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Session: Building Relational Coordination for High Performance in the Veterans Health Administration

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Rob: I'd like to introduce our presenter today. Jody Hoffer Gittell, PhD, is a professor at Brandeis University and the executive director of the Relational Coordination Research Collaborative and a chief scientific officer of Relational Coordination Analytics. Jody, can I turn things over to you?

Dr. Jody Hoffer Gittell: Yes, I'd be happy to take over. Thank you so much, Rob. Hello! Very happy to be here to share this work with you. This is work that we are starting to carry out in the VA and various colleagues have been doing so for years, so really thrilled to have a chance to speak with you today and get some of your feedback on how this work applies to what you are doing right now in the VA.

Just wanted to share that this is the Relational Coordination Research Collaborative where a lot of this work is being done around the U.S. and beyond, around the world, and that this is the measurement organization, RC Analytics, that is supporting the work that I'm going to talk about today.

So with that, I'd like to really turn it over to you and find out with our first poll question what is your primary role in the VA?

Rob: The poll is up. Answers are streaming in. The question, what is your primary role in VA. Answers are student, trainee, or fellow; clinician; researcher; administrator, manager, or policymaker; or other. And we do understand that you may wear many hats in the VA or in your organization, so if you'd like, you can go ahead and supply details by using the questions pane. Just go ahead and write whatever it is and I can read that off when the poll is finished. Jody, we have about 70% voted, and it usually levels off around 75 to 80%, which it has, so I'm going to go ahead and close this poll and share the results. Tell you that 24% of your respondents chose student, trainee, or fellow; zero are clinicians; 41% chose researcher; 18% chose administrator, manager, or policymaker; and 18% chose other. Now we're back on your slides.

Dr. Jody Hoffer Gittell: Okay, thank you. So yeah, well, I am a researcher myself, and it's good to have a bunch of researchers in the room. This is work that is translating nicely into practice, so it'll be good to get some reactions from administrators, managers, and policymakers as well as the researchers in the research community.

With that, I wanted to share that the starting point is really to focus on what are the challenges that the VA is facing right now, and it's not so different from the challenges that other health systems around the country are facing. It's a very complex system, got many roles with very distinct areas of knowledge and expertise, and the population you serve is highly complex. The Veterans have needs that extend across the VA, go beyond what any one care provider can attend to and beyond the VA increasingly. And due to the Veterans Choice Act, there's a growing demand for care providers within the VA to be coordinating care with external entities. So one question I've really got is how to leverage VA strengths and the real sense of mission that I find when I talk to people in the VA to best respond to these coordination challenges. So that's a real question I think that we have that we're facing today in this presentation.

So one way to look at the complex coordination challenges that the VA is facing is looking at this relational map. You've got multiple stakeholders who are coordinating around the Veterans, multiple types of case managers, care managers, and so on. But also including informal parties like the family members themselves. So it's quite a complex challenge. And then if we look beyond that to what happens when we look to the broader community and the social determinants of health?

We're looking at a map that then really gets to a whole other level in terms of the different parties that might be involved when caring for the Veterans who are really at the core of the VA mission. So just kind of keep those maps in mind. We'll come back to these maps and how we really assess how well coordination is working across those stakeholders. But it's one way to visualize the coordination challenge.

So why are we here today? So there's a growing interest in RC. In the Veterans Administration, it was the keynote topic at this year's State of the Art Conference. And right now, VA employees for this coming year are eligible to become partners in the RCRC. That might extend beyond the current year but certainly is true for the coming year. And there's also a competitive process, and I'll say more about this at the end, to get funding for a baseline assessment of RC in some, one or other of the VA entities, whether for the purpose of research or an improvement project, or both ideally.

So today's agenda is we're going to talk about how well does it currently work in the VA, this dynamic of relational coordination and what is it. How well do organizational practices that the VA has in place currently support it? Then introduce four tools that can help to support this process of relational coordination.

So what is RC? It really is the set of relationships that shape the communication through which coordination occurs and it happens sometimes in this very smooth way where the different parties in that network map have a sense of shared goals, shared purpose. They understand each others' roles, and that's what we call shared knowledge. It's kind of a systems knowledge of who does what here. And a respect for each others' roles, and that tends to support, we found empirically, sufficiently frequent communication, timely communication, accurate problem-solving communication.

But another scenario, which is just as common, is that people are really stuck in their functional goals and can't see beyond that to really identify and focus on the shared goals. The knowledge is exclusive in the sense that people don't know what each other knows, and so you get these silos. And there's a perceived lack of respect for one's work, which tends to support insufficiently frequent, delayed, inaccurate communication. And when things go wrong, a resort to blame shifting rather than problem solving because if you know you've done everything the right way and something goes wrong, then the only solution is that someone else had to have made a mistake, as opposed to a breakdown in communication so that the actions, they may all have been the correct actions, but they were not well-aligned. So that's really what we're looking at here in terms of the "for better or worse."

