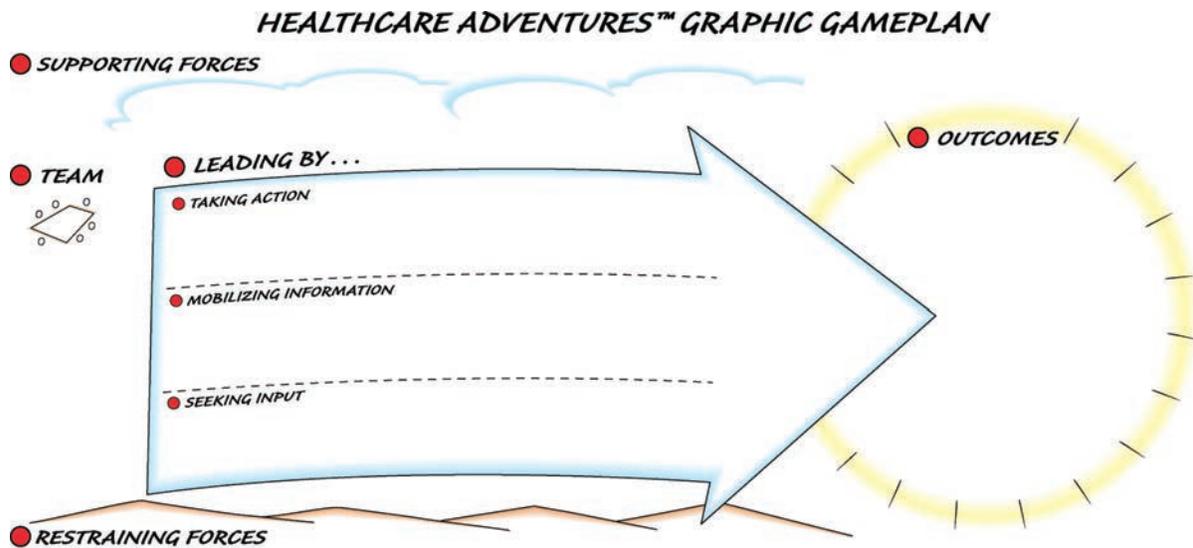




A FACILITATOR'S GUIDE

The Healthcare Adventures™ Graphic Gameplan For Patient Safety

JAY W. VOGT • MICHAEL SALES • SARA J. SINGER • JEFFREY B. COOPER



The Center for Medical Simulation, Boston, Massachusetts

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HOW TO USE THIS GUIDE

The first two sections (pp. 4–7) frame the theoretical and
evidence-based context for understanding this new tool.

The next two sections (pp. 8–21) provide a how-to guide
for practitioners for using this tool.

The appendix (pp. 22–32) provides additional useful
resources.

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www.grove.com/site/index.html

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IMPROVING QUALITY IN HEALTHCARE

PATIENT SAFETY LEADERSHIP AND THE GRAPHIC GAMEPLAN

Leaders and managers in healthcare must respond to needs (and occasionally, to demands) for improvement in both the efficiency and the quality of the health services their organizations provide. Patient safety leadership in response to these needs is critical — and can be challenging on a host of fronts. What if leaders and managers could engage in a patient safety and quality improvement process that was outcome focused, evidence based, clear, *not difficult*, and even enjoyable? The Healthcare Adventures™ Graphic Gameplan is that process, and it elicits these kinds of reactions from participants:

“I have loved using the Gameplan. Our project is going really well, at the speed of light. People have taken the bull by the horns in their roles now that they know what they are.”

“We had a baseline rate of 78% compliance with target. As a result of this discussion, we focused. In our last measurement, compliance was 94%, maybe higher.”

Before we introduce the **Healthcare Adventures™ Graphic Gameplan for Patient Safety**, we offer some discussion of the contexts for its utility.

