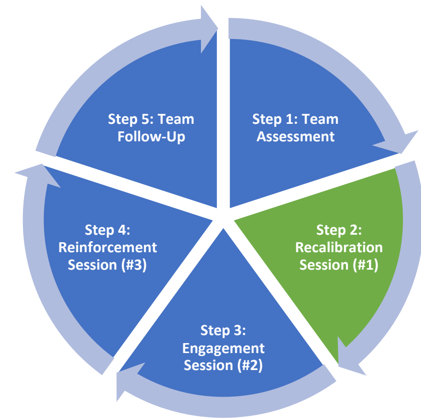
It is important to note, however, is that even with these issues, the team sincerely wanted to make things better. When asked specifically what they wanted to see change, they shared a desire to "work in an environment where things could be addressed in a cohesive, respectful way", where "the artificial divide between team groups would be dismantled", and where they would "be given a great chance to contribute to team solutions". It was obvious that even with the issues they were having, that this was a good team of smart people who wanted to engage.

**Exhibit 1: Sample Team Assessment Questions**

1. What skills/competencies (personal, technical, leadership) do you think the Chief requires to be successful in his role with this team and in this system?
2. How would you rate the overall effectiveness of the Hospitalist team? Are they cohesive? Are they functioning *as* a team? What are the major issues?
3. What are the major obstacles you think the team faces currently? The biggest points of leverage?
4. How does the team handle conflict? Are people willing to step forward and address difficult issues? Does leadership address conflict when it's happening? Is the team effective in dealing with conflict?
5. What does the team need to start – stop – and continue doing at this time to function more effectively?

## Step 2: Recalibration Session (#1) - June




The goal for the initial Recalibration Session was to focus on level-setting with the team and establishing a productive baseline. We wanted to address outstanding (and unvoiced) issues, underlying conflicts, and provide a safe space for the group to come back together around team goals and purpose.

In design, the first session was a 4-hour evening session, conducted off-site. Conducting it away from the hospital was an important detail that many organizations often fail to appreciate. By bringing the team together away from their day-to-day environment, we created a neutral space that allowed the group to feel less guarded and more open to discussion around some of the core problems the group was having. A small subset of the organization's regional leaders also attended in order to show the team their support, including the Regional CMO, the Geographic VP of Operations and the Regional Director of Operations.

The goal of the first session was clear – to clarify and agree on the most challenging team issues, to reorient the team to their shared purpose, to help them see the value of each other as *complementary* (versus adversarial) colleagues, and to build alignment around their goals and the approach to their important work as Hospitalists.

The evening was tailored and structured around some very specific to-dos. Firstly, it was important to share the feedback the team gave as part of the assessment, and we did this in an anonymous, collective manner. Team members found this transparency both humbling and validating, in that it illuminated team blind spots *and* showed team members that they were not alone in their feelings about particular issues.

It was also very important that the Chief acknowledge the negative feedback about his performance from the team, and to demonstrate his sincere willingness to make personal change. After that, we could begin the real work of the session, which focused on:

1. Discussing how teams get stuck in dysfunction and how trust can get rebuilt (by exploring the perceptions, assumptions and behaviors that can build or destroy trust in the group)
2. Having the team come back to baseline on their shared purpose and why they were all there
3. Having the team define, agree on and prioritize their top 3-5 critical issues or challenges that they were facing at that time
4. Having the team get a better understanding of each other's working style and communication approach by exploring how their behavioral style impacts their working relationships
5. Having the team create working agreements for how they wanted to work together going forward
6. Having a clear definition and agreement on next steps – i.e.,
    i. The key challenges the team wanted to address first and how decisions would be made
    ii. How the team wanted to proceed and by when, and who needed to be involved

See *Exhibit 2* for an overview of the team's shared definition of purpose and their prioritized top challenges created conjointly during the Recalibration Session.

**Exhibit 2: Recalibration Session - Team Purpose and Top Challenges**

| Hospitalist Team Purpose – Why Are We Here? | Top Challenges for the Team (Prioritized)? |
|---|---|
| *"To create a practice where we (the physicians) want to come to work, feel like we're doing meaningful work, and ensure continued access to care in a supportive environment."* | #1: Interpersonal communication<br>#2: Avoidance of conflict (and capacity to deal with conflict)<br>#3: Fear of repercussions for speaking out<br><br>Other Team Challenges Identified:<br>• Team divisions / "factions"<br>• Poor consultant response<br>• Getting information from transfers<br>• Lack of recognition of unique differences<br>• Low morale / positivity<br>• Problems with punctuality<br>• Low transparency and low psychological safety<br>• Limited view of the big picture |

The team members participated fully in open discussion during the session. In this safe environment people felt free to surface longstanding issues and talk them out in a productive way. Energy was high and the team asked to meet again in 3 months. *Exhibit 3* shows a brief overview of the working agreements and next steps that the group identified.