And we really, so we call this process relational coordination, very simply defined as communicating and relating for the purpose of task integration. Sometimes people define it as coordinating work through shared goals, shared knowledge, mutual respect. But it's a pretty simple concept. All seven dimensions are pretty understandable. But we find it's very hard to achieve, at least at the start, given the kind of organizations that we've inherited.

So here are three books that kind of represent where the journey has been. The work started in the airline industry, then moved into healthcare, and now is moving more generally into really the change process. How do you get from here to there, which is what the Transforming Relationships book addresses.

Here's where the work started, the flight departure process. I won't talk long about this, but it's really where the research began as well as a doctoral student at MIT many years ago. This is what I chose to study, really wanted to understand how people work together and what difference does it make.

And what I found in this, I did a nine-flight study of flight departures with these four airlines, measured all kinds of quality and efficiency outcomes and measured RC for the first time among these 12 groups, pilots, flight attendants, gate agents, and so on.

And what I found is just summarized in this graph. I mean obviously a lot more than this one picture, but that when you aggregate the relational coordination to the level of each airline. I studied Continental, Southwest, United, and American. And the performance outcomes, both the quality and efficiency outcomes that were assessed, what I found was relational coordination was a major predictor of flight departure outcomes, whether it was turnaround time at the gate or on-time performance or customer satisfaction, baggage handling performance, everything. So that was a real ah-ha. By the time I got to these results, I was not so surprised because apparent in talking to people that that coordination, when it's missing, has a lot of consequences for getting work done effectively and getting the outcomes that you care about in terms of efficiency and quality.

So I moved soon after that into the patient care arena. And as I was carrying out the flight departure study, I went into the hospital as the first time in my life as a patient to have a baby. And I realized that there were huge coordination challenges even in a very simple process like an uncomplicated birth. But became interested in doing this as a follow-up study, so my first teaching job, Harvard Business School, pulled together a group of nine hospitals and studied the surgical process called joint replacements.

So that study as a nine-hospital study, as I mentioned. We measured quality and efficiency outcomes, again, length of stay, clinical outcomes, as well as patient satisfaction with the process. Also looked job satisfaction for the first time, and here adjusting for doing the risk adjustment that is necessary for a good study of patient care outcomes. And this time measured relational coordination, this network of ties among doctors, in this case they were surgeons, nurses, physical therapists, social workers, and case managers.

What I found is summarized here that the hospitals with the weaker relational coordination also had poorer outcomes on this risk adjusted quality/efficiency performance index. And the hospitals at the other end of the continuum with high RC had substantially higher quality and efficiency performance outcomes. So that was basically a snapshot of the findings from study number two.

So research has continued into a lot of different realms, the areas I never would have imagined relational coordination being studied. And those go from, as we know, airlines and then into banking, retail sector, manufacturing, construction. Education is now a growing field for RC concerns. And then of course a whole range of healthcare sectors, surgical, medical, emergency, intensive, obstetrics, primary care, chronic care. And increasingly the growth area in healthcare is this look at regional health and wellness and how regions are coordinating across multiple stakeholders in order to address the social determinants of health. So a lot of growing areas of importance for relational coordination in the healthcare sector really square in the arena of the Veterans Administration where you are not only needing to coordinate complex care internally but increasingly with a large set of external stakeholders.

This work has been happening around the world, which is exciting to see the translation of something that could be seen as very culturally specific. It turns out it's not. Mutual respect is an issue that people resonate with everywhere, whether goals are shared and so on. I think part of it is the professional silos are very common across different countries. The other thing that's very common is we've inherited a bureaucratic model that tends to, where the organizational structures unintentionally keep people in silos when really we need to be connecting across them for the outcomes we're trying to achieve. So we'll come back to that.

But the places we've seen this grow in healthcare go from the inpatient setting to the outpatient setting and increasingly into the community regional context. In some countries, it's the municipality. In the U.S., it tends to be at the regional level where we're seeing a lot of this innovation.

The performance outcomes of RC include not only the quality and safety and the efficiency and financial outcomes that had been studied earlier, but increasingly people are linking RC to higher levels of client engagement and worker wellbeing as well as learning and innovation, just the ability to see opportunities for doing work better and having the connections to actually get those changes made. So learning and innovation is a very promising outcome of building relational coordination.

So why does it work? I think it's because the relationships of shared goals, shared knowledge, and mutual respect are actually the kinds of relationships that are the culture that supports process improvement. You think about Deming and his work, shared goals is a key element. Respect for the work and even the problem solving orientation, showing driving fear out so people focus on problem solving rather than blaming, so this really gets at the culture that people have long identified with learning organizations and process improvement.

