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A Case Study: A Team Approach to Professional Development and Accountability

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ABSTRACT:

Excellent front-line care givers are often promoted to supervisory positions due to their abilities, knowledge, and excellent communication and critical thinking skills. However, they often lack knowledge in the 5 essential leadership domains. These newly appointed supervisors and managers are eager to learn these new competencies, but often their organization is not able to provide them. Management and leadership skills are often learned on the job. Professional development is left up to the individual. As stewards of their organization, it becomes crucial for upper management to assure those in first line and middle management are given the opportunity to develop their skills and advance their careers. The author describes her journey of organizing and developing a self- directed Imaging Leadership Team and the success and professional growth that can be achieved if one remains committed to the goal. She also observed that this journey paralleled Bruce Tuckman's description of team development. As such, this article is formatted to highlight each of these stages.

KEY WORDS:

Professional development, Self-directed teams, Stewardship.

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Health caregivers usually start their careers as first line employees. Therefore, it comes as no surprise that most supervisors, managers, directors, and other middle management employees have risen through the ranks. Employees that move through the ranks in this fashion have demonstrated the ability and the need to learn and to think critically. They were flexible, adapted well to change, and were exceptional communicators. However, other skills are also needed to manage.

Many books and articles have been written describing traits, actions, and competencies of leaders. *(1,2)* They describe self-awareness, capability to motivate and communicate, capacity to create a culture of accountability, ability to make unbiased decisions for the good of the team and the organization, and build trust as behaviors essential to success. Most new leaders do not exhibit all of these talents. Additional education is needed to augment their innate skills. They rarely get the specific training that they need while on the job.

Stewardship is defined as an ethic that embodies the responsible planning and management of resources to include responsible leadership succession. Several years ago, I realized that being a steward of my organization was one of my more important priorities. I took a hard and honest look at Imaging's 6 Assistant Directors (AD) and 17 Supervisors. I believed that very few of them exhibited the attributes that would allow them to be successful if promoted.

The ADs understood the *what* and the *why* of institutional goals and objectives, but they did not know *how* to execute tactics to meet them. Our supervisors, while well meaning, had their own understanding of what the goals were and were not able to see the forest for the trees.

They were “independent contractors” working in a silo. Each believed that their supervisor colleagues compromised their efficiency and effectiveness.

At the same time, our organization was struggling to realign itself to prepare for the changes in health care due to the passage of the The Affordable Care Act that was passed in 2010. We, like all other health care institutions in the United States were struggling to decrease costs and to become more efficient. These massive changes resulted in the down-sizing of many management positions. Those remaining had to be very good at leading, enforcing my belief that my team had to develop better skills to reduce costs and to improve departmental productivity, patient safety, and employee engagement.

I began by doing a lot of reading on managing, leading and the power of teams. After extensive reading I thought that the best way for our department to meet the challenges and goals that were being assigned was to develop a self-organized team. High performing teams have many characteristics *(3,4)* but the ones I found to be the most important were: they create a learning environment, they focus on the collective mission, they establish their own goals with their own consequences, they challenge the status quo, and they take ownership of their actions and outcomes. They are masters of performance improvement.

First Things First

I started with the Management Team. This team, comprised of myself (the Executive Director) and the 6 ADs, met bi-weekly. We prioritized and measured hospital goals and discussed tactics to achieve them. We also focused on policies and procedures. Execution of these tactics was difficult and getting all ADs to adhere to policies and procedures was a struggle.

It is believed by many that companies that embrace Six Sigma methodology *(5),* are more competitive and can adapt quickly to market changes better than their non-six sigma counterparts. Based on this, I enrolled the ADs in a green belt (term given to an intermediate six-sigma training class) course, lasting 6 weeks. This was not a very popular decision, but to their credit, they attended, and passed!

Concurrently, The Management Team evaluated the supervisors. Not surprisingly, each AD thought that their supervisor was the best. After careful data driven analysis they came to the same conclusion: each had been high functioning first line employees that had little leadership training. In addition, the supervisors did not have a clear understanding of their roll. Most had never had a formal discussion with their AD regarding long-term career paths or goals.