The Chief took the extra step of committing to the team what he called his own "personal pledges". These were specifically "to stop owning all decisions", "to slow down and listen more", "to follow-through more effectively, and "to instill a sense of fairness and inclusiveness among ALL team members". His pledges were received positively by the team and his effort was acknowledged. Surprisingly, one of the physicians who was extremely guarded and considered the most problematic in the group, approached our facilitator at the end of the session and gave her a hug of gratitude.

**Exhibit 3: Team's Defined Agreements and Next Steps from the Recalibration Session**

1. "Commit to moving FORWARD"
2. "Strive for open communication: have the courage and promote a safe environment to have one-on-one dialogue between team members"
3. "Schedule follow-up special team meeting in 3 months"

***Outcomes from the Recalibration Session:***

The team immediately began demonstrating improved functioning after the Recalibration Session. The Chief continued in his efforts to make personal change, as illustrated in his move from a "top down" team meeting structure (where he would talk and they would listen), to putting items on the next meeting agenda that were much more inclusive of the concerns of the team – e.g., time for a discussion of peoples' key takeaways from the Recalibration Session, whether the session started to change the tone, and what they wanted to cover at the next session, a discussion on how to stay informed and promote transparency in the team, and how he, as Chief, could increase the level of support the team feels. Team members reported feeling more respected and listened to by leadership. They began spending more time in the common room and the atmosphere in the shared office space lightened considerably. Humor returned. Within a few weeks one senior level executive commented via email that after years of dysfunction they were *"amazed at how quickly the team is learning, growing and evolving".*

The team was briefly polled two months after the Recalibration Session, to get a pulse of how things were progressing and to prepare for the next session. The responses were largely positive. While it was noted that there were still issues within the team, it was generally felt by the group that the trajectory of the team's function was going in the right direction. See *Exhibit 4* for an overview of the team's survey responses. The honest commentary from team members allowed leadership to recognize that while progress was being made, there was still more work to be done.

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**Exhibit 4: Hospitalist Team's Responses to the August Survey**

**Q1: Since our June team session, have things changed in a positive way?**

- **58%** said "Yes, absolutely – things feel much better"
- **47%** said "Yes, somewhat, but we still have issues"
- **0%** said "No, things haven't changed for the better"

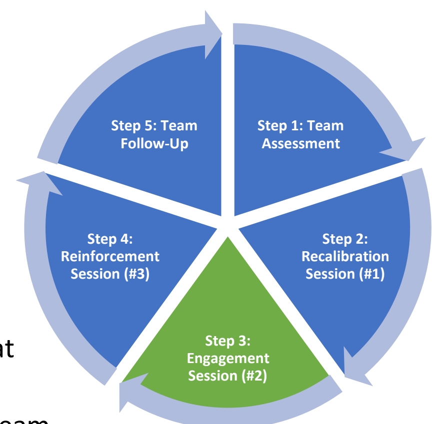
**Q2: Currently, how well do you feel the team is functioning as a whole?**

- **92%** of the team said either "**Very well** (we're really starting to feel like one cohesive team)" or "**Somewhat well** (the barriers between groups seem to be reducing but we still have work to do)"
- **8%** said "**Poorly** (individuals are trying to make efforts but as a whole the group hasn't bought into the idea of one, cohesive team)"
- **0%** said "**Not at all** (nothing has changed)"

**Team member additional comments:**

- "I feel there has been a change in attitude and openness towards problem-solving… Leadership has been more open to hearing other opinions"
- "There has been better and more communication all around. I feel that the opinions of the team matter more now and their input is valued. As a team we are still a work in progress, but things are definitely much better"
- "Seems like there is more positivity (at times), but there are still underlying issues that are problematic"
- "While the dialogues are happening between groups and among team members, we are far from functioning as a whole. Safety remains a major barrier to constructive conversations"
- "Overall team dynamics are much better but we are still functioning as two teams instead of one, possibly due to lingering personal interaction issues …. But giving everyone a voice at the table has gotten much better"
- "There is more interaction between all staff, and some team members are now eating together!"
- "I notice people are taking the initiative to create a better work environment and avoid conflicts"
- "Overall, the environment seems to be more positive and the team members appear to be more relaxed, open and engaged"

## Step 3: Engagement Session (#2) - September




A second, 4-hour session was conducted with the team in September with the goal of maintaining the positive momentum and engaging the team members directly in addressing real-time challenges and priorities. The session was again conducted off-site in the evening, and 100% of the team members who were invited came and participated.

This session was tailored and structured to the needs of the group at that time. We began by reviewing feedback received from the pulse survey about current team functioning/environment and addressing what the team

wanted to get out of the Engagement Session. Following that, we spent time reviewing the Team Agreements and Next Steps created in the June Session and reflecting on current status of the team, asking *How Are We Doing?* This created an open space for people to safely discuss any new or residual issues.