It also, having these relationships helps care providers and administrators see how they connect around and with the patients, literally, because that network map really helps you see. You see your work in a way that's different than the organizational chart. Basically a network of ties rather than who you're reporting to. They both matter, but this is a visual that we don't currently support with the, from the perspective of the organizational chart.

And then finally, one of the things we find is that positive relationships, this has been shown in some of the neuroscience research, evoke positive emotions, and that actually activates a more advanced part of the brain, so it actually gives us more cognitive capacity when we are working in a positive context. And so that's pretty powerful.

I think that helps to explain a couple of recent findings that RC significantly improves engagement, satisfaction, and burnout for nurses in five rural hospitals. This is a paper that just came out in October.

Then in a study of surgical units across surgeons, nurses, technicians, and secretaries, we found the same positive outcomes for providers. Engagement, satisfaction, reduced burnout, and so it's just kind of new area of research. And certainly relevant to the VA where, and all of, I think, the healthcare sector in the U.S. where we're finding such high levels of burnout, this is a dynamic that not only helps us to get our work done more effectively, but it also creates greater provider wellbeing. And why is that?

I think it's because if you look at what, when you're able to coordinate more effectively and you are not working against the efforts of others but you're able to work in alignment, it's a lot less exhausting to get the same outcomes. So I think that's a big part of it. The coordination actually reduces this stress of the work and allows you to achieve the same outcomes more efficiently, and yeah, with less burnout.

So what we find is that RC matters most when work is highly complex. And what we mean by complexity is very specific. Your tasks are interdependent so that just doing your own job is not going to lead to the outcome. It requires somebody else to do their job. And that can be frustrating when it's not well managed, but that task interdependence is what really makes RC valuable. When things are uncertain, meaning that you don't have all the information you need at every moment. You're often, information is emerging from the situation. That's true in healthcare in general. As you learn more and more about the patients that you're treating, that uncertainty is what causes the need for continual updates among the team and that kind of, the relational coordination in order to coordinate on the fly as new information continually emerges.

And at the same time, we're doing this under time constraints. We don't have all the time in the world, either due to our staffing levels or due to the nature of the illness itself there's an urgency to the work. So these are the conditions that really create a benefit to having high levels of relational coordination, so I'm kind of curious as you think about your own work to what extent do you face task interdependence. Or the work you study if you're a researcher, task interdependence, uncertainty, time constraints.

And that really bring me to our second polling question and there really are three questions embedded here. But the question is how well, in your experience, whether in the area of the VA that you work in or in the area of the VA where you are doing your research, how well does it currently work?

Is it working more in this kind of positive cycle where people's goals are aligned, they understand each others' work, there's a great deal of respect for each others' work, communication is sufficiently frequent, it's timely, it's accurate, focused on problem solving?

Or is it more in this realm?

And how does that differ depending on whether you're looking within a department, across departments, or reaching out to other parts of the health system beyond the VA? So if you could just address those three questions, I'll hand it back to Rob to help out with that.

Rob: Okay, so Jody, I'm about to start the first of these third questions, but audience members, we have three questions. How well does RC work in your own department, with other departments, with non-VA entities? And I'll just, we wanted to give you a moment to think about that before we launch it.

Dr. Jody Hoffer Gittell: Yeah, and really with that second one it's like between yourself and other departments and between your department and the non-VA entity, so yeah.

Rob: Okay, so the first poll result is up and answers are coming in. How well does RC work in your own department? On a scale of one to five, very weak, somewhat weak, neither strong nor weak, somewhat strong, and very strong. We have about half of our attendees voted so far, so we'll give people a few more moments to go ahead and submit their answers. Things have leveled off, so I'm going to go ahead and close this poll and share out the results. What we have, Jody, is that 16% answered very weak, 24% answered somewhat weak, only 8% answered neither strong nor weak, 40% answered somewhat strong, and 12% answered very strong. Do you have comments you want to make on that or should I just launch into the next poll?

Dr. Jody Hoffer Gittell: No, no. I'm just curious to see how it's working with other departments.

Rob: Okay. So here's the second question. How well does RC work between your department and other departments? Is that correct?

Dr. Jody Hoffer Gittell: Yeah. Exactly.

Rob: Yeah. Answers are streaming in. We have about 60% voted, so we'll give people a few more moments to answer the question how well does RC work between your department and other departments? Very weak, somewhat weak, neither strong nor weak, somewhat strong, or very strong. And things have leveled off, so I'm going to go ahead and close the poll and share out the results and read them back to you. Twenty-five percent answered very weak, 21% answered somewhat weak, another 21% answered neither strong nor weak, 33% answered somewhat strong, which seems to be a theme so far, and 0% answered very strong. Shall I launch right into the third question?

Dr. Jody Hoffer Gittell: Sure, please.

Rob: Okay. The third question, how well does RC work with non-VA entities? I imagine that's between your department and non-VA entities?

