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MAKING HEALTH TEAMS WORK:

AN EDUCATIONAL PROGRAM*

by

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ABSTRACT

MAKING HEALTH TEAMS WORK: AN EDUCATIONAL PROGRAM

Health care teams are being used to deliver care in many settings. Research on over forty such teams reveals that many are seen as not functioning as well as potentially possible. Because teams provide the most sensible answer to care delivery in many health care settings, there is a need to increase the operating efficiency of these teams.

One possible way to improve team productivity is through structured educational programs. One such program, developed by the authors, is designed to help teams clarify and/or establish their (a) goals/objectives, (b) roles/responsibilities, and (c) working procedures (e.g., decision-making). Field tests with this program in twelve team settings have led to reports of improved team coordination, higher morale and cohesiveness, better follow-up and management of patient care, better utilization of health workers' resources, an increased sense of effectiveness on the team, and a perceived improvement in patient care.

INTRODUCTION

Many health care systems are experimenting with a new model for the delivery of health care. Groups of health workers are pulled together and asked to coordinate and integrate their efforts to meet patient needs -- to function as a "team" rather than as solo practitioners. As could be expected, experience with this new model has been mixed.

Research and experience in over forty settings where teams are being used has led to the conclusion, shared by many administrators and team members, that most of the teams are operating at levels well below that which is potentially possible. The majority of team members and administrators in these settings report that teams are functioning only "fairly well." Few report that teams are functioning "well" or "very well." Critics of the team approach will point to these data as "proof" that the team approach cannot work, that it is ineffective and inefficient.

This conclusion is incorrect.

Certain health care goals require a team approach. For example, goals such as comprehensive, family-centered health care (a commonly stated goal in community settings) require the coordinated efforts of several interdisciplinary health workers. Seldom is any provider, even with the best intentions, capable of achieving such a goal for any large number of patients. The interdependence of these health workers, be it through referrals or joint, hands-on care, makes them a team by definition whether or not they formally call themselves a team.

The relevant focus then is not upon whether to have health

teams or not, but rather upon what needs to be done to improve the effectiveness and efficiency of health teams (or any group on interdependent health workers) given that they are necessary.

The remainder of this article will address this question by discussing an approach to team functioning and describing the main elements and field test results of a specific educational program which has been developed to improve team functioning.

GENERAL APPROACH TO TEAMS

What is a Team?

If a task or job to be done requires the interdependent efforts of two or more people, then a team situation exists. Interdependent means that the individuals involved must work together and coordinate their activities with each other -- the job cannot be done by one person alone.

Many health care problems fit this definition of a team situation. Different individuals, with different knowledge, skills, attitudes, backgrounds, training, etc., must function interdependently to get the task done. There is a dilemma, however, in that the individual differences which are essential to effectively accomplish the task also represent potential obstacles to efficient teamwork. Interdependence creates its own problems.

Problems Caused by Interdependence - The Symptoms of Poor Teamwork[1]

The symptoms of poor teamwork are easily discernable and are reflected in the following kinds of concerns held by team members

and administrators in team settings:

- there is often an unnecessary duplication of effort;
- some things just don't get done, they seem to "fall in the cracks";
- we seem to be pulling in different directions;
- I'm always having to check to see if things get done, decisions are not followed up as well as they could be;
- some people seem less than enthusiastic, like they are just going through the motions -- there is a lot of grumbling behind the scenes;
- our meetings could certainly be better;
- communication is sloppy, messages and dates are lost or forgotten -- some just don't get filled in about what is happening;
- you really have to be careful about what you say around here -- never stick your neck out;
- the job is getting done, but only because I'm busting my back -- I'm not sure I can keep it up.

These concerns are not, as is often assumed, the result of "personality quirks." Rather, their existence is an indication that a team has not successfully dealt with the problems inherent in trying to accomplish a task requiring interdependence. The problems caused by interdependence fall into four general areas:

1. "What are we supposed to be doing?" - problems

caused by different goals (short and long range) and priorities;

2. "Who is doing what?" - the issues of role responsibilities and problems caused by different specialists working in an integrated way;
3. "How do we accomplish our work?" - problems caused by the need to develop effective and efficient mechanisms for group decision-making, problem-solving, communication, etc.;
4. "How does it feel to work around here?" - interpersonal issues which arise when people function interdependently, such as trust, need for support, etc.