We then had the team define and agree on:

a. Their priorities as a Hospitalist team at that time
b. Their team's overall goals
c. The results they were aiming to achieve as a team and why

See *Exhibit 5* for an overview of the priorities, goals and results the team defined together during the session.

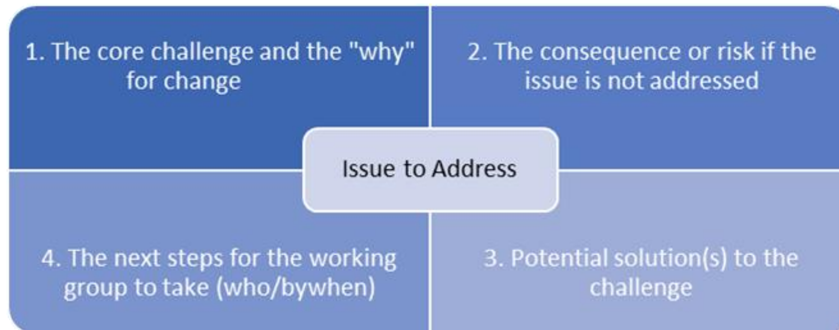
**Exhibit 5: Team Priorities, Goals and Desired Results**

| Team PRIORITIES identified: | Team GOALS identified: | Team RESULTS desired: |
|---|---|---|
| **#1:**<br>A healthy, cohesive working environment<br>**#2**:<br>Continued team development and focus on communication<br>**#3:**<br>Improved team trust<br><br>*Other Priorities Identified:*<br><br>• Overall improvement in patient care (metrics)<br>• Improved collegiality<br>• Best care in the nation | **#1:**<br>Promote a better lifestyle for team members<br>**#2:**<br>Continued open and effective communication and team unity<br>**#3:**<br>Being a strong and cohesive team<br><br>*Other Goals Identified:*<br><br>• Be the top performing team within the Region<br>• Optimize communication between Physicians/RNs/Consultants<br>• Practice standardization<br>• Team initiative and responsibility<br>• Team retention | **#1:**<br>Efficiency, Excellence, and Team Accountability<br>**#2:**<br>The Best Patient Care<br>**#3:**<br>A Healthy and Happy Team<br><br>*Other Results Identified:*<br><br>• Decreased cost<br>• Improved metrics<br>• Optimization of patient experience and outcomes |

After that, we had the group break into working groups to tackle the real-time challenges that they had identified and prioritized in the Recalibration Session in June – for this team the particular challenges were:

1. *Team measurement and results*
2. *Team engagement and involvement*
3. *Group norms*

During the session activity each working group had to discuss, identify and share with the larger team four key components of their challenge – these were:




See *Exhibit 6* for the team's answers to these components drafted during the session.

To ensure follow-up, the Chief and the team agreed specifically on how each working group would continue working on their challenge, how they would implement their next steps, and how progress would be measured.

We ended the Engagement Session by focusing on the core team goal of enhanced communication. Each person identified three immediate changes in communication or behavior that they personally would make. We then had them draft their "one thing" statement – i.e., "To build my communication and contribute positively to our team overall, the ONE immediate behavioral change that I will commit to is _______, so that I can improve ________ in our team's working environment". Examples of team members' "one thing" commitments included:

> "I will commit to *checking myself before I make an assumption about someone's intention*, so that I can improve *trust* in our team's working environment"
>
> "I will commit to *being on-time for shift change*, so that I can improve *feelings of equity* in our team's working environment"

The session ended on a positive note, with team members feeling energized and empowered by their ability to tackle challenges in ways they'd been previously excluded from. They left with renewed momentum and commitment to the team.

**Exhibit 6: Working Group Issues / Component Overview**

| Sub-Team / Discussion Points | Core Challenge / Why for Change | Consequence / Risk of Not Addressing Challenge | Potential Solution | Next Steps |
|---|---|---|---|---|
| **Team Measurement and Results:** *Is the way that we are currently being measured (i.e., individual scorecards, annual performance evaluations) as effective, efficient and meaningful as it needs to be for us? What is working and not working? How do we (as a team) measure ourselves in order to get closer to the results we seek?* | Our current measurement structure is effective but with too many limitations | We don't improve as clinicians | Educate others | Have a team discussion on how to improve commitment and accountability to metrics |
| **Team Engagement:** *What are the most important areas for team engagement /involvement? Where do we need to all be at the table? How do we best structure ourselves to facilitate engagement of our entire team, not just select team members?* | We need value and respect, participation and optimism; continued structured meetings (w/ punctuality, participation and acceptance ... show up!) | Disengagement and apathy | Include a survey (ask team); Diplomacy; Help team value different opinions; Build mutual accountability; Use constructive criticism | Discuss how to solve issues of our voices being heard and accountability to each other |
| **Group Norms:** *Does the current Group Norms document meet our needs? Do we need one? How do we define and agree on Group Norms?* | Current norms are a work in progress; we do need a norms document and it needs to be a collaboration between the team/org/hospital | Variations | Revise Group Norms to include everyone' input and agreement | Discuss group norms document in team meeting; steering committee and voting |

***Outcomes from Engagement Session (#2):***

The leadership's enthusiasm for the results of the Engagement Session were evident in the Chief's follow-up email to the team: "What an evening last night! What a display of intellect, humility, passion for patient care, and commitment to better communication and individual accountability. What a team! It was nothing short of inspiring. It was an evening to remember."