Dr. Jody Hoffer Gittell: Exactly.

Rob: Very weak, somewhat weak, neither strong nor weak, somewhat strong, or very strong. We have about 40% voted, so we'll give people a little bit more time.

Dr. Jody Hoffer Gittell: And Rob, I don't know if it's possible, but I'd love to see the mean of each of these three.

Rob: I don't have the capability of showing statistics, but I've written everything down.

Dr. Jody Hoffer Gittell: Okay.

Rob: So we can figure it out.

Dr. Jody Hoffer Gittell: Okay, no problem.

Rob: Things have leveled off. I'm going to go ahead and close this poll and share the results. What we have is 27% answered very weak in terms of how well their department works with other departments in terms of RC, 32% answered somewhat weak, 23% answered, I'm sorry, yes, I got it wrong. Twenty-seven percent answered very weak, 32% answered somewhat weak, 23% answered neither strong nor weak, 14% answered somewhat strong, and 5% answered very strong.

Dr. Jody Hoffer Gittell: Interesting.

Rob: Now we're back on your slides.

Dr. Jody Hoffer Gittell: Yes.

Rob: Or we ought to be.

Dr. Jody Hoffer Gittell: Thank you. Let's just get, yes, from here. Yeah, so that's really interesting. So it looks like, and it's not so surprising that it's easier to coordinate within your own department than it is to coordinate across department aligns, and typically harder than when you go externally to other, so if we see the numbers trailing off as we go from within department to across the VA to beyond the VA. There are some times when it's easier to coordinate with people externally, really depending on the nature of the work. Would love to explore this further and will share with you just in a bit how we actually measure RC along the seven dimensions and how we represent it so that you can see where the coordination challenges are and in a way that's highly actionable. This is pretty, the kind of information I just asked for is pretty vague and not very actionable. What do we do about that? But I will share with you shortly how measuring RC can be extremely useful for moving into action. So here we go.

So really the question is if we have these challenges in coordination, we have to start asking how well do our organizations really support relational coordination? And what does that mean? I mean sometimes it's not even clear what would it take to help people be more aligned around shared goals, really understand each others' work and respect each others' work and engage in high-quality communication?

What I've found through theory building and a lot of research is this, that there a number of, where our everyday human resource management practices and operational practices that can be designed in a way that's either highly supportive or highly undermining of these networks of relational coordination. So it starts with the job design. Does your job, is your job designed in a way that includes the coordination responsibilities that are involved in doing your job effectively? Are people selected for teamwork and being able to be a good coordinator or just for the functional expertise? Are they trained further in those capabilities? Are people held accountable for the coordination across tasks and not just for doing their own tasks? Are the rewards shared across those who have to coordinate with each other?

Are there methods for resolving conflicts that are inevitable in a tightly run organization so that those conflicts become opportunities for learning and enhanced coordination? Or do they, and you will see the opposite in a moment. But in addition, do we have well-designed boundary spanner roles? That would be our case managers, our care coordinators. And we do have a lot of those in the VA. Do we have shared meetings and huddles across the right groups for getting the right coordination done in a timely way? Do we have shared protocols that help us to understand who does what and what are kind of the standard operating procedures from which we then can innovate as needed? And do we have well-designed shared information systems that help people stay on the same page and understand, have a common basis of knowledge for making their decisions? And when we have those, those are strong predictors of these networks of relational coordination that drive the outcomes that we talked about earlier.

But very often, and this is probably true in the VA as well, we tend to have more siloed job design. It doesn't account for the relational responsibilities and the coordination responsibilities of every person's job. We may tend to select individual players, particularly into some roles. That tends to be true with doctors, for example. Train people to be individual players as opposed to well-coordinated team players. We may still have some remnants of siloed accountability. Siloed reward structures very likely. Siloed conflict resolution. So people have different conflict resolution processes that, so there may be one for nursing and one for physicians, for example, and yet many of the relevant conflicts that really could be high value added are happening between those workers but not a well-established way. Or we may have it. I mean this is really just a diagnostic at this point.

Do we have boundary scanner roles that are, we have plenty in the VA. Are they well-designed? I think that is an area of strength for the VA. Meetings and huddles that are inclusive of the right parties at the right times, protocols that are designed to connect across the relevant groups working with the same patient populations and so on. So when those are missing, that's where we have a weak relational coordination and poor performance outcomes. That is at least a tendency. There are other factors that play, but these are factors that make a big difference.

