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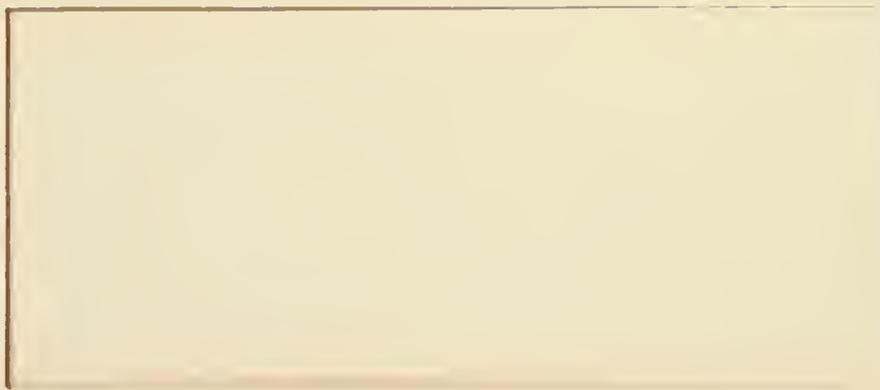
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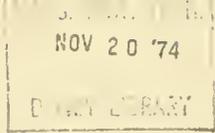
MAKING HEALTH TEAMS WORK:
AN EDUCATIONAL PROGRAM*

by

Irwin Rubin, Ronald Fry, Mark Plovnick
May, 1974 WP 710-74

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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.

Based on our research and experience in over forty settings where teams are being used, we have concluded, as have many administrators and team members, that most of the teams are operating at levels well below that which is potentially possible.* Critics of the team approach will point to these data as "proof" that the team approach can't work, that it is ineffective and inefficient. The data are correct -- teams are not functioning well -- but the conclusion is incorrect.

The question is NOT, as often posed, "teams vs. no teams." For certain health care goals, a team approach is required. For example, no solo practitioner has the knowledge and skills necessary to deliver comprehensive family centered care (a commonly stated goal in community settings). Certain health care goals, require the coordinated efforts of several interdisciplinary health workers. The interdependence of these people makes them a team by definition whether or not they "formally" call themselves a team.

The relevant question thus becomes: can anything be done to improve the effectiveness and efficiency of health teams (or any group of interdependent health workers)? Based on our work over the past three years, the answer is yes. Through educational interventions, focusing on the actual work a team

*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."

needs to get done, health care teams can learn to function more effectively.

Our intent, in the remainder of this paper, is:

- a. to discuss briefly our own general approach to teams;
- b. to describe the main elements of a specific program which has been developed to improve team functioning; and
- c. to summarize the results achieved in several health care settings in which the program has been pilot tested.

GENERAL APPROACH TO TEAMS

What is a Team?

The first point which must be addressed is "What is a Team?" Our own definition has a very strict task focus. If the task or job to be done requires the interdependent efforts of two or more people, then a team situation exists. Interdependent means, in this case, 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. The dilemma, however, is clear: the individual differences which are essential to effectively accomplish the task also represent potential obstacles to efficient teamwork. Interdependence, in other words, creates its own problems.

*This does not imply that a team does everything together in a face-to-face interactive way. It does imply that at various points in time, the nature of the task will require coordinating to schedule work, allocate priorities, solve problems, etc.

Problems Caused by Interdependence - The Symptoms of Poor Teamwork*

The symptoms of poor teamwork are easily discernable and are reflected in the following kinds of comments made 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

*For more details, see Rubin, Irwin and Beckhard, Richard, "Factors Influencing the Effectiveness of Health Teams," Milbank Memorial Fund Quarterly, July, 1972, Vol. L, No. 3, Part 1.

Also see Fry, Ronald and Lech, Bernard, An Organizational Development Approach to Improving the Effectiveness of Neighborhood Health Care Teams: A Pilot Program, Masters Thesis, MIT, Sloan School of Management, June, 1971. Available from Dr. Harold Wise, Martin Luther King, Jr. Health Center, 3674 Third Avenue, Bronx, New York 10456.

general areas:

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

The needs to (a) set goals and priorities; (b) analyze and allocate role responsibilities; (c) examine the team's work processes; and (d) examine the relationships among people, to reemphasize, stem from problems inherent in a task requiring interdependence.* These needs will not disappear. Nor, as is often FALSELY ASSUMED, can most teams innately know how or learn solely through work experience how to more effectively deal with these issues.