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In the following months, PLG continued to coach the Chief in order to build his capacity to help the team make the incremental change required to meet their goals. Each working group continued to engage, meet and work on their challenge areas, with initial conclusions being offered by each of them within the following 1-2 months. Each working group assigned themselves a physician lead who was then tasked with providing the structure, setting up the meetings and giving updates to the larger team via email and regular team meetings. Each working group engaged with their hospital partners and organizational leadership as necessary, to answer critical questions and/or gain buy-in. The participating physicians spent dedicated time out of their very busy schedules to tackle these challenges that they knew were weighing on the team. *Exhibit 7* outlines some of the initial conclusions that the working groups shared as part of their improvement efforts.

**Exhibit 7: Working Group Output – Initial Conclusions by Group**

| Working Group | Initial Conclusions: |
|---|---|
| **1. Team Measurement and Results** | Metrics discussed: HCAP scores, LOS, F:D ratio, CMI, EDD, ACP coding, readmission, and WRVU<br><br>Initial conclusions included:<br>1. "We focused on the EDD metric and a decision that this was the most meaningful metric that truly reflects physician performance, that it would now (and in the future) help the workflow for the nursing staff and hospital, as well as physicians"<br><br>2. "That EDD is a metric that the team has traditionally failed in and unanimously felt that this should be one of the meaningful metrics that all physicians try to improve and score in the 80%ile range"<br><br>3. "Also discussed HCAPs but felt this is subjective and does not add much to physicians' individual performance; however, it does have validity for the group as a whole, but should be removed from the individual scorecards"<br><br>4. "LOS, F:D ratio, readmissions and CMI are considered meaningful metrics, albeit not perfect, and should be charted on a quarterly basis and then noted for yearly trend" |
| **2. Team Engagement** | 1. "There is an opportunity for improvements with the **sign-off / hand-off procedures** at the end of each physician's work day – we have the idea to use the reporting area in EPIC in order for off-going physician to write a few lines for the oncoming physician to see (which would be different and not a permanent part of the patient's medical record)"<br><br>2. "Cross-communication can be enhanced by **team education /presentations** – setting a day aside each week for team members to present a topic for discussion, such as:<br>    1. New treatments<br>    2. Difficult or unusual patient cases<br>    3. New information for diagnoses<br>    4. Changes in standards of care"<br><br>3. "Collaboration can be enhanced by the **development of a "learning culture"**, supported by:<br>    1. Creating an environment focused on learning, not blaming, and without risk of retribution<br>    2. Building a safe team space for open discussion of patient issues, concerns, and misdiagnoses<br>    3. Creating a collegial environment where the team could learn from each other's experiences in a safe and cooperative environment<br>    4. Creating an environment that reinforces that we are one team working as a whole rather than as individual practitioners" |

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**Exhibit 5: Working Group Output – Initial Conclusions *(continued)***

| Sub-Team | Initial Conclusions: |
|---|---|
| **3. Group Norms** | 1. Behavior changes – while small – were recognized to need time to change and that some issues (e.g., punctuality) would be more challenging to resolve with the group<br>2. Key elements of **Clinical Expectations** discussed included:<br>a. Rounding/Day Shift<br>b. Discharging<br>c. Admitting<br>d. Consulting<br>e. End of shift transition<br>f. Swing shift / Night shift<br>3. Other key elements of **Non-Clinical Expectations** discussed included:<br>a. Team meeting attendance and participation<br>b. Scheduling rotations, posting and changes<br>c. Committee attendance and participation<br>d. Individual performance metrics and incentives |

The team's performance metrics tracked during this period reflected the team's improving cohesion and performance. Between July and October, the team saw an **overall improvement of 13% in their HCAHPS**, a measure of overall patient satisfaction. Their overall Length of Stay metric began trending downward as well. The **improvement in LOS** metrics was celebrated with the team, with the Chief sending an email that shared his enthusiasm for their hard work: *"I cannot contain myself and have to let you know that we knocked our LOS down to below 4 days (3.85 days). My goal for the end of year LOS was originally 4.5. I couldn't believe it when I heard this number. I cannot be more proud of our team who has been working really hard on this."*

**Step 4: Reinforcement Session - December**

The team came back together after another three months for a year-end Reinforcement Session. The goal of this session was to provide a space for team members to reflect, discuss the progress that they were making, problem-solve new and residual issues together, and demonstrate gratitude for the efforts of their teammates over the past year. Within a 3-hour evening session conducted on-site at the hospital, the session began with a reflection back on team's defined purpose and how well the group felt they were living that purpose. Recognizing that some conflicts had arisen over the months in between sessions, we continued with a structured discussion on how to get to healthy conflict and tools for conflict resolution. *Exhibit 8* below shows the team's brainstorm regarding how to see conflict as a potential positive for the team.