So the bottom line is actually that these structures can either strengthen or weaken RC and performance outcomes depending on how they're designed. So we could say, well, that's really easy. Let's just redesign these structures. But if you think about all of the tradition and all of the, dare I say, bureaucracy that goes on behind every single one of those structures, they don't just turn on a dime. It requires some real work and real understanding of why do we need to change them in order to support these clinical outcomes that we care about. And sometimes we don't even see the direct connection between them. How does human resource management affect coordination and our clinical quality and efficiency outcomes? Well, they do. But that's not the way we typically think about things. So it's really an ah-ha that I'd like you just to kind of take that to heart and think about what would be the process for moving forward if this is the case.

So that's what I want to move into next. Where to start? Because we don't just want to get stuck in this, well, wouldn't that be nice if we all had this? Yeah! But most organizations don't. So where do we start? Let's just get real.

And we have this six-stage process that is pretty straightforward. Each stage has its own challenges, but it's clear. One is choose a pilot site or a couple of pilot sites where you want to do some innovation. And that's typical in research projects or clinical improvement projects. So this part, so far that's doable. Identify what are the desired performance outcomes for that site. What is the work we're carrying out and what are we trying to achieve? Who are the key stakeholders involve? Some of them are really obvious. Some of them are a little bit invisible, so you don't, you really have to start looking to see who they are so you don't miss anyone who might be critical in that coordination challenge. And what is the coordination challenge? And then if there is a significant coordination challenge involved in getting to those outcomes, this would be when you introduce the RC framework to the stakeholders.

And in doing so, you're really inviting people to join a change team. And that would be a representative or two from each of those key groups. And how do we motivate people from those groups because they have different perspectives, often very different levels of power to contribute their precious time and their precious effort to a change process. They have to care about the outcomes that are at stake. And those outcomes could be patient outcomes. They could be cost outcomes. They could be personal provider outcomes. All of them are connected together, and typically there will be, in a place that is lacking good relational coordination, there will be something in this effort for most parties.

The next step would be within this change team, how do we facilitate sensitive discussions, creating a safe space to disagree respectfully? If we think about Amy Edmondson's talk a couple of weeks ago, a lot of psychological safety, psychological safety is a major issue for creating change. And this is exactly where that process can start with a good facilitator. And one way to do that, one way to get all of this kind of dialogue going across these stakeholders who don't typically have a chance to connect around issues of common concern in a safe, kind of equal way is to engage in relational mapping. So this is the first tool I wanted to share.

This is relational mapping. You invite your change team to identify a work process that they want to coordinate better. It could be just caring for our Veterans. Likely it's something a little more specific. Which are the workgroups involved? Draw a circle for each workgroup. And this is basically the mapping process in a very abstract way.

Here's what it really looks like. It's pretty messy. But you start to see, okay, baseline. Where is the coordination particularly strong? Where is it okay but it could be better? And where is it really weak? This is a top management team in an Australian health system. But they're asking exactly that question around a surgical booking, you know, scheduling process. So it can be very specific.

And here it is in a regional mental health effort in San Francisco, carried out by UCSF. But you can see here in the cross-organizational space, you don't have any green lines, at least in their case. It was either red or blue, either poor coordination or moderate. But that was the base state. It helped them to start having the conversation about where are we right now, where are the coordination challenges, and what might we do next?

So you really get to ask those questions just from that simple mapping exercise, and a good facilitator can be valuable in getting the most out of that exercise.

This next thing I would recommend is to actually measure RC. The RC survey that has been used and I've referred to in all of the research can also be used in practice, we have found, to assess the current state. How are we, how is coordination doing right now? And to do that accurately, inclusively, it takes about 20 minutes to complete, max. I mean it's just seven questions. And the results will remain anonymous. The results then get shared as the basis for designing interventions. So this is not just your change team. It's the change team inviting all of their colleagues in this work process to respond to a 20-minute survey so that we can see where we are right now from an RC perspective. Where are our coordination challenges?

The questions are pretty simple. It's the frequent, timely, accurate, problem solving communication as well as the shared goals, shared knowledge, and mutual respect. In this case, it's around post-operative care for our surgical patients, but it could very easily be care for our patients in the broader community for our Veterans.

And then you look at those findings, and I'll show in a moment how visual they are. But you're sharing, people talk about this as being like looking in the mirror or putting the elephant on the table. It's really a way to start new conversations and be able to have reflection in order to create change. And here's where we recommend that the change team first look at the measures, the outcomes themselves and make sense of those data so that when they turn and share with their colleagues they're ready to help make sense of it, help turn this from looking at data to moving into action.

So here is one way that the findings are presented. There's the overall RC index, which is basically what we've just measured. It's how is it overall? But that's really just a simple average of these seven dimensions. Is the communication from each of these others sufficiently frequent? Is it timely? Is it accurate? Is it focused on problem solving when things go wrong? Do these people in these other groups share my goals? Do they understand my work? Do they respect my work? And what we see in this example is that this biggest strength was that communication was sufficiently frequent. However, it was quite lacking in terms of timeliness and problem solving focus, as opposed to blaming, and that these participants did not feel, they did not understand each other's roles very clearly. Shared knowledge tends to be a major concern in complex health systems. So this might be the kind of results that you might find at baseline when you're just getting started. It's just one example.