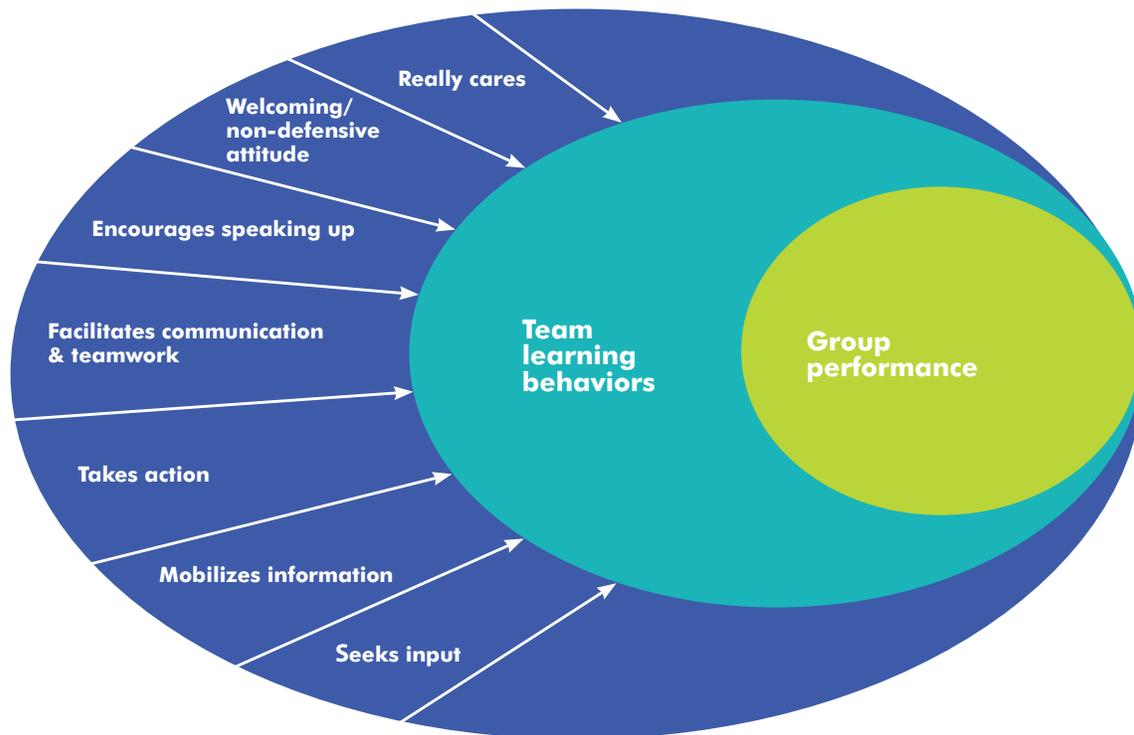
The Challenge of Improving Quality in Healthcare

The need for improvements in the quality and efficiency of healthcare continues, as is demonstrated by an ongoing accumulation of studies (McGlynn 2003). The history of such improvements has been mixed, however (Leape and Berwick 2005; Auerbach et al. 2007), and the evidence for clear and sustained advances on specific quality improvement initiatives is still decidedly limited (Landon et al. 2007; Landon et al. 2004; Mittman 2004; Shojania and Grimshaw 2005).

One of the challenges to implementing successful quality improvement (QI) initiatives in healthcare has been engaging senior managers (Blumenthal and Kilo 1998). Effective leadership by senior and middle managers is critical because of their disproportionate cultural influence, financial control, and decision-making authority (Carroll et al. 2006). Healthcare is not unique in this regard: securing the right sort of leadership engagement for quality improvement is challenging across a variety of industries (Westphal et al. 1997). The issue is not simply a matter of managers’ interest in quality (Batalden and Stoltz 1993), which, in healthcare, has increased markedly in response to both mounting requirements for transparency around quality and burgeoning pay-for-performance initiatives. Rather, successful quality improvement requires that leaders be genuinely and consistently engaged in the effort, and that attention to patient safety be embedded in the fundamental DNA of the organization.

An organizational climate of empowerment and continuous learning results in greater quality improvement output and performance (Carman et al. 1996). The literature on organizational learning—considered here to be one aspect of an organization’s overall climate—provides insight into effective ways to engage managers in quality improvement. It posits that organizations are more likely to learn—whether through QI initiatives, experimentation, or reflection about day-to-day operations—if leaders create a climate of curiosity, exploration, and reflection (Hackman 2002).