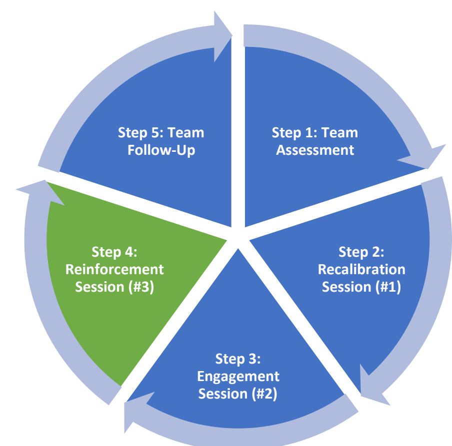

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**Exhibit 8: How to Move Towards Healthy Conflict on the Team**

| As a team, how can we define conflict in a positive way? | What are some potential positive outcomes of conflict on our team? |
| --- | --- |
| See it as:<br>• Solutions<br>• Challenge<br>• Opportunities for greater understanding!<br>• Actionable feedback<br>• Breakthrough<br>• Meeting of different opinions<br>• Opening of our minds | • Improvement<br>• Showing respect for each other's ideas<br>• Learning about – and from – each other<br>• Greater resolution<br>• Greater tolerance / acceptance of each other's differences<br>• Greater flexibility<br>• Better opportunities for innovation<br>• Team initiative and responsibility<br>• Team retention |

After our conversation around healthy conflict, we did a facilitated group exercise on "Looking Back to Move Forward" – i.e., we had the team define their 'lessons learned' from the past year and we gained alignment on how to move forward into the new year. The team actively engaged in this lively discussion, and *Exhibit 9* illustrates what the team collaboratively created.

**Exhibit 9: "Looking Back to Move Forward" Exercise**

As part of the overall reflection back on the year, the team identified a number of "Lessons Learned" from their year of working on team dynamics and overall performance.

Firstly, on what DIDN'T go well:

| What DIDN'T go well for our team this past year? | What did we learn? | What can we do differently as we go into next year? |
| --- | --- | --- |
| • Significant "relapse" to old behaviors in some team members<br>• Conflict avoidance<br>• Inability to have the one-on-one conversations to address issues that we committed to in June | **What did we learn?**<br>• We discovered that trust is delicate and gets broken very easily<br>• That our own behaviors truly affect others<br>• That we must reprioritize the team's needs in real time<br>• That trust is a challenge (but worth it)<br>• That relapse begets relapse<br>• That positive team behavior takes intentional effort | • Commit to ONE personal change going forward<br>• Ask each other for feedback and share personal vulnerabilities<br>• Extend trust to each other |

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**Exhibit 9: "Looking Back to Move Forward" Exercise *(continued)***

Secondly, lessons learned from what DID go well:

| What success stories reflected how our team has GROWN this past year? | The ONE THING our team did best? | Our team's proudest moment? |
|---|---|---|
| • The degree of effort and participation in our team's development<br>• We got better at assuming people's intentions were positive<br>• We got much better at thinking as a TEAM – more collaboration<br>• Improvements in swing shift!<br>• A shift in mindset towards teaming<br>• A more Hospitalist-friendly environment within our hospital | • Improved communication – more open, more attentive<br>• Our openness to developing ourselves and our team<br>• Our level of engagement in the process<br>• Our improved clinical quality! | • Our willingness to share our feelings and thoughts for improvement<br>• The fact that our people show up!<br>• How we've rallied around team members in their times of need – how we came together to have each other's backs |

And third, things they wanted to commit to as a team moving forward:

| Looking forward, what challenges will our team face this coming year? | What do we want our team to achieve MORE of this year? | What will each of us do individually to help the team? |
|---|---|---|
| • Increased workload in the short-term<br>• Losing team members<br>• Pressure to standardize our workflow further<br>• Continued rapid change<br>• Increased need for resilience | • Greater experimentation as a team – finding things that work<br>• Re-evaluation of things as we go – real-time improvement<br>• More advocacy and voice for the Hospitalists<br>• Opening of more doors with our Health System partners<br>• Continued relationship building<br>• Continued sensitivity to costs and embracing of fiscal accountability<br>• Continued focus on and improvement of our Joy of Work! | • Give each other the benefit of the doubt<br>• Volunteer to help out<br>• Be flexible<br>• Take leadership opportunities when they arise<br>• Continue to build trust with each other:<br>    ○ PAUSE… challenge your own assumptions about somebody's motives or reasons for doing something … ASK instead<br>    ○ Always assume positive intent! |

Following the team reflection, we conducted a group gratitude exercise to allow teammates to identify and share what they were grateful for regarding individual team members and regarding the team as a whole. This created a much-needed space for teammates to acknowledge the efforts of every single person on the team, and to give their gift of thanks to one another. This was a powerful way for the group to level-set, focus on what was most important to them, and create an environment of cohesion as they moved forward together.