But you can look at those same results as a network map. So here we see, in this case, the patient care system, the PCA, is the one. We know they have a lot of direct contact with the patient, and yet they may not have their coordination needs met from these other groups. And that's the case here. The care coordinator with the CC, they have pretty strong ties with multiple groups, but they have not been able to create strong ties among the other groups, which would be really what you would hope from a boundary spanner, that they'd be helping others to create connections and not just connecting well with each group individually. So you can see a lot of more specific opportunities for improvement here.

That really becomes, you can look even behind that network map and see what's going on. This is the matrix that underlies every network map, and here it gives you more insight into how that same relationship is experienced in both directions from the perspective of each party in those two bubbles. So this, happy to do more on this or just get in touch with RC Analytics that walks people through this every day.

Then finally, here's a map that will show in a community. This was addressing youth violence, but it could be looking at any community-wide process. And the measurement basically says we have a lot of weak ties at this time at our baseline. But we also have some strong ties that we could build on between probation, police, parole, and so on. But you can imagine any network is likely to have a few strong ties that could really help as you build forward, and you can look at the matrix behind this.

But this is really where I think the rubber hits the road. We are now at this stage of designing interventions and getting very close to the end of this presentation where I really look forward to hearing your thoughts and questions. So when you get to the point of designing interventions, you have data that you can rely upon in terms of how strong is the relational coordination, where are the opportunities, and where might we work to start strengthening those ties, whether it's timely communication. Well, we can talk about timely communication. What is timely for you? Okay, there's a lot that, a lot of useful conversations that can come from sharing these measures. Shared knowledge may be a challenge. Well, what is your work and how does it connect to the work that I do? Those are conversations of interdependence. But as I mentioned here, you can also assess the current structures and see where they could be enhanced in order to better support relational coordination.

So this is the second tool I wanted to share; actually the third. The second one was the RC survey. The third one is the organizational structures assessment tool.

And here is a kind of a visual version of it. There's also a highly research oriented version of it that has an interview protocol that I'm happy to share. But this is, I first used this with colleagues at Boston Medical Center and then at Stanford Healthcare where I'll show you in a moment. But you create a matrix with the roles from your relational map across the top, add your organizational structures to the left column, and you're basically asking how well does this structure currently support relational coordination. And so here, look for example. This was a surgical care process in one of our local health systems. Do we have relational job design for each of these roles? Somewhat for the OR and PACU nurses; not at all for our surgeons and anesthesiologists in this case, and yes, we definitely have it for the service line, goodness, coordinator, and the final role, which I can't see right here. Oops! The OR scrub tech.

Hired for teamwork. We see that there is hiring for teamwork. There's an attention to that when we're hiring our OR, our nurses in general, but not our physicians, and only somewhat with these other roles. Are they trained for teamwork? Well, yes, our nurses, they are probably doing team steps. They are getting teamwork training. Somewhat for our physicians, and yes our, yeah, so you can see the point. If you look here at the bottom, shared information systems in this particular healthcare system, we're strongly supporting all of the roles. They had come pretty far with that. But if you look at shared rewards, that really was not available across any of these roles.

So you can start to see where some of your interventions might be useful. We could start working on, and some of these are going to be easier to do than others, but thinking about, well, why aren't we hiring for teamwork while we're looking at our surgeons and anesthesiologists. We want them to be highly, highly skilled but also have collaborative capacity so that we can better serve our patients together. And you can go through that kind of logic with each of these.

This is really where you want to start partnering. You can do some innovation on your own at the frontline and in your VISN, but you may also need to start partnering with the National Human Resource Management Office. And yeah, that will require higher levels of leadership support. So when you get to structural interventions, that's where partnering at higher levels can become very useful. But this is really one way to look at the whole scope of the situation, that we're looking at the structures that shape relational coordination in order to drive the desired performance outcomes and that when we want to start tinkering with those structures, we could do some things locally. But we're likely to require some middle and top leadership support.

But to get the process started, what's really most effective is working with the relational interventions and the work process interventions. And those are typically a local, under local control: Creating a safe space, putting your change team together, assessing the current state, engaging in humble inquiry coaching and listening. Just doing that starts to already change the culture. Work process intervention. Using all of the tools that we have at our disposal for quality improvement and continuous quality improvement in order to, and Lean to the extent that we use that in Six Sigma to really assess and improve the work in this collaborative way, building. And both of those help to shift the culture in a way that will start to change our performance outcomes. What we found is that in order to sustain that over time, we also have to address these structures. And that's really where we want to start partnering with the human resource management parts of our organization.