The Process of Team Development

The knowledge and skills needed to manage the inherent problems caused by interdependence can and must be learned through an explicit educational process called team development. Teams are like complex pieces of machinery -- made up of human parts -- with comparable needs for maintenance. Two major implications of team development are:

1. The longer one avoids any explicit, planned maintenance activity, the more severe, drastic, or energy-draining

*The symptoms listed earlier (pg. 3) can be seen to stem from these problem areas e.g., the complaint that "there is often an unnecessary duplication of efforts" often stems from unclear role expectations, "who is doing what?"

will be the inevitable need for maintenance. Avoiding periodic maintenance (e.g., by smoothing over or avoiding conflicts that arise), runs the risk of posing an eventual problem of serious consequences (e.g., many people want to quit).

2. One cannot expect to eliminate completely the need for maintenance. In order to "get into better physical shape," for example, an individual engages in a relatively strenuous exercise program. Once "in shape," however, he can cut back substantially, but not completely -- periodic exercise is still required to stay in shape. Similarly with groups -- having made an initial investment in team development, they will find that periodic reinforcement will be sufficient.

Team development, therefore, consists of activities aimed at helping the team to minimize, but not eliminate, the energy spent on maintenance and maximize the energy devoted to accomplishing its task. In this way, team development is like a planned maintenance activity (like periodic lubrication of a car) to prevent major problems from occurring.

In the next section we will describe the major elements of one program in team development designed specifically for health care teams.

A PROGRAM FOR HEALTH TEAM DEVELOPMENT

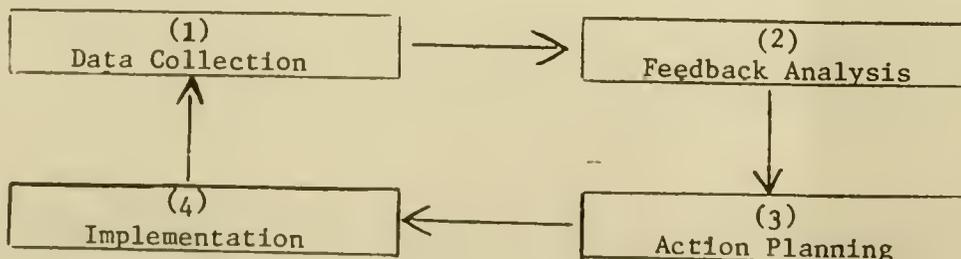
Overall Objectives

The team development program has two overriding objectives: (1) to help a team solve a specific task-related problem (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 (knowledge, models, procedures) 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, in other words, to "get into better shape" and be able to "stay in shape."

(For those interested, specific session titles and objectives are included in Appendix A. Sessions were designed to explicitly help a team deal with the four problem areas discussed earlier.)

Developmental or Learning Model

The "task-oriented" focus means that 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 actual problems which result from the nature of their job. The underlying model or approach is called the "action-research approach to team development."^{*}



^{*}See, Beckhard, R. Organization Development: Strategies and Models, Addison-Wesley Publishing Company, Reading, Mass. 1969.

The team is helped to collect information "from themselves" about a particular obstacle to team effectiveness, e.g., clarity of goals, roles, etc. The team, in effect, 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, at some later point, re-evaluated (new data collection).

This action-research approach helps to solve the immediate problem, "getting into shape" and, when internalized, becomes the vehicle for "staying in shape."

Self-Instructional Approach

The program is designed so that it can be run by the team itself, with no outside consultants, trainers, observers, etc. In our own early experience with health care teams, we functioned as traditional outside consultants who worked directly and personally with teams in team development activities.* The success of those experiences** 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 us to create this instrumented program. In effect, we have tried to "replicate on paper" the process we (and others) had followed in working directly as consultants to health teams.***

*Fry and Lech thesis, op.cit.