The Management Team also realized that the supervisor's job descriptions were too task oriented. Along with Human Resources, the supervisors' job descriptions were rewritten with a focus on goal achievement, customer satisfaction, and employee engagement. Each supervisor would receive a review that was from their AD and the Executive Director (ED). The review was weighted: 80% AD, 20% ED.

Both the AD and I met with each supervisor to review the new appraisal tool and to explain the weighted scoring system. This was timed with the current review cycle. The supervisors would

be reviewed with the old tool, but next year's appraisal would use the new weighted tool. There were lots of questions and suggestions. Changes were made, and the new form was approved.

In the Forming Stage:

I am fortunate that my medical center has an active and well-developed Organizational Development Department (ODD) within their Human Resources Department. ODD was enthusiastic about my vision to develop a self-directed supervisor team. After a lengthy discussion, ODD helped me craft a vision statement. It was simple: *Tap the collective insight and experience of the Associate Directors and Supervisors to address issues, improve processes important to our patients and staff, and to professionally develop its members.*

I called a meeting of our entire Leadership Team that includes the Associate Directors, Supervisors, and Team Leaders (TL). Team Leaders in our organization are not considered first line supervisors. They are non-exempt employees and often are doing assigned work. However, they manage patient flow, breaks and lunches.) I acknowledged the difficult and stressful situations they often found themselves in. I shared the vision statement and the hope, that by working together, goals would be attainable and some of the barriers that have been created between teams would be eliminated. To this end, the Supervisors and Team Leaders would be forming a Supervisor Action Team (SAT) to work together to promote more effective patient care. I had no idea at this point that the stages that this team would go through, mimicked Bruce Tuckman's Stages of Team Development, (6). Figure 1.

The first few meetings of the SAT were chaired by ODD. They decided that membership would be comprised of the Supervisors and Team Leaders, each group forming its own committee. They developed the committee's structure. Figure 2. The SAT was renamed the Image

Governance Council (IGC). Each committee elected a co-chair. All members elected an IGC chair

Other rules and procedures were decided. They set meeting attendance requirements and developed traditional meeting guidelines such as no cell phones, etc. Bylaws and guiding principles were created that included terms of office for chair and co-chairs (2 years). Figure 3. The IGC decided that there would be focused lectures on leadership development and that their collective goal would be to work on employee recognition, because that was identified as an opportunity in the last employee engagement survey.

At the end of the first year, The IGC leaders reported overall satisfaction with the team. They were pleased that the meetings were well attended but only a few members managed to get to the meetings on time. This decreased the team's effectiveness.

In the Storming Stage: One to Two Years Later:

The next hospital's annual employee engagement survey indicated that staff did not feel valued. The department did not meet productivity goals, or other efficiency and growth goals. The supervisors had received their first review using the new, weighted annual review tool and most did not receive the glowing evaluation that they were used to. The IGC leaders sent an anonymous survey to all members.

This survey indicated that the IGC liked the professional development and management lectures but were significantly disappointed in the less than stellar employee opinion survey results, and failure to meet departmental goals. They believed that their ADs did not support them and that the IGC was not productive.

Based on the survey's results, I added the IGC chair to the Management Team. This would allow bi-directional feedback between the Management Team and the IGC.

The IGC chairs were given the authority to review each member's performance and commitment to the IGC's goals and objectives. The IGC membership reviewed the effectiveness of the chair and co-chairs. This score was added to the supervisor's review and was given a 10% weight, decreasing the ADs' weighted review to 70%. The Team Leaders annual review tool was revised to be consistent with the Supervisors and was also weighted (70% supervisor, 20% AD, and 10% IGC). White and yellow belt training (introductory and beginning six sigma training) courses were offered to all IGC members.

The IGC created three goals for themselves: Improve staff productivity, improve employee opinion survey regarding recognition, and reduce the number of falls in the department. Each task force selected their leader. The IGC organized and sponsored a very successful holiday charity event to help disadvantaged community members. Per their own bylaws, they held their first bi-annual election of IGC officers.

