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CHAPTER 14

Coaching Healthcare Teams to Improved Performance

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INTRODUCTION

In 2008, avoidable medical injuries cost the US economy $80 billion (Shreve et al. 2010). Eighty percent of medical errors are caused by stress, poor communication, multitasking, and physical and emotional fatigue (Leonard and Tarrant 2001). The complexity of patient care demands effective communication and collaboration between team members to minimize error and maximize quality and safety. The potential for error remains high until people are clear about the tasks they must complete and the way they should be performed (Spear 2005).

Disruptive behavior in care delivery teams commonly occurs (Rosenstein and O'Daniel 2005). Breakdowns in communication and poorly managed conflict drive suboptimal team performance and undermine the quality and safety of patient care (Weinberg et al. 2007). Although a few people who engage in unprofessional conduct receive inordinate attention from hospital leaders (Weber 2004), we also need to focus on improving team performance. This chapter describes how a hospital transformed a poorly functioning

cardiothoracic (CT) surgery unit into a cohesive, high-per forming team with improved patient outcomes.

CASE PRESENTATION

Overview

California Medical Center's1 hear t surgery program was a center of excellence. However, ongoing disputes between its two surgeons were threatening its reputation. Referring cardiologists had grown dissatisfied with the lack of communication and collaboration between the two CT surgeons, particularly in the postoperative care of their patients. Referrals began to decline.

Team Challenges

The chief of staff was planning to refer one of the CT surgeons, "Dr. Smith," to a program for physicians with disruptive behavior because Dr. Smith frequently yelled at staff, refused to respond to pages in a timely fashion, and told nurses, "That's not my patient; call 'Dr. Jones' and stop bothering me!" Dr. Smith yelled whenever he had to repeat something, shouting, "Is ever ybody listening to me? I'm only going to say this once! Don't call me later with a dumb question I've already answered!"

The CT team, OR, and ICU staff split into camps based on the surgeon they preferred. Team members avoided Dr. Smith, calling him "Dr. A-hole" behind his back. As a birthday gift, team members were given the day off from working with Dr. Smith. Dr. Jones chose to ignore Dr. Smith's behavior and work independently, which led to disjointed, confusing work orders for the staff, a lack of collaboration among team members, and low morale.

Dr. Smith refused to par ticipate in discussions about team complaints. He told the hospital CEO and chief of staff that he was not

the sole problem and highlighted other team issues. Six nurses and OR technologists quit, and more were threatening to leave.

The hospital had already spent more than $5 million to release a previous surgeon from his contract and pay severance to nurses and OR staff. The hospital CEO realized that the only way to stop this downward spiral was to challenge the CT team to improve its dynamics. The hospital needed to involve team members, not just the surgeons, at every level.

The Call to Action

The CEO and the chief of staff felt that firing Dr. Smith was not an option because clinical outcomes did not warrant revoking his hospital privileges and reporting him to the state medical board. Instead, they decided to invest in developing Dr. Smith's capabilities as a CT team leader.

The CEO brought in our consulting team comprising a physician, an executive coach, a psychologist, and a group facilitator to work with the CT team. Dr. Smith agreed to participate in the intervention because he believed that his perception of the team's issues would be validated. The goal of the intervention was to deal with chronic difficulties in the group, restore the reputation of the heart program, and build the CT group into a high-functioning team.

The Program for Improvement

The improvement program included three phases:

Phase I: Assessment

Over a period of five weeks, we confidentially interviewed each member of the CT team, including the two surgeons, CEO, chief of staff, and chief nursing officer. We used a structured interview format (see Key Concepts 14.1) to give participants an opportunity

Key Concepts 14.1: Structured Interview Used in the Assessment Phase

Part I: Assess Individuals' Perception of the Problem

Ask:

- How would you describe the difficulties the CT team is having?
- What do you think the problem is?
- Can you give us an example or tell us a story to illustrate the problem?
- What is your understanding of why we (consultants/coaches) were called in to work with your team?

Part II: Invite Individuals to Offer Ideas for a Solution

Ask:

- What do you think needs to happen to remedy these problems?
- Who do you think needs to change?
- What would be the best way to approach the problem and solve it?
- What would improve your satisfaction on the CT team?