**Wise, Harold et al, Making Health Teams Work: A first Step, Bellinger Publishers, May, 1974.

***Rubin and Beckhard, "Factors Influencing the Effectiveness of Health Teams" op. cit.

Beckhard, Richard, "Organizational Issues in the Team Delivery of Comprehensive Health Care," Milbank Memorial Fund Quarterly, July, 1972, Vol. L, No. 3, Part 1.

The Investment

The investment required to "get in shape" is not insignificant. Once a team gets started* they will spend 3 to 3½ hours per week over a period of eight weeks in team development activities (a total of 28-32 hours). 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 and learning teamwork for the 40 hours per week when they must deliver.

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 we shall discuss in the next section, preliminary results from initial test sites strongly suggest that the returns warrant the investment.

*The first two modules are designed to explain the program and to help a team decide if they feel a need for the program. See Appendix A for more details.

**The total 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).

SOME INITIAL RESULTS*

Some Specific Effects: Managing Problems Stemming from Interdependence

The problems caused by interdependence, as we discussed earlier, fall into four general areas. Preliminary results from initial test sites will be organized into these general areas.

A. "What Are we Supposed to be Doing?" - Problems with Goals

Meeting patients' health care needs is, in and of itself, a very frustrating task. Success, in such global terms, 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?"

The initial modules of the program (Modules Three, Parts I, II) are designed to begin the process of reversing this situation. Teams find these two modules among the most difficult in the entire program for several

*Evaluation data was gathered in several 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 used by twelve teams. The settings include: several community centers delivering comprehensive care; the three shifts in a mental health setting; several university-based clinics with both teaching and ambulatory primary care responsibilities. Half are located on the East Coast, the remainder are spread geographically.

reasons: (a) they are just beginning to learn how to work together on a team task-setting goals; (b) setting goals is very hard work; and (c) they are struggling to adapt to the self-instructional nature of the team development materials. The results, however, are often marked as can be seen from the following:

"I think it also increased our feeling of going somewhere in the sense that we've seen output if something happened as a result of actions. Maybe we need to practice more on whether it got done, but at least you feel like something productive came out of your time and energy which is new to this place."

"Something that happened through the modules that has gone on is that we have a sense of how good it feels to accomplish something - to set ourselves a goal, to get through it and to get through it well.... I think it's carried over in that we continue, however haphazardly to set goals, maybe sometimes higher than we think we can accomplish, and to want to get to that point again of accomplishing it and having done it well.... I think it came from making ourselves do the work and that's fantastic."

We can see from the above two separate, but related consequences from successfully managing problems associated with goals. Agreeing upon a set of goals and priorities conserves energy -- people are not "pulling in different directions." In addition, setting realistic, achievable goals and accomplishing them acts like a "shot in the arm" -- it adds energy.

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

No "standardized job descriptions" exist for team doctors, team nurse, team social worker, 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.

Therefore, team members need skills and procedures to enable them to define the role relationships appropriate to their particular situations (goals, skill mixes, patient needs, etc.) and redefine these relationships as required. Module Four of the team development program is designed to provide these skills.

In every case, this has been a high point in the program - in terms of short-range gains and long-run usability and relevance.

"First of all you learn to identify each individual in the team and who you are going to need and who can provide it. And when you make that referral to that particular individual you know it's going to be taken care of because the acceptance has already been expressed through the team development that took place.... It's a great development of comfort and confidence with your teammate. It opens up channels of communication."

"I think also that people feel less isolated. They are willing to take on much more work."

"Everybody has some sort of input, whether they're a medical person, professional, non-professional, whatever. They have some sort of idea about the case and everybody has the feeling to speak up.... You know, they feel as though they're as important as anybody else, whether they be a bus driver or a dental clerk."

"Another thing has been that to some extent people who hide information, very directly related to health maintenance, who did not offer it up before are now making inputs."

"Another thing is the confidence issue. After team development, individual providers were more inclined to get more deeply into people's problems because they knew they had the confidence to come back and get help with it. Before, they weren't sure. They were hesitant to take a new thing."