A. Problems with Goals

Meeting patients' health care needs is, in and of itself, a very frustrating task. Success is very hard to measure. In the absence of specific, short-range measurable goals, team members may never get the sense of having accomplished anything. In addition, without an agreed-upon mission or set of objectives, individual team members are very likely to go off in a variety of different directions, each doing "his own thing." Conflicts then develop around how time should be spent, by whom, around which kinds of tasks, etc. These get interpreted as "personality clashes" when, in fact, they stem from different and unshared priorities of "what's important -- what are our goals?" Even in instances where the organization or administration has stated specific goals, wasted time and energy can result if individuals do not take the time to clarity their interpretations and ownership of these mandates.

B. Problem of Roles

No standardized job descriptions exist for team doctors, team nurses, team social workers, etc. Individuals who fill these roles on teams have been trained to be individual specialists, not team members. On most health teams, therefore, full utilization of the team's human resources is stymied because people relate to each other solely as role categories. Indeed, it is unlikely, given the complexities of the task, that completely exhaustive job descriptions will ever be feasible for team care.

C. Problems with Work Structures and Procedures

There is no single right way to organize a team. How a particular group makes decisions; how it conducts its meetings; how it decides who is to initiate, consult, or support various activities all depends upon the particular task and particular individual roles in a given situation. A team must therefore spend some time in meetings talking and deciding upon how to coordinate itself. This time and energy spent in meetings is often wasted because health workers are seldom trained to work in groups or to manage collective problem-solving or decision-making sessions. As a result, meetings are often characterized by unclear decisions, mixed commitments to follow-up, low energy to volunteer or participate in future team meetings, etc.

D. Problems with Interpersonal Relationships

Most "personality clashes" are actually the result of problems stemming from one of the above three areas. Sometimes,

however, after having dealt with the above issues, interpersonal tension and conflicts are still apparent. This can happen because the frustrating nature of the task (delivery of care) creates strong needs in many for peer support, positive feedback on one's competence, etc. Thus, behaviors that lead to or detract from trust, self-confidence, support, pleasant working relationships, etc. are issues to be worked on by the team as a whole.

Sometimes, interpersonal problems may be indicative that someone actually is mismatched with the job. It could very well be that one is not suited for a job or a team, but this alternative should only be considered after the other three categories of problems have been addressed (for the same reasons that surgery is used as a last resort).

Team Development

The needs to (a) set (or clarify mandated) goals and priorities; (b) analyze (or clarify) and allocate role responsibilities; (c) examine the team's work processes; and (d) examine the relationships among people; all stem from having to work interdependently. These needs will never disappear, nor can most teams learn how to effectively deal with these issues solely through their work experience or through guidelines and protocol from others outside the team. The knowledge and skills needed to manage the inherent problems caused by inter-dependence, on a day-to-day basis, can and must be learned through an explicit educational process called team development.

Team development consists of activities aimed at helping the team to minimize the time and energy lost mismanaging the problems

stemming from its members' interdependence, and maximize the energy the team devotes to accomplishing its task. Team development is like a planned maintenance activity to prevent major problems from occurring. The rationale for team development is that by investing time to explicitly focus on the problems of coordination among team members, the team will avoid greater time and energy losses resulting from ineffective coordination.

The following sections describe the major elements of one program in team development designed specifically for health care teams.