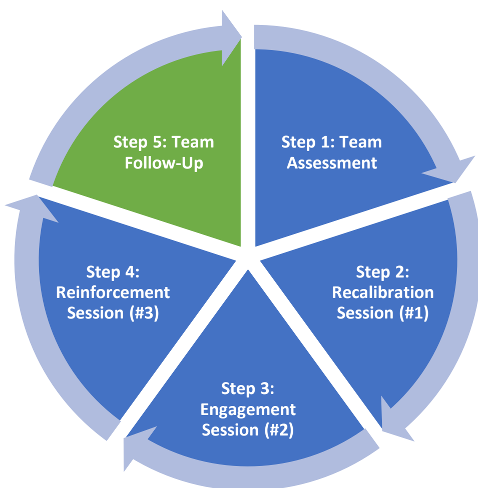
As before, the team actively participated in the Reinforcement Session and appreciated the ability to recognize people for their efforts in what had been an incredibly difficult year. Team cohesion was palpable, and new members of the team felt very favorably about the group that they were joining.

***Outcomes from Reinforcement Session:***

The team ended the year on a positive note, with a better sense of collaboration and team wellbeing. The group was performing well and functioning more effectively.

Their improved team functioning strengthened their ability to deal with two major crises that beset them in the New Year: a sudden, life-threatening diagnosis for one of the team leaders, and the onset of the COVID-19 pandemic. The team was able to mobilize quickly to address each of these challenges and come together in support of one another. Together they came up with the idea of supporting their diagnosed colleague with a modified leadership role that took him out of direct patient care but helped him maintain his income as he weathered his illness. Moreover, the team rallied behind one another during the early days of the lockdowns and pandemic anxiety and fatigue. Even throughout the strain of COVID, the team continued to get positive input from their hospital partners, as exemplified in this unsolicited email to the Chief from one of the Physician Directors of the hospital's Surgical Services: *"I participate in Leader Rounds with Case Management. The case manager on oncology today spoke very highly of your group of hospitalists. She said they're 'extremely helpful' and 'awesome'. You should be proud."*

## Step 5: Team Follow Up – 6-Months Post




**Re-Evaluation Data (@ 6-Months Post)**

PLG conducted a survey follow-up in June the following year (2020), at 6-months post intervention and 3-months into the pandemic. When asked to rate their team's overall functioning (in terms of environment, team cohesion, collaboration and/or performance) **68%** of the team rated it **as an 8/10 or higher** (with 40% rating it a 9/10 or a 10 /10), *even with the stress of the pandemic*. On a 4-point scale, the highest ratings were given to relationships between team members (3.9), overall "attitude" of the team (3.7), team cohesion and collaboration (3.6), and sharing of ideas (3.6). See *Exhibit 10* for the team's reasons for their positive ratings.

**Exhibit 10: Reasons Given for Positive Ratings of the Team's Current Functioning**

- "A core group of the team has taken a greater active role in educating and leading discussions"
- "We work well as a team now, discuss patient cases, working to improve LOS, ACP, CMI and we are sharing more as a group"
- "Since I started working with this team last August, they have been amazing. They are hard-working and dedicated physicians and I really appreciate the team work and camaraderie amongst us"
- The "team" is working great together, morale is great and there is great cohesiveness in this difficult time"
- "Team members are all very cohesive and work tirelessly to provide quality care"
- "Excellent team dynamics - great group of people to work with"
- "We are working well together; cohesion is at an all-time high. We have some small communication issues to continue to work on such as patient guided communication between weeks, but overall, much improved"

Further, the team was queried about improvements that they had seen as a *result* of the team development efforts we had done over the prior year, and their answers were candid and revealing, citing everything from improved team communication for critical care delivery issues, to the ability to simply share their thoughts within the group. See ***Exhibit 11*** *for* a sampling of their responses.

**Exhibit 11: Improvements Shared as a Result of PLG's Team Development Efforts**

- "Factions have gone away. Much more of a true team"
- "We have improved cohesion"
- "Better team communication and working together to decrease LOS and improve handoff communication"
- "Stronger team cohesiveness and group effort to improve and adapt to changes that can positively impact patient care and at the same time metrics and goals"
- "Overall, team members are trying to work together"
- "We are a strong and cohesive team that has a great increase in our morale.
- "Much better communication"
- "We genuinely enjoy working with each other"
- "Team cohesion, respect, ability to share thoughts between team members has greatly improved"
- "The team becomes more cohesive and more transparent and comfortable among each other"
- "The resolve and comradeship of physicians has intensified towards a common goal"

**Long-term Impact of the Intervention**

While there were obvious improvements in team functioning, morale, and target performance measures from the shared development work, there was also another side to the story, which unfortunately, is all too common in teams such as this.