I do have an editorial that will be published in the Journal of General Internal Medicine, the special issue for the VA that will be addressing exactly this HR challenge and this opportunity that the VA has to better support coordination, not only through the care coordinators but really through the entire HR apparatus at the VA. So that should be really exciting to get that conversation launched.

So what I want to share next is who is involved in designing these interventions? It's the professionals themselves, people doing the work in all of the roles that we've mentioned but also supported by leaders. And we call that relational leadership when it is the kind of leadership that is attentive to connecting with people and creating connections between them where needed in order to do the work effectively, and not necessarily just connecting people as individuals but really connecting roles and creating, helping to create mutual respect among them. One of the places I really observed that was Herb Kelleher at Southwest Airlines where he made a point of showing, through his actions, how much he respected each group and therefore helped them to respect each other. So that's relational leadership. And what that lays a foundation for is being able to engage in co-production with the Veterans that the VA serves every day, and their families.

And co-production, as we know, is when you can't do everything. The outcomes you're trying achieve can't be achieved just by the health professionals themselves. It really requires partnership with the VA, that proactive patient-centered care that involves the Veteran and his or her family. And by having higher relational coordination among ourselves, supported by relational leadership, it is much easier to reach out and extend that same partnership to the Veterans and the families that we serve. So that's really the logic of it. And involving those voices in the intervention process is one way to really ensure that all of these perspectives are being honored.

So the final step, the easy step, because so much of the hard work has been done in the interventions and the diagnosis and the conversations to understand the initial diagnosis, is simply to implement the interventions that have been designed, and then of course to assess the progress over time by looking at RC and desired outcomes and how they are changing over time. So that's where I want to end up.

These are the six stages of change. And with that, I'd like to ask you how do you see this work as being relevant for the VA and what do you see as the level of readiness to do this work? And I'm sure it varies tremendously depending on which part of the VA. It's a huge organization with a lot of variability. But really would love to hear your thoughts and any questions that you might have at this time.

Rob: Thank you, Dr. Hoffer. Audience members please, if you would, consider these two questions and use the questions pane to provide answers if you like. Also if you have questions, use the same method. We do have one question that came in fairly early on.

Dr. Jody Hoffer Gittell: Oh sure.

Rob: This person asks how does relational coordination fit with other change initiatives that might be already happening in a group?

Dr. Jody Hoffer Gittell: Yeah. That's a great question. I'm just going to move back to this; this visual I think can be helpful because a lot of the change initiatives that are going on may fit into, for example, work process interventions. If we're looking at patient-centered care, often it will involve some re-designing the processes through which we care for patients. And so we see RC as a strong partner, basically, with other efforts that are underway in many health systems today. For example, if there are opportunities or efforts underway to create new ways to have meetings or to re-design our information systems, or yeah, our case management roles, our boundary spanner roles, for example. We can see those as structures that can help to reinforce and support relational coordination if they are designed in the inclusive way to cover, to actually connect the stakeholders who are needed for patient care.

So it's not that, RC is certainly not everything, but it is often supported or undermined by many of the initiatives that are underway. And being attentive to this framework can help us to just get another perspective on the current change initiatives and even add an RC measurement so that we can see where the opportunities might be. It may help us to even better target the efforts that are currently going on around patient-centered care. Where are the weak links? Where are the strong links? How can we address, how can we learn from the strong ones to increase the strength of the coordination where it currently is most lacking. So that would be my answer is really see it as a partner in those efforts. I think it could be helpful.

Rob: Thank you. We only had one person actually reply to the discussion. This person says results happen at the speed of relationships. Not exactly sure how that, what that means in terms of the two questions. But that person can go ahead and write in more if they like. But we did get another question. This person writes in an ideal world, would you start this work at the leadership level or the local level or both?

Dr. Jody Hoffer Gittell: Ah, I love that question! The first time I got it was like five years ago in northern Denmark, and I'm like I don't know! Because, and I think in the subsequent years I've really seen it both ways. And either one has its own challenge. So it's typically, in the experiences that I've had typically starts at the frontline with the leader of some unit saying we need to do better and this is going to help. So they tend to have success within their unit. But then the question is how do we sustain that and how do we get support to change some of the structures that I can't change within my own unit? Right? So you have, you run into a ceiling when you start at the frontline and you, but if you start at the top, and I know another health system trying to start at the top. And I think in some ways it's even harder when you start at the very top because then you have to convince so many people that, and people are wondering why does the leader want this, it wasn't our idea. So I actually think I'd rather have the challenge of starting at a frontline and keeping very informed. And I think here's maybe this over-simplistic answer. Wherever you start, you have the challenge of moving it beyond the starting point. And you want to start that effort early by sharing with people what you're doing, keeping them informed.