At the end of year 2, department metrics indicated that two out of the three goals were not met. The annual employee engagement survey indicated that staff still did not feel recognized. The projected improved productivity did not materialize. Falls decreased and exceeded the target. The IGC review indicated that members were extremely disappointed (and emotional) in not meeting their goals. They hated the IGC. I began to doubt the wisdom in forming a self-governance team.

I reread the references on teams. Most indicated that this took A LOT of time to change culture and that all teams go through Tuckman's stages. Most fail because they could not get past the storming stage. I decided this journey would continue.

I asked to attend the next IGC meeting. I read back the IGC evaluations verbatim. We discussed what was said, what was meant, and what was heard, and if the comments were constructive. After a very long silence, the team began honest dialogue. They were embarrassed. They discussed how you say something effects the outcome, but they also asked (begged would be a better term), for the IGC to end.

In the Norming Stage: Three Years Later.

When the team realized that the IGC was not going to dissolve, they started to resolve their differences. The newly elected chair focused on development of emotional intelligence. *(7).* White and yellow belt classes, previously offered as an elective, became mandatory. Three new goals were selected, and the weights of their yearly evaluations were changed. The IGC review now counted for 20% of the evaluation, reducing the AD's weight by another 10%. The team began to appreciate each member's different perspectives and strengths. They started to ask each other for help and provided constructive feedback.

They organized an employee stress reduction event that included fitness classes and neck messages. Healthy living lectures was held with most employees attending. Their three goals, improvement in the employee opinion survey, improving patient flow and reducing critical errors got traction.

In the Performing Stage: Four Years and Counting.

The imaging department's employee opinion survey was the highest in the medical center. Patient satisfaction surveys were the best in the hospital. Most areas reduced delays and waits by 35% despite increased patient visits. Employee safety surveys were strong. All departmental goals were exceeded. Imaging exceeded expense reduction goals. We were thrilled when the hospital adopted some of our tactics house wide to improve employee engagement.

Conclusion:

Imaging goals have changed annually, and most have been met. Imaging has been recognized as one of the most successful department's in the medical center, based on metrics. The IGC is self-organized and performs independently. It has become an essential part of Imaging leadership. Most IGC members deploy process improvement techniques and have started to develop their employees. However, few have started to do this effortlessly. They struggle with setting employee goals and holding them accountable to them. The health-care picture is still fuzzy for some of them. Five IGC members have been promoted. This was not an experiment to determine if Tuckman's observations of Team Development were accurate. There was no control group, or a different model to determine the best tactic to use to improve performance. However, it was the knowledge about these stages, storming in particular, that kept me from disbanding the team when things seemed to be going very badly.

Health care is a team sport. Each member of a team must play their role excellently for the team to be excellent. The supervisors, although excellent techs or clerks, were not excellent leaders. I believed that if these leaders improved collectively as one team, Imaging could

improve their health care delivery model. That is why I charted the SAT. The supervisors and the Team Leaders created the IGC.

Through this process I also developed as a leader. I delegate more responsibility and less tasks. I have learned that one must shift power and ownership to make teams self-organizing, independent, and effective. When decisions are allowed, ownership is developed. The management structure needs to be dismantled to reduce "command and control". If responsibility is outsourced without power, the leader's power is reinforced. If this is done too fast, most will object, lack context and direction and will believe there is a leadership void. I learned to not give up when outcomes are not as imagined, but to change tactics, not the vision.

In the words of Ken Blanchard: *None of us are as smart as all of us.* This is our compelling call to action.