Part III: Determine Congruencies and Incongruencies Among Team Members

- Identify gaps in team members' perceptions and attitudes.
- Highlight areas of misperception that may be root causes of team dysfunction.

to share their obser vations and express their concerns. The assessment also included a review of job descriptions, incident reports, clinical outcomes measures, and staff turnover data and direct observation of the CT team. In summary, the assessment revealed

- a disconnected group of outstanding professionals struggling to maintain a sense of cohesiveness and purpose in a sea of miscommunication and conflict;

- frequent and turbulent changes due to staff turnover and dissent, which had destabilized the team and impaired recruitment and retention;
- a workplace culture fostering blame and gossip and staff divided into surgeon camps;
- unresolved feelings about past events manifested in hostile and negative behaviors;
- ineffective communication and inadequate policies and procedures that were increasing exposure to medical errors (exemplified by different standing orders from the two surgeons, differences in how patients were handed off to the ICU, different types of information required by surgeons from the ICU night staff, and different roles and responsibilities for the physician assistants, depending on the surgeon they were covering);
- unclear roles and responsibilities among nursing staff and a lack of collaboration and cooperation between the CT team, OR, and ICU staff, which had divided the nursing staff and was contributing to suboptimal continuity of care;
- both surgeons' inability to communicate effectively, including an inability to manage conflict, despite their leadership position within the CT team; and
- inadequate knowledge and skills among CT nurses due to lack of training and education, which were prompting complaints from the surgeons.

Phase II: Intervention

Presentation of the assessment results to the hospital leadership team induced a sense of urgency to address the problems. The CEO and executive team, directors of the OR and ICU, and the two CT surgeons participated in a 12-week leadership development program, which is summarized in Key Concepts 14.2. We coached each surgeon for six months to address behavioral problems and support use of the leadership and communication skills they were learning. During a full-day retreat with the entire 32-person CT team (including the

Key Concepts 14.2: Leadership Development Overview

The following topics were the core concepts taught in the Leadership Development course:

- Identifying and learning effective leadership styles (Goleman, Boyatzis, and McKee 2002):
  1. Commanding: Soothes fears by giving clear direction in an emergency, but because so often misused, can be highly negative (when appropriate: in a crisis, to kick-start a turnaround, or with problem employees)
  2. Pacesetting: Meets challenging and exciting goals, but can be highly negative when poorly executed (when appropriate: to garner high-quality results from a motivated and competent team)
  3. Democratic: Values people's input and secures commitment through participation (when appropriate: to build buy-in or consensus or to obtain valuable input from employees)
  4. Affiliative: Creates harmony by connecting people to each other (when appropriate: to heal rifts in a team, motivate during stressful times, or strengthen connections)
  5. Coaching: Connects what a person wants with the organization's goals (when appropriate: to help employees improve performance by building long-term capabilities)
  6. Visionary: Moves people toward shared dreams (when *appropriate: when changes necessitate a new vision or when clear direction is needed)*
- Understanding temperament and learning styles (e.g., using the Myers-Briggs Type Indicator to identify different personality styles and how they work together)
- Learning characteristics of high-performing teams (e.g., high levels of trust, interdependency, and collaboration)

- Leading with emotional intelligence (i.e., strategies for skill building in self-awareness, self-management, social awareness, and relationship management)
- Strategies for building high-performing teams and leading **change (i.e., using awareness of self and others to establish trust, maintaining consistency and transparency, walking the talk, and using these skills to stimulate action)**
- Leadership communication (i.e., communicating strategically with the right information, to the right people, at the right time, and in the right amount)

surgeons, OR and ICU nursing staff, hospital CEO, OR director, ICU director, and chief of nursing), we performed a SWOT (strengths, weaknesses, opportunities, and threats) analysis and engaged the team in developing a shared vision for patient care, with goals, strategies, and target dates. Strategic planning efforts focused on seven issues: (1) developing physician leadership capacity, (2) improving team communication, (3) establishing a common mission and vision, (4) improving CT team education, (5) revising protocols and standardizing orders to develop a seamless process of patient care, (6) developing a staff recruitment and retention plan, and (7) integrating community cardiologists. Project teams comprising the surgeons and CT staff members were formed to move initiatives forward.