"It makes me more confident that if I go in there to a person with big problems, I know I can act quickly because I can go to _____. With her kind of knowledge, she will help me deal with that person quicker. And it's happening. When I find a family with a big, big problem, I know where to go to get help from each person."

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

Many of the factors already discussed above, in a sense, reflect a marked improvement in the team's work processes. Specific gains in

several other important areas have been noted. For example, with respect to team meetings:

"Team meetings are fantastic now."

"We really have an agenda and a certain amount of cases we discuss at these meetings. We have an allocation of time for each one."

"I really feel we've developed a way to run our team meetings."

"In the past when we discussed things, nothing was ever resolved and we didn't have a format for really discussing things. They never seemed to get anywhere."

In addition to specifics such as agendas, goals, etc. there are some clues which indicate why it is that teams' work processes are more effective. A meeting per se, in other words, is not enough - people need to behave toward each other in productive ways. As a result of the team development program, (a) the responsibility for team functioning becomes more widely shared, (b) conflicts are confronted more directly and resolved, and (c) team members find ways to support and reenergize one another.

"I think if we stray from our objective, things get haphazard and people start talking across the table, there's more of a real impulse now to say 'stop,' - there's no stigma in doing that. I mean everyone is sort of relieved when that happens. There might have been one or two people who would have done that all along (in the past) and they were the sort of nasty ones who always called us back to work."

"You also have a mechanism for when things are going wrong, you have some kind of mechanism for getting them back."

"If somebody was doing something to make their job a little more difficult, they could say something about it. You know, I could do this and it would make the day run smoother."

"Or, if there was anger, it was expressed all the way through, it wasn't destructively expressed."

"I think we all became aware of the necessity to support each other and work together as a group. When people were not feeling supportive or supported, they were able to bring that up. I think that's fantastic when people can do that."

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. We do not, at this point, have quantitative data in this regard. Instead, 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.

"From my point of view I think the impact on patient care has been that a patient does not have to practically be dying before we will make some attempt to help him or her follow up on her own care. We are a lot more conscious of helping a patient to follow through on their own care, by following through ourselves."

"I think that something that may have already been implied is that with our greater knowledge of each other's resources and also much more personal relationships, we can come up with much more original solutions to some sticky problems, like chronically ill patients or people who don't come up for their appointments and they really need to. We can come up with all kinds of solutions about what to do about that, and not just toss out the patient as an uncooperative patient."

"Whereas my inclination might have been in the past to say 'oh, I'll take care of it,' as if we both understood what that meant. I now think that when two people are discussing 'it', that we spend more time saying specifically that 1, 2, 3, 4, and can do x, y, z. That goes a long way with client services."

"I also feel that we're much better able to see direct results and much better able to function as a team. We're much more efficient and helpful towards each other and also to the patient. I don't think as many people get lost in the discussion or the flow."

"I also think that clients are not getting lost in the system as easily as they were in the past. I think there's much more of a monitor on who's doing what because there's more communication, and there's also more goal directed outcome of the discussion."

In looking back over all of these comments, it is interesting to note how

few of them deal with people's feelings per se ("How does it feel to work around here?" - the forth general area). To be sure, people "feel" much more positive and enthusiastic - not because they are friends, but rather, they have more successfully met their own needs to answer the questions: "What are we here to do?" "Who is doing what?" and, "How do we accomplish our work?" 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.* Health administrators and managers are under severe environmental constraints which represent a major obstacle to freeing up the time required for team development.

In addition, however, the managerial answer to the question: "Should we/can we offer a team development program in our organization?" confronts directly the issue of commitment. "Do we really believe in teams?" "Do we really believe that the organization exists to support the teams who are the direct care givers?" Some systems argue, for example, that team development

*See, Rubin, Irwin; Plovnick, Mark; and Fry, Ronald; "Initiating Planned Change in Health Care Systems," Journal of Applied Behavioral Science, Vol. 10, Number 1, 1974.

is important but teams should do it on their own time -- lunch hours, evenings, weekends, etc. A very subtle but powerful mixed message is thereby communicated, e.g., "We do support teams and we do support the need for development -- but -- we cannot do anything to support you in your efforts to develop yourselves as a team."