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Figure 1: Tuckman's Stages of Development

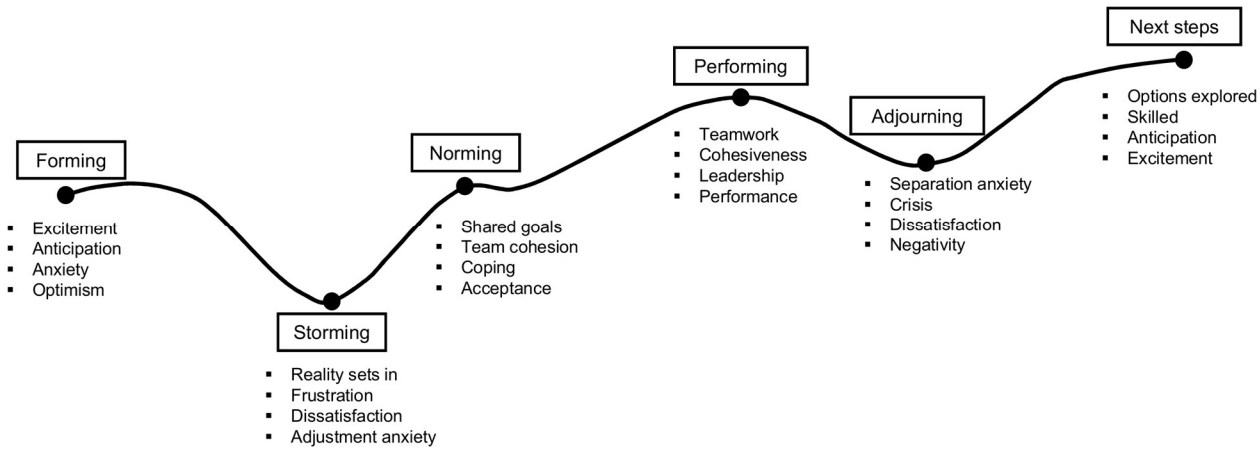

Figure 2: Imaging Governance and Committee Structure

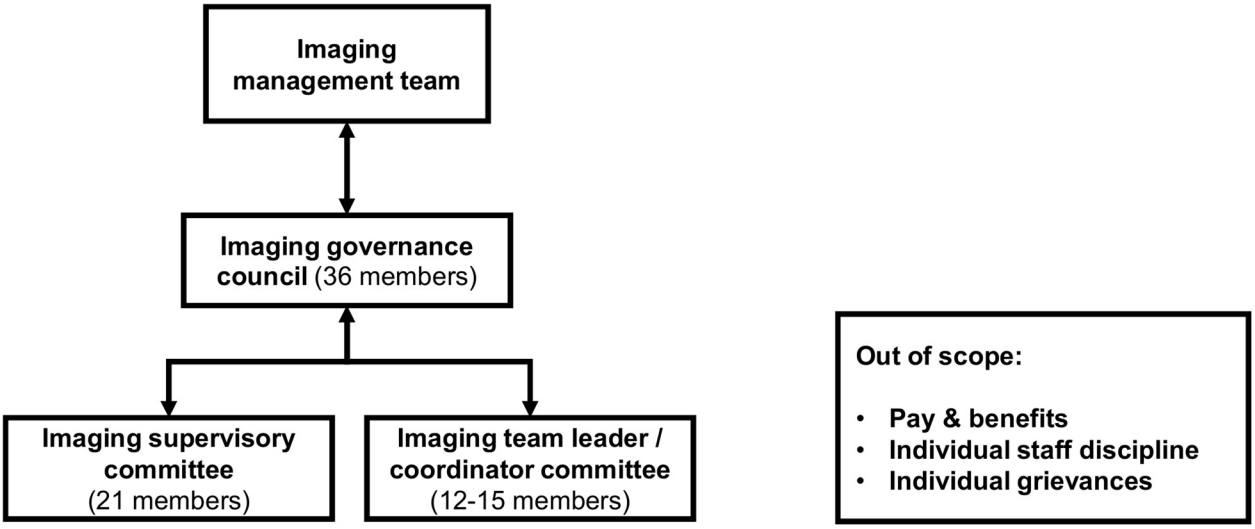

Figure 3: Guiding Principles.

- Focus on issues specific to the imaging department.
- Promote a satisfying work environment and quality of service consistent with the mission, vision, and values of Cedars-Sinai Medical Center.
- Identify and act on system/process issues impairing work performance.
- Cultivate respectful communication, a positive team culture and improve leadership skills.
- Promote a culture of accountability in which all members view their participation as critical to quality outcomes.