As the group's culture began to shift and they became more cohesive and higher performing, their improvement also began to highlight members of the team that acted as "outliers". These were individuals who either could not, or would not, change their behavior in service of the team's bigger goals. As the team improved, these team members began to get more and more marginalized, until it became clear that their negative influence could no longer be tolerated. One team member self-selected to leave, and the other was asked to leave. This change further improved the group's overall communication and teaming ability.

Surprisingly (but inevitably), one of the other outliers included the Chief, whose behavior and lack of leadership skill in the beginning had been the original reason why PLG was brought in. While he had made great strides in his development and made strong initial efforts in his own growth, he had slowly started to regress in his behavior. His leadership had started to degrade over the course of the Fall and Winter as demands from his organization increased. His team's confidence in him began to slip as he started to demonstrate old behaviors, largely driven by his feeling of pressure to perform and his belief that the team "wasn't making progress quickly enough". He grew increasingly impatient with what he saw as a lack of progress. Moreover, he became embedded in his own narrative that he was "the only one trying" to make change, which fueled his slip back into autocratic behaviors once more. He began to tell the team what to do in a condescending fashion, to dismiss the importance of maintaining psychological safety within the group, and to take actions that were contradictory (and undermining) to his words of support. He stopped listening to his team, and he stopped listening to his coach.

Over the course of a few months, and leading into one of the most difficult times that the team had experienced, the Chief seriously lost the confidence and trust from his team. This loss was magnified by the feeling in the group that they had given him a chance and extended him trust as they worked on their team dynamics, but that his regression back to old behaviors made it "worse than if he had never changed at all".

The team itself continued to support each other and perform during this time, but they felt that their success was *in spite* of the Chief, not because of his leadership. Unfortunately, the team's high performance only reinforced the Chief's belief that he had to be "harder" on his team, because he felt the metrics reflected the effectiveness of his approach.

By June of 2020, the team had lost all confidence in the Chief. While the polling conducted by PLG that month had shown very favorable ratings and comments about the team's functioning (see *Exhibits 10* and *11*), it also showed that they were very unhappy with the Chief's leadership. See *Exhibit 12* below for some of their comments from the survey.

**Exhibit 12: Comments about the Chief's Leadership – June 2020**

- "[The Chief's] level of effectiveness increased for several months following our initial discussions, though previous trends have again emerged"
- "There is no transparency or consideration for the team and our goals"
- "I would say that he is worse. It is impossible to work with him"
- "Although he attempted some improvement after coaching and feedback regarding the leadership issue in the beginning, this did not last long, and he's reverted back to his previous style, which is problematic"
- "There was an initial appearance of change in the first months, but this quickly evaporated and grew worse. I was reprimanded for being too critical. He failed to continue to pursue several goals of our meetings with [PLG]… for example, formation of norms was one goal and he abandoned it completely without any implementation of changes"
- "There may be psychological safety among the team, but not because leadership has fostered this"
- "By any measure, [the Chief] has failed to be a leader to the team that fosters team spirit for better outcome. Whatever positive outcome one can see in the team is the result of individual's and team's effort, *despite* his poor leadership"

At this point, the team had decided they could take no more, and once again wrote and escalated a letter of no confidence against the Chief. This blindsided the Chief, as his narrow focus on the team's positive performance metrics had not allowed him to see the bigger picture of what was happening amongst the team members. He failed to recognize (and be able to advocate around) the fact that the kind of change he was seeking from his team was appropriately taking time*, and* that the improvements were happening because of the team's ability to manage themselves, not because of his leadership. *At* that time, the decision was made to remove the Chief from his leadership role, due to the "loss of confidence of his team". The Chief not only left his role, but he left the health system, one that he had been at for almost 10 years.

**A Change in Leadership**

A new Chief was transitioned in who demonstrated a much more inclusive and collaborative leadership style. With his guidance and with the group's strong cohesion, the team's performance elevated higher, even during the very difficult days of the pandemic.

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In fact, the team continued to pull together, and with greater cohesion and leadership they went on to win a number of clinical awards by the end of 2020. In their organization's region with $150M top line revenue, 40 hospital sites and over 600 physicians, this Hospitalist team went on to win:

1. Region's **Most Improved Clinical Performance Score** (18.9% improvement)
2. Region's **Highest Ranking Clinical Performance Score**
3. Region's **Most Improved HCAHPS** (8.3% improvement)
4. Region's **Most Improved Length of Stay** (O/E .22 improvement)

**Key Learnings from this Case Study**

There are a number of important things we can glean from the work done with the Hospitalist team and the results they were able to achieve. Here are the top 3 learnings:

**Learning #1: Make it Safe**

This case study highlights the critical need to **address a team's unspoken issues and provide a safe space** for people to surface conflict. It is important that organizations invest in their teams, even those that seem fractured or beyond repair. As this team demonstrated, when people feel heard, included, and valued can they begin to move forward towards solutions collaboratively. Only when the unspoken issues are aired and worked through in a psychologically safe environment, can the team move towards making change.