Team development represents, to many administrators, a threat to their power and influence. They recognize, often subconsciously, that a "developed team" may create waves, i.e., demand more autonomy, responsibility, etc. This fear, as we shall discuss in the next section, is not unfounded.

The main point, however, is that top management commitment to and support of a team development program is a critical variable in both getting started and the ultimate success of the program. Managerial efforts to do the work needed to offer the programs, e.g., freeing up the time required, in and of itself sets in motion a positive, self-reinforcing motivational pattern.

Team members made the following types of comments in this regard.

"I was just delighted that the center would invest that kind of time in us. I thought that was really something and that we should take advantage of it and I think that's a good selling point that the management is interested..."

"What I think is that just the fact that the administration gave us the time and the fact that we were doing it really made us take ourselves much more seriously both as a team and as individuals..."

The motivation and willingness to really work hard on the program to make it worthwhile was created by the specific act of offering the program and taking the managerial steps needed to support the program.

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.* Newly developed teams are very likely to want to use their new found strength to improve the organization of which they are a part. (The "subconscious" administrative fear referred to earlier.)

In effect, what happens is that teams begin to question the rationale and usefulness of certain policies, decisions, procedures, etc. Now that the team is developed, they feel more capable of handling more responsibility and seek ways to be more autonomous and self-sufficient (e.g., to be more responsible themselves for personnel decisions like hiring and firing). Some comments in this regard were:

"We keep asking them when they're going to go through their own development.** I think in some way, we've made them realize that their defining their roles and getting themselves together is really essential to a better functioning.... In the past, we would not have felt that kind of unity to be able to say that."

"I have a sense that they (the administration) were pretty loose about this (team development) happening because I sense that maybe not consciously, they felt it wasn't going to make that much difference as far as they (administrators) were concerned. Historically, teams and providers have never really wanted to be involved with stuff like that. [Policy decisions and administrative matters which influence a team's functioning]"

*See, Beckhard, Richard, "Organizational Issues in the Team Delivery of Comprehensive Health Care," op. cit.

**We have had one experience with an administrative/management group using the team program. Their reaction was mixed. While some of the same issues were relevant, the hands-on delivery focus of the present program was not. A more generalized educational program for managers, now being pilot tested, might better meet the needs of administrative groups.

Administrators, quite appropriately, react to these phenomena with initial hesitancy and concern. They feel like teams are "ganging up on them" and degrading the role of administration. This tension need not lead to negative results - as was reported in one setting!

"I think they see a more coordinated and efficiently working group of people who are asking realistic kinds of questions, not because they're not performing well and trying to blame somebody, but because they want something done productively, and I think that I, for one, was really pleased at the kinds of meetings we've had recently with the administrators which were not blaming.... 'Hey, we just want to clarify this -- and this is not to roast you over the charcoal, it's really for information so that we can all work better together.' I think the administrators were feeling threatened by that but after these meetings they are less threatened. Although it's hard to take sometimes, they're pretty pleased when that's happening."

In several of the organizations where teams have completed the program, the administration has initiated its own training and/or organization changes to facilitate team and administrative functioning.

"I think the team training has caused the team to become more aware of the problems of the total organization. This has led them to ask questions and make demands on us -- in, I think, usually a constructive way. It has also made us aware of our own need for more training or development."

"In addition to changes on the team itself, some of the team's interactions with us have led to the establishment of mechanisms, like committees and things, to deal with problems that were previously pretty much ignored."

The tension between administration and teams cannot be wished away, because at the organizational level, it reflects a set of dynamics caused by interdependence which are very similar to the team level issues discussed in this paper. Other programs, also educational in nature, are being developed to help administrators of health care settings manage their points of interdependence

both within and outside of their organization.

Conclusions

The results described here are based on field tests with twelve teams. These results tend to support our belief that educated health teams are more efficient and effective deliverers of care than non-educated 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 conclusion 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 trying to resolve the problems of interdependence -- planned programs can help them do it better.