I think that Israel Deaconess here in Boston is actually a great example. They started at the frontline led by the head of the internal medicine inpatient unit at Beth Israel Deaconess, completely combined this with their Lean initiative, to answer the previous question, and did not ask for a lot of top leadership support. But they, at the end of their first week of design, they brought the CEO in or the president, one or the other, to say here's what we're learning and we just want you to be aware and we might need your support at some point. And so that kind of starting at the frontline with the unit leadership completely onboard but then informing and keeping higher level managers and your colleagues in other units. Now they're spreading it to three or four other parts of the hospital, again, with the knowledge. But it's not being driven by top management, but top management is aware and supportive. So to me that seems like the ideal scenario. But I'd love to hear your thoughts on what you've seen with other change efforts.

Rob: Thank you. We had another question come in. Do you have any advice on how to gain buy‑in from the different areas needed for this type of intervention?

Dr. Jody Hoffer Gittell: Yeah. I mean it's, in a way it's, yeah, so here I'll take this as buy-in from the different stakeholders at the same level as opposed to frontline versus top management. So think about the work process that, where you might have surgeons and anesthesiologists on one hand and on the other hand you have nurses and admin and technical clinical workers. So how would you, that's even, quote unquote, at the same level of the organization. There are a lot of different stakeholder interests there. And it's not always, you're not always starting at a time of great harmony. Right? So I think your question is extremely relevant.

And inviting people into the room, we find that one of the ways to do it is to show how we coordinate our work affects so many different outcomes that every group is bound to resonate with at least one of them. Yeah, we're trying to improve quality. Well, we care about efficiency and cost. We care about being able to engage with the client. Well, we really care about just being burned out. And to find that there is a dynamic, something that can actually be changed, that helps in all of those areas simultaneously is one way to create a kind of a win‑win.

It's like we have evidence, and I've not shared with you all the research, I'll share with you in a moment kind of the research that's being done within the VA, but it's being done very widely. Showing that these different outcomes are all supported by getting this better, and this is so common sense to people that it does tend to resonate. I think one of the big challenges is even if we care about these outcomes, we might care even more about our power and status. And if we care more about our power and status than we do about getting to these outcomes, it's going to be a very hard sell because there will be people who feel that they're right now in a very high status position and they can look down on others. When that goes away, they may have a personal sense of loss. And if they are not able to get over that, they're really going to be an obstacle to moving forward.

And that will be a place where, that may be a part of the organization you don't want to start in. You want to start in a place where people who have power and status are willing to, are more interested in getting these outcomes than preserving their kind of differential, they're more willing to explore what we call power with than power over. And that might be, that's sometimes, whether it's invisible or really obvious, the kind of make or break whether people are able to dive into this work or there's just this mysterious resistance. So it's an excellent question, and I hope that's been a little bit helpful.

Rob: Jody, we don't have any other pending questions at this time, so perhaps now is a good opportunity for you to show those results that alluded to.

Dr. Jody Hoffer Gittell: Yes, so I wanted to just share this. This is not an exhaustive list, but it's what we could fit on here where some of the RC work has already happened in the VA. Some of it's just getting launched. Some of it has been done, completed for years. But it's a very large system, and we don't necessarily hear about all the work that's being done. So I just wanted to share this with you and give you the opportunity, as you look at the slides afterwards, to see what colleagues in other parts of the system are doing. And then finally, and if you have any questions about this, please write them.

And then finally, in our last couple of minutes I wanted to share this with you that, share both with you and your colleagues that all VA employees are eligible to become partners in the RCRC through October. I don't know if Tanya is on and wants to speak about that. She's our director of partner relations. But you can visit the RCRC website. It's very easy to find and sign up. And it allows you to jump in on webinars and cafes where people are sharing their work that they're doing right now, both on the research side and on the practice side and helping each other through some of these tough questions that you have just posed for me today.

There's also this process to get funding for your baseline RC survey through Heather Gilmartin at the Denver-Seattle Center for research in the VA. And Heather and a panel of other kind of reviewers are looking at those proposals for funding and allocating funding to do a baseline RC survey, which comes with a lot of support, actually, for making sense of the results and helping you think about how to use them for research or to support a change team in your part of the organization. So I definitely recommend that you get in touch with Heather. And I'll just pause to see if there are any questions about either of these two opportunities or about the research that's already being done here across the system.

Rob: No other questions have come in.

Dr. Jody Hoffer Gittell: Okay, well, then I want to thank you so much for being here. And Rob, I really appreciate your facilitation today. Thank you all and be in touch.

Rob: Great. My pleasure. And audience members, if you would, please do fill out the survey that comes up when I close the webinar. Dr. Hoffer Gittel, thank you very much for your work and for preparing and presenting today this interesting Cyberseminar.

Dr. Jody Hoffer Gittell: Okay.

Rob: Have a good day, everybody.

Dr. Jody Hoffer Gittell: Thank you. Have a wonderful day.

[ END OF AUDIO ]