Using Coaching to Build Skills Engaging these angry and distrustful professionals required many conversations. Through coaching, we helped members of the CT team identify their individual challenges and develop a strategy for improvement. Team members attended a 15-hour course on communication and conflict management skills over a ten-week period (see Key Concepts 14.3). The team developed social contracts to establish ground rules and foster team cohesiveness. We helped team members build greater self-awareness and

Key Concepts 14.3: Key Takeaways of the Conflict and Communication Workshops

Establishment of Communication Guidelines
CT staff developed a social contract including ground rules unique to the team. They summarized their agreement in writing, signed it, and posted the guidelines in common staff areas:

- No gossiping.
- Communicate respectfully (defined as using a moderate tone of voice, no yelling, no name-calling, no sarcasm, and no demeaning comments).
- If you have an issue with someone, address that person directly without running to someone else or to that person's supervisor.
- No matter what your position or role on the team, you have a right to confront anyone with whom you have an issue.
- If the issue is not dealt with respectfully or if reasonable attempts to resolve the issue are unsuccessful, you may involve your supervisor.
- Conflict resolution must occur away from patients and families.
- Express appreciation for each other to foster a positive work climate.

improve empathy and teamwork. When team members had negative, unresolved feelings, they expressed them in individual coaching sessions, after which we facilitated apologies to help team members move for ward.

Culmination of the Inter vention Phase Another full-day retreat wrapped up the intervention phase. The CT team assessed progress, celebrated successes, and continued with strategic planning. Team-building exercises focused on helping the group understand and

respect the complementar y skill sets each member brought to the team. We tasked team members with process improvement projects focused on the following areas:

- Communication Project Team: responsible for orienting new team members to communication guidelines
- Educational Project Team comprising the CT surgeons, the chief of nursing, and the head of ICU: charged with supporting the CT nurses and developing their skills and conducting brief, daily rounds
- Policy and Protocols Project Team: charged with creating a standardized process for patient handoff from the OR to the ICU, identifying ways the surgeons could collaborate with each other to provide direction for the CT team, and clarifying roles and responsibilities

Phase III: Maintenance

The purpose of the final phase was to ensure sustained team progress. Members held each other accountable by following the communication guidelines listed in Key Concepts 14.3. Drop-in coaching and consultation were offered to all CT staff. This support provided a confidential forum in which team members could address concerns, receive immediate feedback, and integrate skills learned in phase II to work through specific challenges. At a final retreat, the CT team identified ways that they could sustain changes and came up with a set of 13 suggestions (see Key Concepts 14.4).

Intervention Outcomes

For two years following the intervention, communication between the physicians and other CT staff members and teamwork improved. Staff recruitment and retention also improved, from approximately 19 percent staff turnover and zero hires in the two years pre-intervention to 0 percent turnover and 12 hires in the three years

Key Concepts 14.4: Suggested Ways of Sustaining Positive Changes Made Post-Intervention

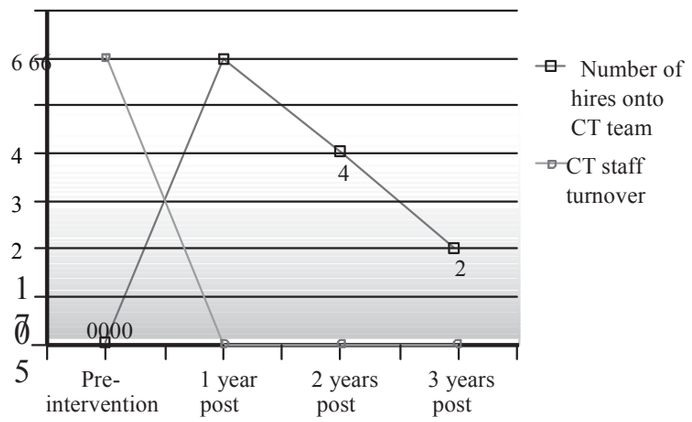
The members of the CT team developed the following suggestions collaboratively:

1. Take personal responsibility.
2. Maintain open communication and follow established guidelines.
3. Orient new CT team members to CT expectations and culture.
4. Standardize protocols through teaching and orientation.
5. Remain open to each other's views.
6. Offer each other help and emotional support.
7. Be genuine.
8. Expand opportunities for the nursing staff.
9. Make sure that the program data (collected as part of a national data collection system) are shared and celebrated.
10. Sponsor social events to build rapport and celebrate successes.
11. Provide staff with mentoring opportunities.
12. Be courageous and assertive.
13. Maintain channels of communication and conflict resolution.

post-intervention (see Exhibit 14.1). By maintaining the CT team's controllable turnover at 0 percent for three years post-intervention, the organization estimated it would save $1 million. Loss of a nurse costs the organization about twice a nurse's annual salary (Hunt 2009), which, at an average of $63,000 (source: payscale.com), would cost the hospital $126,000 per nurse turnover. It costs approximately $330,000 on average to recruit and retain one physician (Hawkins 2009).