We call this learning-oriented environment a *patient safety leadership culture*. Let’s explore it in greater depth by examining seven leadership behaviors that, evidence suggests, help create an organizational culture that pursues patient safety.



A Comprehensive Model for Patient Safety Leadership

The seven behaviors identified in this graphic, and discussed subsequently, comprise evidence-based leader traits and actions that support a culture devoted to patient safety.

ONE: REALLY CARES

In creating a patient safety leadership culture, leaders need to demonstrate what is perhaps the most critical behavior—to show, in ways that are discernible to staff, that they care. How a leader spends his or her time and attention, and what she talks about, and how passionately, send clear signals to staff about what matters in an organization (Clarke et al. 2007). Staff members observe both verbal and nonverbal cues, and model

their own behavior accordingly. Managers demonstrate that they genuinely care about safety and quality in general, and about an improvement project in particular, by being visible and visibly interested in how safety and quality goals get enacted in daily operations. When leaders of an organization express real caring, staff awareness of quality-related concerns increases, resulting in fewer small mistakes that potentially could lead to larger, more-catastrophic errors (Weick and Roberts 1993; Garvin 2000).

TWO: HAS A WELCOMING, NON-DEFENSIVE ATTITUDE

A meaningful behavior is welcoming people's contributions and responding non-defensively to them. This creates an environment in which people feel safe to

When leaders of an organization express real caring, staff awareness of quality-related concerns increases, resulting in fewer small mistakes that potentially could lead to larger, more-catastrophic errors.



take interpersonal risks. Participating creatively and effectively on quality improvement (QI) project teams requires individuals to take some risks, including offering suggestions and experimenting with new ideas. Evidence suggests that people often don't take these risks because they don't feel "psychologically safe" within the group, i.e., to bring up something that might make someone uncomfortable (Edmondson 1996). Taking such a risk is especially difficult in a situation of unequal power, wherein the person to whom a "risky" comment is to be delivered has greater status and authority than the individual making the comment (Janis 1982). This is particularly true in healthcare, in which the value of rigid status hierarchies is instilled across all disciplines. A leader's response, when a staff person takes an interpersonal risk, strongly influences whether that staff member will ever do so again. A defensive response inhibits further contributions; a welcoming response and non-defensive attitude

encourage them. A leader's orientation toward learning, rather than blame, and toward safety, rather than status, is critical in setting a safe, receptive tone.

THREE: ENCOURAGES SPEAKING UP

Another important leader behavior is encouraging interpersonal risk-taking—specifically, behaviors such as speaking up to express safety questions and concerns—that leads to organizational learning and enhanced performance. Leaders do this by asking for input, thanking people when it is given, and acting on suggestions provided (Edmondson 1999; Edmondson et al. 2001; Edmondson 2003; Nembhard and Edmondson 2006).

FOUR: FACILITATES COMMUNICATION

Facilitating communication and teamwork is essential to leaders' creation of the conditions that foster team effectiveness. Such facilitation includes attending to the

“I have loved using the game plan. Our project is going really well—at the speed of light. People have taken the bull by the horns in their roles - now that they know what they are.”

PEDIATRICS TEAM MEMBER

“We had a baseline rate of 78% compliance with target. As a result of this discussion, we focused. In our last measurement, compliance was 94%, maybe higher.”

OBSTETRICS TEAM MEMBER

structure and composition of the team, establishing its purpose, providing coaching as needed, and working with the team to help members use collective resources in pursuing team goals (Hackman 2002). Leaders can also use specific processes that promote teamwork, such as daily huddles, time-outs before implementing key changes, and reflection following implementation (Edmondson 2003).

FIVE: TAKES ACTION

Taking action, even when resources are not optimal, palpably demonstrates commitment to quality improvement. Lack of sufficient resources is a common explanation for the failure of QI efforts in healthcare organizations (Shortell et al. 1995). All hospitals face resource constraints, but leaders can make judicious use of scarce resources through a systems approach to quality improvement (Shortell and Singer 2008). For example, gathering input from frontline workers about safety hazards and ineffective processes can lead to work-system redesign that yields more efficient use of financial and personnel resources, while simultaneously improving patient safety (Tucker et al. 2008). Simple, consistent inquiry and intervention by leadership—to ensure that reasonable actions are taken without delay—can make the difference in getting important work done (Weiner et al. 1997).