SUMMARY OF TEAM DEVELOPMENT PACKAGE

PHASE ONE: GETTING STARTED

Module 1

"What is Team Development"

Objectives

1. To help you understand what is meant by the words, "self-instructional team development."
2. To assist you in deciding if you should take "the next step" and examine the way your group works together to see if team development would be beneficial to you.
3. To assist you in sharing and clarifying your decision in number "2" above with your colleagues.

Module 2

"Do You Want Team Development?"
(diagnosis of "vital signs")

1. To help you examine how you work together as a team.
2. To help you diagnose problems or potential problems you may have in working together that can be worked on in team development.
3. Based on the needs for team development that you identify, to help you decide whether or not to undertake the team development program.

PHASE TWO: CORE "COURSE"

Module 3, Part I

"A Team Trying to do What?"
Goal Setting

1. To come to some agreement on a general statement of core purpose -- "What are we as a group trying to do, anyway?"
2. To begin to develop in more specific form, the sub-elements (tasks) of this core purpose.
3. To learn, while accomplishing "1" and "2" above, about a goal-setting procedure which the team can use whenever necessary.

PHASE TWO: CORE "COURSE"

Module 3, Part II

"A Team Trying to do What?"
Goal Setting

1. To pull together the results from the last meeting and the additional sub-group results; to review these results and test for adequacy and completeness.
2. To the extent possible, to prioritize (categorize according to importance to achieving the DESIRED GOAL) the PERFORMANCE GOALS.
3. As a result of "1" and "2" above, be in a position to enable a subgroup to polish and write in a more final form this team's own view of its DESIRED GOAL and PERFORMANCE GOALS in support of this DESIRED GOAL: to decide who else from within the total organization should read/review/comment upon this total package -- which we will call the Team's Working Contract.
4. To take a "membership check" against these PERFORMANCE GOALS before proceeding further with subsequent team development activities:
 - a. are the people directly involved in the achievement of our top priority PERFORMANCE GOALS committed to going ahead with future developmental activities?
 - b. are there other people who must join the group if further work is to be productive? Who are they? How can we get them on board and actively involved?

Module 4, Part I

"Who Does What Around Here?"
Role Negotiation

1. To begin to clarify what each team member's job or role on the team should be.
2. To begin to work through any disagreements or conflicts that exist over what each team member's role is.
3. To learn a method which you can use to clarify team member's roles and deal with role conflict in the future.

PHASE TWO: CORE "COURSE"

Module 4, Part II

"Who Does What Around Here?"
Role Negotiation

1. To continue the process of clarifying each team member's roles.
2. To organize, structure, and schedule any or all negotiation sessions required to insure that each team member can resolve any conflicts or ambiguities which exist around his own role, and around the other team members' roles.
3. To expand the Role Negotiation Model to include follow-up steps.

Module 5

"How Things get Done
Around Here"

1. To have everyone on the team become familiar with a general problem-solving procedure and the process of decision making involved in it.
2. To enhance everyone's understanding of this model by applying it to several examples from the team's own past experience.
3. To commit, as a team, to practice using this model in the future to improve the team's decision-making and problem-solving capability.

Module 6

"What It Feels Like to
Work Around Here"

1. To describe the behavioral habits (norms or unwritten rules for behavior) which have become a part of this team.
2. To explore the impact that these habits are having on "what it feels like to work around here."
3. To agree, as a team, to eliminate some "bad" old habits and to develop some "better" new habits.

Module 7, Part I

"The Rest of the Puzzle:
The Patient"

1. To design a procedure for gathering feedback as to: "How well are we doing?" "Are we meeting the goals we set for ourselves?" (Assessment)
2. To identify the problems indicated by this feedback: "Where are we doing OK?" "Where do we need to improve?" (Analysis)

PHASE TWO: CORE "COURSE"Module 7, Part I (cont.)