While patient acuity remained unchanged, the team's observed mortality (operative) dropped from 3.6 percent pre-intervention to 1.9 percent post-intervention and remained at 1.5 percent and

Exhibit 14.1 CT Team Turnover Pre- and Post-Intervention



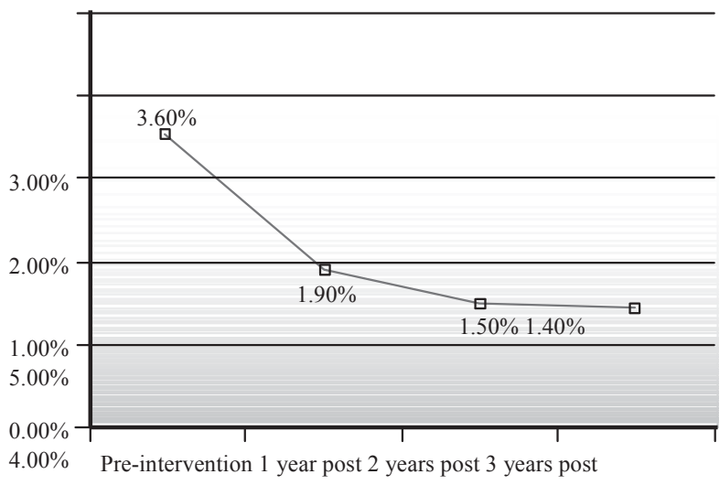
1.4 percent for the next two years, respectively (see Exhibit 14.2). Given the number of operations performed by the CT team over this time (an average of 187 per year), an estimated 12 lives were saved. These data align with study results that show that high-functioning teams with low staff turnover have lower rates of risk-adjusted mortality (Wheelan, Burchill, and Tilin 2003; VHA Center for Research and Innovation 2002).

The work environment and team morale also improved. Both surgeons gave monthly lunch-and-learn presentations to nursing staff and community cardiologists. Nurses felt more supported and valued, and the physicians had fewer complaints.

An Internal Executive Champions the Change

Over time, a lack of implementation of the communication guidelines, coupled with a lack of unit direction to sustain the momentum and hold CT team members accountable, caused old behaviors to

Exhibit 14.2 CT Team Observed Mortality Rate (Operative) Pre- and Post-Intervention



reemerge and the project teams to break down. This time around, however, the executive leadership team had the tools to handle conflict before it affected employee morale and clinical outcomes.

A Catalyst for Change

An event occurred in the OR that created a burning platform for change (Kotter 1995). A series of procedural errors, coupled with disrespectful behavior from the surgeons, broke down communication and teamwork during a difficult case. Although the patient survived, the errors in the case became an example of how miscommunication and poor problem solving in times of stress are a risk to patient care.

The chief of nursing saw an opportunity to address the breakdown. She worked with the two surgeons and OR director to understand the reasons underlying their complaints about the OR staff. When the chief of nursing proposed firing the entire OR staff, both surgeons recanted many of their complaints and focused on

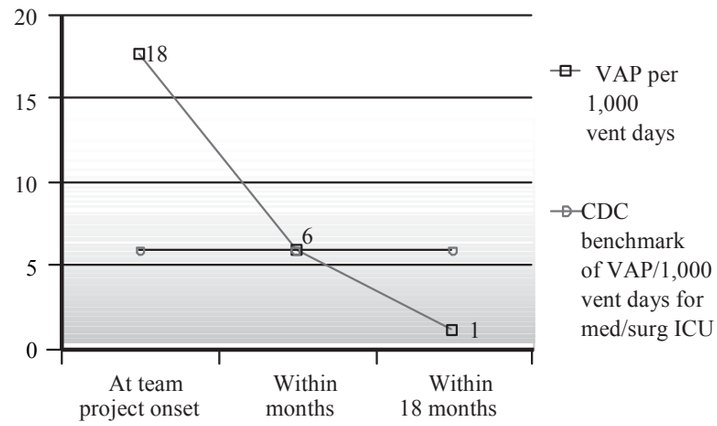
identifying the low performers. The nursing leaders built an alliance with the surgeons based on problem solving and process improvement strategies. By collaborating with nursing leaders, the surgeons changed their perspective that the entire team was incompetent and developed an appreciation for members of the OR staff.