A PROGRAM FOR HEALTH TEAM DEVELOPMENT

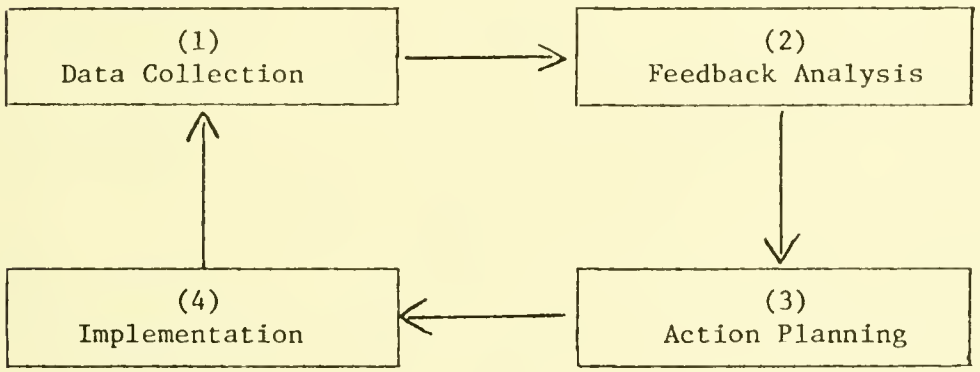
Overall Objectives

The Health Team Development (HTD) program has two overriding objectives: (1) to help a team solve specific task-related problems (e.g. goal setting, role allocation, etc.) and therefore begin to function more effectively right away; and (2) to provide the team with a set of skills and concepts which they can apply in the future as similar problems develop. While this dual goal has some costs (e.g. primarily the amount of time investment required which will be discussed in a later section), it is important that both goals be maintained if teams are to derive any long-run benefit from the effort. The team is helped to "get into better shape" and to be able to "stay in shape."

Developmental Learning Model

This program is not like a traditional lecture or classroom training period. Rather, the activities in this program are real in the sense that they focus on helping the team to solve their own problems which result from the nature of their job. The underlying model or approach is called the "action-research" approach to team development.[2] (See Figure One.)

FIGURE ONE: The Action Research Model



The HTD program helps the team to collect information from themselves (diagnosis) about a particular obstacle to team effectiveness (e.g. clarity of goals). The team asks itself "Where are we on this issue?" These data are then summarized and shared (feedback and analysis). At this stage, the team answers, for itself, the question: "Are we where we need to be?" Discrepancies between where they are and where they need to be become the stimulus for new action plans. These action plans are then implemented and re-evaluated (new data collection) at some later point.

Self-Instructional Approach[3]

The program is designed so that it can be run by the team itself, with no outside consultants, trainers, observers, etc. The authors' early experiences with health care teams were as traditional outside consultants working directly and personally with teams in team development activities.[4] The success of those experiences[5] plus the belief that (a) more health teams existed than could be handled by the available number of consultants, and (b) many health teams did not have the resources to hire outsiders, led to the creation of this instrumented program.

Content and Flow of the Program

The program consists of two phases (a more detailed description of the program content can be found in the Appendix):

1. Phase One: Core Work - this phase consists of seven, three-hour sessions or modules and makes up the basic team development package. These modules focus on the most essential elements of team effectiveness (i.e. goals, roles, procedures). Each module has some individual preparation (usually 15-30 minutes) and specific action outcomes to be achieved by the team. In this phase, the team is strongly encouraged to follow the sequence in which the modules are presented and not skip any modules.

2. Phase Two: Optional Resource Modules - this phase consists of six optional, special interest resource modules, each directed at specific problem areas which a developed team may encounter (e.g. bringing new members on board). These resource modules can be used as either individual reading guides or guides for a team

session to work on a particular issue. After completing Phase One, the team is free to choose whichever (if any) of these they want to work on at any time.

The Investment

The core program requires a team to work together for seven, three-hour sessions preferably once per week over a seven-week period. For many, the initial reaction is: "It's too much. Can't it be done faster?"

The paradox can perhaps best be understood by comparison to a football team. A football team spends 40 hours per week practicing and learning teamwork for the two hours on Sunday when they must deliver. Teams in other settings -- like a health team -- seldom spend two hours per year practicing.

Given the realities in most health settings, however, freeing up the time required is a major obstacle. Administrators in settings using teams must, therefore, be prepared to provide short run support to permit a team to get in shape.* In no setting in which the program has been used has this been an easy task. However, as is discussed below, preliminary results from initial test sites strongly suggest that the returns warrant the investment.

*The program includes a set of Guidelines to Administrators designed to help administrators (a) get the organization ready to support the team development program, and (b) introduce the actual program to a team (or teams); and Guidelines to Users.

SOME INITIAL RESULTS

Some Specific Effects: Managing Problems Stemming from Interdependence

Evaluation data was gathered in various ways: (a) periodic questionnaires from team members; (b) xerox copies of session outputs, e.g. goal statements, role relationships; (c) audio tape recordings of teams discussing their own progress; and (d) group interviews conducted with administrators and teams after completion of the program. Once a team began the program, we did not personally intervene into or influence the program in any way until the team finished the program.