3. To develop and implement the action steps required to deal with areas of needed improvement. (Prescription)

Module 7, Part II

"Interacting with the Organization and the Wider Environment"

1. Using the information generated in PART I, identify problems whose solution involves other parts of the organization (that is, outside of the team), or the wider environment (for example, city housing boards, an associated hospital, etc.). (Analysis)
2. To develop and implement action steps required to deal with these problems. (Prescription)

PHASE THREE: SPECIFIC, "HOW-TO-DO-IT" AIDS (optional)Module 8

"Bringing New Members on Board - Joining Up"

1. To understand the problems associated with bringing new members into the team.
2. To learn about some techniques that can be used to bring new members on board and up-to-speed more quickly and effectively.
3. To develop your own strategy for bringing new members on board.

Module 9

"Running a Meeting"

1. To understand some of the problems associated with conducting a meeting.
2. To learn about some techniques that can be used to help you conduct and contribute to effective meetings.
3. To begin to help you and your team develop your own strategies and techniques for conducting effective meetings.

PHASE FOUR: SELF-RENEWAL (done 2-3 months after Module 7)Module 10

"Our Present State of Health"

1. Examine the team's present state of health, focusing on progress already made and areas that may represent problems (assessment).
2. Identify and prioritize new or recurring problems, if any, indicated by this assessment (diagnosis).
3. Develop and implement the action steps needed to resolve priority problems (action planning).

OVERVIEW OF A HEALTH TEAM DEVELOPMENT PROGRAM

The total team development program (excluding for the moment the Guidelines for Administrators) can be broken down into three phases.

Phase One

Phase One consists of two modules. Module One is primarily descriptive and aimed at answering the following questions: What is team development? Goals? Methods? What benefits can it provide? As a result of reading this module and discussing it with the administrator who introduces/offers the program, the team should be prepared to move to Module Two.

Module Two is designed to help the team decide "Do You Want Team Development?" Individuals will complete a Team Effectiveness Diagnostic Instrument and the entire team will discuss these data. By examining these "vital signs," as we call them, teams will (a) experience our action-research approach to team development (data collection -> feedback -> joint action planning) and (b) develop more of a felt need for team development -- that is, get "hooked" by the idea.

Given this felt need, an understanding of what team development is, and an understanding of what they will have to invest over the coming weeks; teams are then helped to make a "go" or a "no go" decision. Should they decide to proceed (which we obviously encourage them to do), they move on to Phase Two.

Phase One requires a time investment of about 4½ - 5 hours (maximum); a 3-hour team meeting around vital signs and individual preparation of about 1½ hours (maximum).

Phase Two

Phase Two contains the core of the entire program. As designed, all teams are expected to go through it -- it is the "required" course. While a team can obviously decide to stop at any point, we explicitly avoid giving them this option. The module content follows directly the major categories of vital signs:

- a. "Why We Are Here"
- b. "Things About My Job"
- c. "How Things Get Done Around Here"

Module Three (a two-part module requiring two team meetings of about 3 hours each) deals directly with the issues of goal clarity and goal conflict. The team creates its own "working contract" which specifies a shared view of "What is our primary mission?" and "What are our top priority goals in fulfilling that mission?"

Building directly on this output, Module Four (also a two-part module requiring two team meetings of about 2½ hours each) is designed to help team members understand "who should be doing what" in terms of their top priority goals. As a result, each individual will have a clearer understanding of his own role, others' roles, and have some greater skill in the process of negotiating. This latter skill is important because of the dynamic, fluid nature of interdisciplinary teamwork.

Almost by definition, decision making is central to health team effectiveness. Whether the context is a total team conference or daily interactions between pairs of health workers, decisions are being made all the time--it is "how things get done around here." Module Five (requiring one team meeting of about 3 hours) will highlight the range of decision-making modes and the consequences of each mode on the logical soundness of the decisions made and team members' commitment to implementing these decisions.

Module Six (requiring one team meeting of about 3 hours) confronts directly the issue of team norms. How do team members behave toward one another, in an interpersonal sense, which could lead an individual to feel positively or negatively about "What it's like to work around here." As a result of this module, team members will better understand how they support each other (recharge their own batteries) rather than pulling each other down (draining energy).

The final module in Phase Two is Module Seven, "Patient Feedback" (requiring two team meetings of about 3 hours each and some outside work) is designed "to close the loop." As a result of Module Three, the teams will have set some very specific top priority goals. Module four to six will help them to build the internal strength they need to maximize the energy available to achieve these goals.