The chief of nursing did an internal audit to explore the breakdowns. She discovered areas where critical information was not shared and processes failed due to poor communication. Through a series of structured meetings, she shared the results of her audit with the CT team members. From these meetings, they realized that effective team functioning and high-quality patient care depended on the knowledge and skills of all team members. They focused on mitigating mistakes through effective communication and shared knowledge. The CT team made changes in the OR to ensure that the entire team was aligned during the course of a case. For example, rather than rely on one person's pen-and-paper notes, the team tracked instruments and sponges on a whiteboard. The chief nursing officer identified process improvement projects for the team, and the surgeons facilitated monthly meetings to share progress, align the team, and make course corrections, as needed.

Improved Effectiveness

Team effectiveness improved after this intervention. The OR staff, CT surgeons, and ICU and OR directors attend every meeting and report back to the group for input and feedback. The chief of nursing also attends the meetings to implement important decisions in real time. Clinically, no significant negative events affecting patient care have occurred in the 12 months since the CT team pulled together and began meeting regularly to implement procedural changes. Obser ved patient mortality (operative) remains 1.4 percent. Communication and information sharing between team members in the OR has become more streamlined, and their ability to respond to issues and solve problems as a team has improved as well. Once a daily occurrence, the surgeons no longer complain

Exhibit 14.3 Rate of Ventilator-Associated Pneumonia (VAP) per 1,000 Ventilator Days in the ICU



about the OR staff. Dr. Smith's angr y outbursts have subsided significantly. Team morale has also improved.

Extension to the ICU

The rate of ventilator-associated pneumonia (VAP) in the ICU was three times the benchmark rate for a med/surg ICU set by the Centers for Disease Control and Prevention (CDC). Seeing an opportunity to replicate the CT interventions in the ICU, the ICU director engaged her staff in project-based problem solving to reduce the VAP rate. She mobilized the ICU team with a shared goal and put the team in control. She assigned projects, provided the ICU staff with the resources they needed, empowered them to make decisions, and then got out of their way. Within 12 months, the ICU team reduced the VAP rate from 18.65 percent (18 cases of VAP per 1,000 ventilator days) to the CDC benchmark rate of 4.96 percent (6 cases of VAP per 1,000 ventilator days) (Edwards et al. 2008). Within 18 months, the rate dropped further, to 1 case of VAP per 1,000 ventilator days, where it has remained (see Exhibit 14.3). Because the number of ICU

Key Concepts 14.5: Tips for Successful Team Performance

1. Trust your team, and gain your team's trust.
   - Gain your team's trust by walking the talk of management and demonstrating that you have clinical and operational credibility when you are intervening in a particular area.
   - Trust your team by empowering team members. Ensure that they have what they need to do the job, and then let them do it.
2. Don't assume that you recognize the complex dynamics in dysfunctional teams.
   - Fully investigate issues and do not make assumptions.
   - Good strategy involves splitting a team into groups and having them work separately on projects to determine who is influencing the team.
   - Address the issues head-on.
3. Don't underestimate the power of team-building projects.
   - Align your teams by assigning them a common goal that matters to them and giving them control over it.
   - The best way to build teams is to engage and inspire them in what they do.
   - Encourage team members to communicate and resolve conflict as a means of achieving their goal.

patients on ventilators increased during this time (from 311 to 423), the drop in the rate of VAPs represented a 96 percent improvement. At an approximate $12,500 cost to the hospital per incident and an average of 4.3 days added to a patient's length of stay (Warren et al. 2003), this intervention saved an estimated $1.6 million.

Extension to the Organization

The chief of nursing has rolled out similar programs for team effectiveness in other groups in the organization. Her top three tips for success are detailed in Key Concepts 14.5. In 2011, she carried

leadership development efforts even further by creating a Nursing Leadership Academy for the organization.

The hospital recently won national recognition as a "Top 25 Place to Work." The execution of leadership development efforts at all levels of the organization is a large contributor to its success.