SIX: MOBILIZES INFORMATION

Effective leaders ensure that QI team members have the information necessary to achieve project aims, and that critical information is shared across the institution. Leaders must institute processes for documenting, interpreting, and disseminating knowledge (Garvin 2000). By systematically sharing knowledge, organiza-

tions prevent duplication, enhance creative problem-solving efforts, and—because staff feel that their thoughts and experiences are valued by the organization—improve employee morale (Husted and Michailova 2002).

SEVEN: SEEKS INPUT

Seeking input is a key behavior for leaders. A lack of formal authority can limit the ability of frontline workers to reach across disciplines, work units, and shifts to obtain needed information or to effect necessary change (Tucker and Edmondson 2003). An important function of an engaged leader is to seek this input, span these boundaries, and ensure both that information flows as needed and that appropriate individuals gather to discuss issues of mutual importance (Ancona and Caldwell 1992; Argyris 1985).

PATIENT SAFETY LEADERSHIP CULTURE

Learning requires change, but too often, change is endured rather than enjoyed (Edmondson et al. 2001). This can be as true for those initiating change as for those “on the receiving end.” An important aspect of a leader’s “coaching” role is recognizing people’s disorientation and discomfort with new conditions, and communicating a motivating rationale for expending the effort to make the change successful (Podolny et al. 2005). Once people can envision the benefits of implementing new approaches, the costs become secondary, and individuals are more likely to work toward a shared purpose, with end goals in mind (Batalden and Stoltz 1993; Senge 1990). Together, these leader behaviors create the conditions for a thriving patient safety leadership culture.

THE HEALTHCARE ADVENTURE™ GRAPHIC GAMEPLAN FOR PATIENT SAFETY

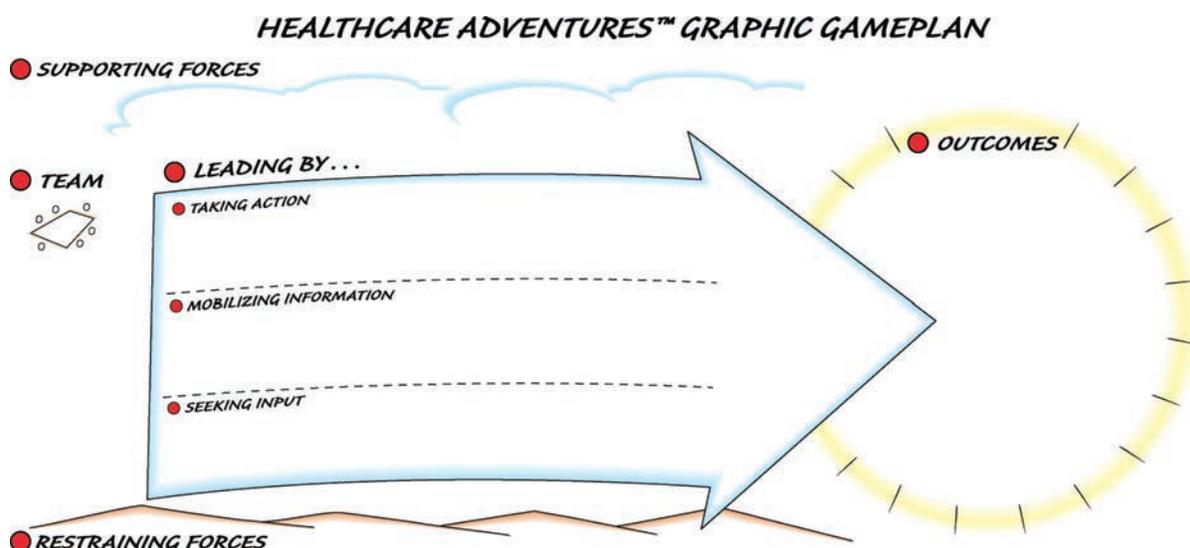
Healthcare Adventures™ (HCA) is a customized, day-long, team-training workshop for intact leadership and management teams from across the healthcare spectrum. The purpose of the HCA workshop is to help healthcare leaders grow individually and collectively in ways that support the creation of patient safety leadership culture; it employs the Graphic Gameplan as one of its tools. The HCA workshop is designed to improve individual and team performance by developing collaboration and communication skills consistent with the patient safety leadership model described in the previous section. A typical Healthcare Adventure includes challenges with a simulated patient in a highly realistic clinical setting. Through this richly textured, simulated environment, even teams composed entirely of non-clinicians actually get the chance to care for a patient, and to experience real patient safety issues first-hand.