Amy Edmonson, a Harvard researcher whose work around building 'fearless organizations' created the concept of psychological safety, says that in teams it is: *"A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes…it is not a personality difference but rather a feature of the workplace that leaders can and must help create." (Amy Edmonson, 2019)*

The results in this case demonstrate how critical psychological safety is in building team performance. Only when the members of the team feel that they can be candid with each other, that they can engage in conflict in a healthy way, and when they're not afraid of negative consequences for speaking up, can a team begin to thrive as this one did. It can be almost impossible for a team to achieve its goals without this foundational element. The team's identified goal in this case – to create a practice where the team members wanted to come to work, where they felt like they were doing meaningful work, and where they could ensure continued access to care in a supportive environment - would not have been possible without a meaningful degree of psychological safety and trust that was demonstrated in words and actions.

**Learning #2: Reframe Leadership**

As this case clearly demonstrates, leaders at all levels have to really know themselves and the mindset that they bring into their role. In the rapid change pace of the current healthcare environment, clinician leaders *more than ever* have to carry the servant leader attitude. They **must recognize that the goal is**

**not for them to be leading the charge at all times, but to enable their clinician teams to self-lead and engage in mutual accountability for meeting their shared goals**. For some leaders, this takes an intentional reframing of what they think leaders are and should be. It takes the ability to step back and enable others to both take the lead and contribute to the decisions being made in a meaningful way.

Moreover, it has been well-known for many years in the practice of change management that the **most effective way to get people to make the change you seek is to engage them in creating the solutions they're being asked to follow**. Leaders need to also be intentional in this process, by not only saying that they are interested in hearing from their teams, but taking actions to demonstrate that fact. They need to practice a visibly inclusive form of team leadership, where peoples' points of view are listened to and valued, and where they are called to contribute with their experience and expertise in defining the changes to be made. When people feel like they can be architects of the change they are being asked to make, and when they feel that they too can be leaders in their team, we see greater levels of engagement and sustainability. In this case, when the team began to be engaged in prioritizing and addressing their biggest challenges was when meaningful change began to occur. And as this case also shows, teams may sometimes become better leaders than the individuals that are positioned in the formal role.

**Learning #3: Make the Difficult Decisions that Support a Healthy Culture**

As this case showed, there are times when it is necessary to make the difficult decision to remove people who are hampering team development and growth. As a group's goals become clearer, the **team itself needs to collaboratively decide what the ground rules are for the greater good of the team.** And as such**,** team members who are not willing, or do not make sufficient effort to follow the ground rules or make change, may need to be counseled out. On the flip side, those team members who are willing, and *do* make the effort, need to be acknowledged and their motivation needs to be maintained. Organization and team leaders themselves need to be the accept the reality that they are owners of the team's culture – they set the tone and reinforce the norms of behavior that support greater psychological safety and team function.

**How to Apply This to Your Team or Organization?**

To understand where your own clinical team(s) may fall in the spectrum of high- to low-functioning, and whether or not they would benefit from a team intervention such as this, ask yourself the following to assess the level of safety in your group:

- Do people on your clinical teams feel able to bring up problems and tough issues with each other?
- Do they feel safe to take risks?
- Do they find it easy or difficult to ask other members of their team for help?
- Do they feel others would deliberately act in a way that could undermine their efforts?
- Do they feel that mistakes are held against people?

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- Do people reject others for being "different" in any way?
- Do people feel that their unique skills and talents are valued and utilized?

Additionally, consider whether:

- The team is functioning optimally - *or are there consistent or chronic complaints and issues that haven't been addressed adequately?*
- The culture is healthy - *or do people tend to blame each other for low performance?*
- The clinical team's metrics (LOS, readmission, patient satisfaction) are where you want or need them to be – *or are there "human factors" that are getting in the way of improving those?*
- Your clinical team is adequately resourced – *or are they struggling with high turnover and/or extensive use of locums?*
- The people on your team seem happy, energetic and like they enjoy their work together– *or is there a high level of stress, interpersonal conflict, and/or process breakdowns that cannot be explained by usual care delivery stressors?*

**For more information, or to schedule a complementary consultation about your organization's needs, contact:**

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***Physician Leader Group (PLG) is a multidisciplinary coaching and consulting group dedicated to building effective physician leaders that can engage with their colleagues to drive change.***

*Through Physician Executive Coaching, Leader and Team Development, and Physician Leadership Strategy and Program Development and Delivery, PLG works with physicians, their teams, and their organizations to build the skills required to be effective within their unique culture and environment. We help physicians be as successful as leaders as they are as clinicians, and equip them with the skills to drive the results that directly benefit the patients and communities they serve.*