CASE ANALYSIS

The story of the CT team is important because it is not unique. Lack of effective teamwork in healthcare has been identified as a leading source of adverse/poor clinical outcomes, staff turnover, and decreased ability to provide reliable care (Baker et al. 2005; Rosenstein, Russell, and Lauve 2002; Rosenstein and O'Daniel 2005; Frankel, Leonard, and Denham 2006). For these reasons, healthcare practitioners from all disciplines must be able to work together effectively in teams (Lucian Leape Institute 2010; Joint Commission 2008).

Team-related issues—disrespect, lack of role clarity, lack of trust and collaboration, and poor communication—are the primary factors that drive nurse turnover (Hunt 2009). Recent data suggest that every 1 percent of turnover reduced saves direct costs of $250,000 and indirect costs of $500,000 (Betbeze 2010).

While nurse turnover has been connected to negative clinical outcomes, such as increased mortality (Rosenstein and O'Daniel 2005), higher nurse engagement that comes from effective teaming has been connected to higher levels of patient satisfaction (Bacon and Mark 2009). Investing in care delivery teams' effectiveness is a win-win-win for frontline professionals, for healthcare organizations, and most important, for patients.

Developing High-Functioning Care Delivery Teams

Although many healthcare executives understand the need for better teamwork in their organizations, many do not know how to achieve

the end goal of high performance. To develop high-functioning teams, leaders must recognize and act on problems to help healthcare professionals learn to work more interdependently. Leaders also need to visibly support their efforts and ensure that team training opportunities are integrated into organizational strategic planning.

The ten steps listed in Exhibit 14.4 are an overview of ways healthcare leaders can address existing issues and help their teams build the core competencies required for high performance.

CONCLUSION

Healthcare leaders know that the true currency of their organization is their ability to improve clinical outcomes by creating cultures that make quality and patient safety their highest priority. To accomplish this goal, they must integrate training in effective teamwork and communication into all aspects of healthcare organizations (Joint Commission 2008). Hospitals must address the human factors that contribute to failures in patient safety and increased healthcare costs rather than focus only on protocols, policies, and procedures. Improved team performance is within the grasp of every healthcare organization.

LESSONS LEARNED

- Quality of care is rooted in the competency of healthcare providers, their relationships with one another, and optimal team performance.
- Performance improvement and cost management are directly connected to the effectiveness of healthcare teams.
- High team performance coupled with effective operating systems creates outstanding clinical outcomes.
- To optimize teamwork, leaders must address underlying organizational cultural issues and develop improvement strategies so team members focus on common goals.

Exhibit 14.4 Ten Steps to Building High-Functioning Healthcare Teams

1. Have the courage and insight to address suboptimal teamwork, particularly when problem physicians are involved.
2. Assess your team to identify, first, the root causes of individual and team problems (e.g., psychiatric/substance abuse, process breakdowns between units, and tolerated unprofessional behavior, such as gossiping), and second, the individual and team strengths you can leverage (e.g., nurse leaders with historical knowledge, conflict management skills, and high levels of influence).
3. Design and implement skills training to improve communication, professionalism, conflict resolution, accountability, collaboration, and respect among team members.
4. Cultivate a culture of professionalism by practicing cooperation, collaboration, and respect for peers and patients. What we permit, we promote.
5. Give teams a common goal. Project-based tasks help team members build problem-solving skills and establish positive working relationships.
6. Identify an internal champion to drive and sustain performance improvement efforts (i.e., a respected leader who has decision-making power and clinical credibility in the organization).
7. Keep channels of communication open so team members can bring up issues and give and receive feedback.
8. Visibly support team efforts by participating in meetings and addressing issues directly. Ensure that team members' concerns are heard and that they are in the loop as issues are resolved.
9. Have a forum for public acknowledgment and celebration of team members' outstanding performance.
10. Ensure that teams' efforts to enhance their effectiveness are integrated into larger organizational strategies and goals so team members know that their efforts matter and that resources are available to support them.

- Healthcare executives need the insight and courage to challenge suboptimal teamwork, especially when problem physicians are involved.
- Effective team behavior can be taught and must be reinforced over time to sustain optimal clinical performance.

- In the long run, the effectiveness of work done by outside consultants depends on the extent to which internal leaders take ownership of, champion, and engage team members in the effort.

NOTE

1. The name of the institution has been changed for confidentiality purposes.

REFERENCES

References appear at the end of the book on pages 250–252.