The primary goal in Module Seven is to help the team design a patient feedback system to work the interface between the team and its primary outside environment--the patient. A secondary goal is to help the team work the interface between itself and other support groups, e.g. medical records, pharmacy, etc. The negotiation skills developed during Module Four are directly transferable to the team's relationship with other groups or systems.

Without this latter module, teams would appropriately wonder why they had gone through the past modules. A patient orientation is, by definition, central to the team approach to primary, ambulatory, and family-centered health care. Finally, from our experience with health teams to date, one of the most significant forces which operates to "drain energy" is the continuous frustration created by not seeing any progress and by not gaining a sense of achievement. By setting specific goals, getting themselves "together" internally, and being able to measure their progress, health teams will be able to begin to experience some success.

Some Characteristics of Phase Two

Several characteristics of the activities in Phase Two need to be made explicit. A total of about 24 hours will be spent in team development meetings. Individual preparation - reading, responding to diagnostic questions, etc. - will total about 6-8 hours. Subgroup work outside of team development meetings will consume about 4-6 hours.

The sequencing of activities has several characteristics. Over time (i.e. from Goals --- Norms), the level of risk rises as team members are asked to focus increasingly "closer to home" -- the way they behave toward each other. The sequencing also reflects a best guess as to where most teams are likely to be. A given team, for example, may already have a clear idea of primary purpose and top priority goals or a shared picture of role expectations. This is the essential dilemma of a self-instructional approach. A consultant, if he were there, would make on-the-spot sequencing decisions based on his diagnosis of priority needs.

A related issue concerns the sequential positioning of the decision-making module. One could argue, that, in the process of completing Modules one to four, teams will be making many decisions. From this posture, maybe decision-making should come first. In other words, if their decision-making process is "poor," how can they decide on goals, roles, etc? Two factors have influenced our decision to position the decision-making module where we have.

First, in designing Modules one to four, we have structured out, to the extent possible, the potential negative impact of an ineffective team decision-making process. This is accomplished through very detailed instructions, supporting materials (e.g. forms, scales, etc.), and a rather directive approach on our part (e.g. You should do this....). Second, our experience tells us that problems which are perceived to be primarily relationship-oriented (i.e. decision-making styles, norms), very often result from unclear/unshared goals and ambiguous/conflicting role expectations.

Finally, throughout all of the modules, particularly in Phase Two, we are trying to balance two overriding objectives. On the one hand, we are trying to help a team solve a specific problem in an immediate sense. As important, however is the objective of providing the teams with a set of skills which they can apply in the future as similar problems develop. While this dual goal has some costs (e.g. modules may be longer) it is important that both goals be maintained if teams are to derive any long-run benefit from the effort.

Phase Three

Phase Three contains two elements. Modules Eight-Nine focus on two salient and recurring team needs; the socialization of new members and the conduct of total team meeting or conferences. They will be shorter, "how-to-do-it" types of input vs. the more involved action-research oriented

(e.g. data collection --> feedback --> action planning) module of previous modules. When the problem arises, the team will be able to use the guidelines in these modules to improve the process, for example, of integrating a new team member.

Module Ten is designed to be implemented some time after the completion of Module Seven (the end of Phase Two). Sequentially, it represents a progress check-up on the impact of Phases One and Two. Two categories of skills are developed: a diagnostic capability to help a team identify areas of needed improvement; and a problem-solving capability to develop alternative action plans to solve the problems which have been identified. With the capstone module, the "ideal" team will now be a self-renewing system capable of identifying its own team development needs and developing the strategies to meet these needs.

BASEMENT

Date Due

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|-----------------------|-----------------------|
| MAY 12 '79 | ██████████ |
| AUG 4 1979 | FEB 13 1985 |
| JAN 09 '80 | NOV 10 1985 |
| MAY 23 '81 | MAY 15 '86 |
| AUG 31 '81 | MAY 12 '87 |
| DEC 1 1981 | NO 13 '87 |
| ██████████ | NOV 1 1988 |
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