To date, the program has been completed by twelve teams. The settings include: several community centers delivering comprehensive care; the ward shifts in a mental health setting; several university-based clinics with both teaching and ambulatory primary care responsibilities. Half are located in the New England area, the remainder are spread geographically.

The problems caused by interdependence, as discussed earlier, fall into four general areas. Preliminary evaluation data from initial test sites are organized into these four general areas.

A. "What are we Supposed to be Doing?" - Problems of Goals

As a result of the program, the teams produced written statements of their general goals and rank-ordered lists of more specific performance objectives to attain these goals. For most teams, this was the first time such a task had been undertaken and completed. Many discussions occurred around subtle differences in semantics (e.g. quality "comprehensive" health care versus quality

"medical" care), with the realization that there were differences within a given team that had never been dealt with before. Two general effects of this process were: (1) it created a sense of direction and forward movement for the first time; and (2) the sessions, in and of themselves, gave the teams a sense of having set goals and accomplished an output for the first time. The analogy of a "shot in the arm" giving additional energy to team members to devote to delivering care was reported several times.

B. "Who is Doing What?" - Problems of Roles

In most cases, these sessions were reported to be the high points of the program. Team members reported that the sessions on role negotiation and role definition helped them to open better lines of communication, confront problems collaboratively, and clear a lot of confusion regarding who should be doing what. Specific outcomes reported by team members included:

1. more willingness to make referrals now that individual capabilities and responsibilities are clear;
2. less feelings of isolation and more willingness to take on more work as a result;
3. more appreciation for other's inputs in case problems or organizational matters;
4. much more information being volunteered without prodding;
5. more in depth problem-solving with patients because providers felt they could depend on others for support, back-up.

C. "How do We Accomplish Our Work?" - Managing the Team's Work Structure and Processes

One area of marked improvement in all cases was team meetings and case conferences. Teams reported that as a result of the program more people have taken responsibility for creating meeting agendas, more shared leadership is occurring in meetings, and discussions have become more pointed and closure is clearer. In general, more is getting done in the same time as before. More cases are addressed, and there are more follow-up discussions concerning previous decisions.

In the area of general team functioning, team members reported that responsibilities are more widely shared, conflicts are confronted more directly and resolved or managed, and people are making greater efforts to support one another.

D. Impact on Patient Care

The ultimate objective in engaging in any form of team development is, quite obviously, to improve a team's ability to deliver care. At this point, rigorous empirical data about patient care is not available. However, there is substantial perceptual evidence -- from both team members and administrators -- that better care is being delivered as a direct result of the developmental program. Such perceptions were evident in the following reported results:

1. there are greater conscious efforts to follow through on tough cases because team members are following up with each other;
2. there are more original and creative solutions to

patient health problems because of greater knowledge and use of team members' resources;

3. better, more efficient care is being delivered because team members check with each other more about their objectives and responsibilities in specific instances;
4. fewer patients are getting "lost" because team members are coordinating more and being more helpful to each other (which rubs off on patients as well).

It is important to note how few of these perceptions deal with people's feelings per se. To be sure, people seem to "feel" much more positive and enthusiastic - not because they have been through some strange therapy, but rather because now they are coordinating their efforts more successfully, and as a result, see direct effects on their ability to meet patient needs.

The Managerial Role

The management of a health setting using teams plays a critical role in the total process of team development at two specific points -- getting started and dealing with the after effects.

A. Getting Started - Top Management Commitment

Getting the program to a team has invariably been a lengthy and difficult process.[6] Health administrators and managers are under severe environmental constraints which represent major obstacles to freeing up the time required for team development. Management's response to these constraints confronts directly the issue of its

commitment to team care. Some systems argue, for example, that team development is important but teams should do it on their own time -- lunch hours, evenings, weekends, etc. The subtle (but powerful) message thereby communicated is that management is not committed to finding ways to support a program that the team perceives as high priority. The team is likely to lose some of its own commitment in such a situation.

On the other hand, managerial efforts to do the work needed to offer the programs (e.g. freeing up the time required), sets in motion a positive, self-reinforcing motivational pattern. Team members reported two types of comments in this regard:

1. the fact that the center would invest that kind of time in them resulted in an increase in the team's commitment to work on their development;
2. the fact that the administration gave them time made them take themselves much more seriously both as a team and as individuals.