Faculty and professional organizational behavior facilitators work with the team before the simulation to define objectives and expectations, and to identify

a specific and important quality, safety, or other team project to address during the program. After the simulation, the team is debriefed, with the facilitator identifying teachable moments that lead to learning and actionable strategies. Participants gain new insights into their individual and team behaviors. These are kept in the forefront during the development of a Gameplan, under the guidance of the facilitators, specific to the team's project. Team members go home having done "real" work on something valuable and tangible, often advancing a project that had previously been "stuck."

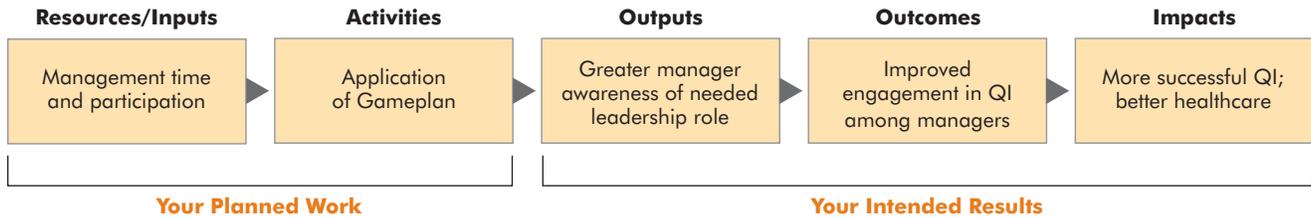
The Graphic Gameplan

The Graphic Gameplan is a team tool for an extended (up to three-hour) exploration of a patient safety project. The original Graphic Gameplan was designed by a consulting firm: The Grove Consultants International of San Francisco. It has been adapted, with permission, by many specialists in many fields; this Graphic Gameplan has been adapted by the authors specifically for use with healthcare leadership teams.



Graphic Gameplan Logic Model

(ADAPTED FROM W.K. KELLOGG FOUNDATION 2004, 1–4)



The objective of the Graphic Gameplan is to create a set of strategic conversations around an important patient safety project. In the graphic on page 8, the Gameplan process is represented by an arrow pointed toward a set of outcomes. The conversations that ensue can take the form of a structured movement from topic to topic; or they can comprise a looser exploration based on open-ended questions that allow the facilitator to offer comments, information, and insights as the material emerges and wherever it fits. A typical process includes some combination of the two.

The Theory of Change Animating the Graphic Gameplan

Managers' intentions in healthcare are often consistent with those that the literature suggests promote learning and improvement. However, the quality improvement tools that many organizations have adopted—such as Plan-Do-Study-Act (Institute for Healthcare Improvement, "How to Improve"), Lean (Institute for Healthcare Improvement 2005), and Six Sigma (Kabcenell et al. 2010)—are limited in the extent to which they provide explicit, pragmatic means of engaging managers. Without such a "formal" mechanism, even knowledgeable, motivated managers often fail to engage as effectively as they know they must. A QI tool that explicitly and formally engages managers may yield superior results.

The Graphic Gameplan is exceptional among quality improvement team tools in that it provides an explicit process designed to help leadership engage in meaningful support of quality improvement initiatives. The theory of change underlying the Graphic Gameplan is represented as a logic model in the figure above.