B. Some After Effects: Managing Developed Teams

The act of offering and implementing a team development program represents an organizational, as well as a team, intervention. A particular team is only a subsystem within a larger organizational system.[7] Newly developed teams are very likely to want to use their new-found strength to improve the organization of which they are a part.

In effect, what happened in the test cases was that teams began to question the rationale and usefulness of certain policies, decisions,

procedures, etc. Once developed, the teams felt capable of handling more responsibility and sought ways to be more autonomous and self-sufficient (e.g. to be more responsible themselves for personnel decisions such as hiring and firing). It is important to note, however, that such action was not directed towards "taking over the organization" or "doing the administration ourselves." The intent in these instances was to make organizational goals and administrative functions more effective and relevant to the team's specific setting, patient population, mixture of disciplines, etc.

Several administrators, quite appropriately, have still reacted to these phenomena with initial hesitancy and concern. They feel like teams are "ganging up on them," and degrading the role of administration. However, this tension has not necessarily led to negative results. In several of the organizations where teams have completed the program, the administration has initiated changes in organization structure and policy to facilitate team and administrative functioning. In some settings the administration has even sought its own training programs as a result of viewing the changes in the teams.

Conclusion

The results described here are based on field tests with twelve teams. These results tend to support the belief that developed health teams are more efficient and effective deliverers of care than non-developed teams. The cost of this development in terms of time is not insignificant and must be weighed against the potential returns. However, it is our contention that to be effective, health care teams (and, for that matter, any team) must spend some time in planned

developmental activities. All teams spend much of their time and energy coping with the problems of interdependence -- developmental programs can help them do it better.

APPENDIX

Content of Health Team Development Program

PHASE ONE: Core Work Program

MODULE ONE: "How Are We Doing as a Team" - Vital Signs

In this session, individuals rate team performance on several scales and then share and discuss this information in a total group discussion. Team strengths and weaknesses are assessed and specific needs for team development are identified.

MODULE TWO: "A Team Trying to do What" - Goal Setting

This is the first of two sessions devoted to clarifying exactly what it is that the team exists to do. The output of this session is an agreed-upon Core Mission or general statement of purpose that the team collectively develops during the session.

MODULE THREE: "A Team Trying to do What" - Setting Priorities

In this session the team begins to operationalize its Core Mission from Module Two. They create specific performance goals which, if met, would satisfy them that they are accomplishing their Core Mission. In addition, they begin to prioritize their most important goals in order to help them focus their energy.

MODULE FOUR: "Who Does What Around Here" - Role Negotiations

This is the first of two sessions devoted to clarifying, defining, and changing roles on the team. As preparation, each member writes "messages" to every other member stating things that the other members could do differently (or the same) to help the "message sender" get his job done more effectively. These messages are exchanged in

the session. The team then learns and practices a face-to-face, give-and-take conflict resolution skill called "role negotiation." Volunteers actually resolve conflicts stemming from their messages in front of the team as a demonstration for learning purposes.

MODULE FIVE: "Who Does What Around Here" - Role Definition

In this module, team members go through all their role messages from Module Four and begin to define their roles by agreeing (in writing) to the messages that are "OK" and by setting up specific times and places to "role negotiate" with other team members concerning messages that are not yet "OK."

MODULE SIX: "How Things Get Done Around Here" - Decision Making

This module helps the team to look at how they make decisions and how they might do it better. A problem-solving model is presented, and the team learns to use a decision-making "checklist" whenever they are at a decision making point in trying to solve a problem. Then the team uses a tool called a "decision chart" to decide how certain particularly important decisions they frequently make ought to be made in the future. The results are new operating procedures or policies for the team.

MODULE SEVEN: "Where do We Go From Here" - Planning Next Steps

This session formally ends the core team development program by helping the team to assess its progress so far and to identify its needs for the future in order to accomplish its Core Mission. The output of this module is an action plan of negotiations, problem finding sessions, decision making sessions, evaluation sessions,

etc., all directed at pursuing and measuring their progress with their performance goals.

PHASE TWO: Optional Resources

MODULE A: "Bringing a New Member on Board" - Joining Up

MODULE B: "Running a Better Meeting"

MODULE C: "How We Interact When we Work Around Here" - Leadership and Membership

MODULE D: "What Does it Feel Like to Work Around Here" - Norms

MODULE E: "Interacting with the Organization"

MODULE F: "How do We Look to Our Patients" - Getting Feedback

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