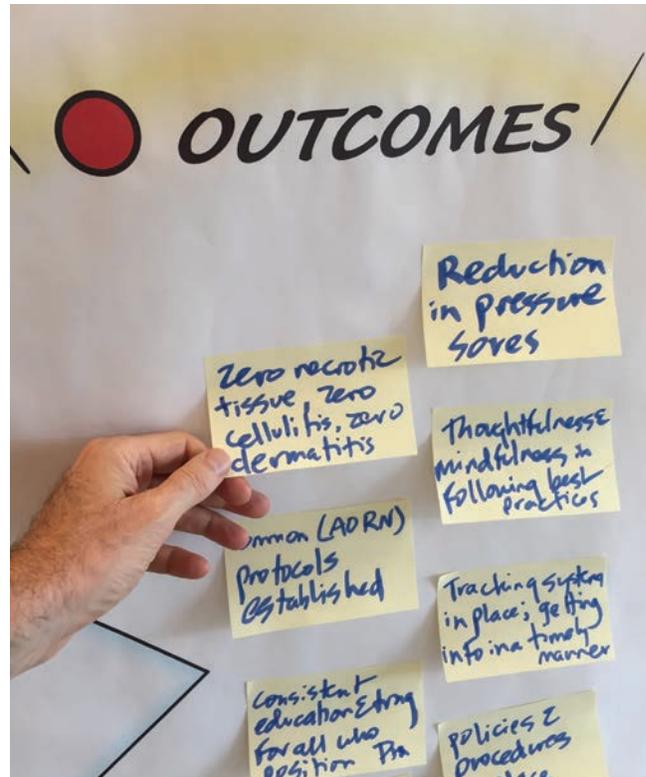


The Graphic Gameplan is exceptional among quality improvement team tools in that it provides an explicit process designed to help leadership engage in meaningful support of quality improvement initiatives.

Developing a Gameplan requires relatively little investment of time and resources. The Graphic Gameplan Logic Model (p. 9) suggests that developing a Gameplan promotes awareness, among senior and middle managers, of the leadership necessary to facilitate a given QI project successfully, and to realize its full potential for organizational learning. Leadership contributions to successful QI project execution are enhanced in two ways:

1. A clear process helps leadership become aware of the key elements of a QI initiative, including: desired project outcomes, project team members, expected supporting and restraining forces, and a sequence of action steps, information requirements, and input necessary for attaining project objectives.
2. A visual tool helps leadership conceptualize these elements and how they interrelate.

The Graphic Gameplan quickly generates a comprehensive, graphic roadmap for an improvement effort, and highlights how managers must intervene to promote project success. The tool can be applied to any improvement effort and complements implementation approaches, such as Plan-Do-Study-Act cycles (Institute for Healthcare Improvement, "How to Improve"). Enhanced awareness promotes more strategic, coordinated, efficient, and effective intervention by managers and others in support of a QI project, which in turn leads to both better teamwork among stakeholders and more successful QI project implementation. Each successful project boosts willingness to initiate



more quality improvement activity, leading to improved quality and cost of healthcare delivery.

Our experience shows that, through its explicit process, graphic framework, and evidence-based content, the Healthcare Adventures™ Graphic Gameplan promotes leadership behaviors that are critical for organizational learning. Such leadership really cares, adopts a welcoming, non-defensive attitude, encourages speaking up, facilitates communication, takes action, mobilizes information, and seeks input.

“Most useful! Identifying team roles and outcomes is really important. It helps to outline the help we need and where to get it. Breaking it down into steps facilitates the plan and timeline.”

ACUTE CARE MEDICAL TEAM MEMBER

FOR FACILITATORS: GETTING READY TO USE THE GRAPHIC GAMEPLAN

The following two resources provide useful information about the role of facilitators. An effective facilitator for a Healthcare Adventures™ Graphic Gameplan will have many of the general skills of a professional facilitator, as described by the International Association of Facilitators (International Association of Facilitators 2003, 1–4). *Basic Facilitation Skills*—a primer published by the Human Leadership and Development Division of the American Society for Quality, the Association for Quality and Participation, and the International Association of Facilitators—provides an excellent overview of the role (Burke 2002).

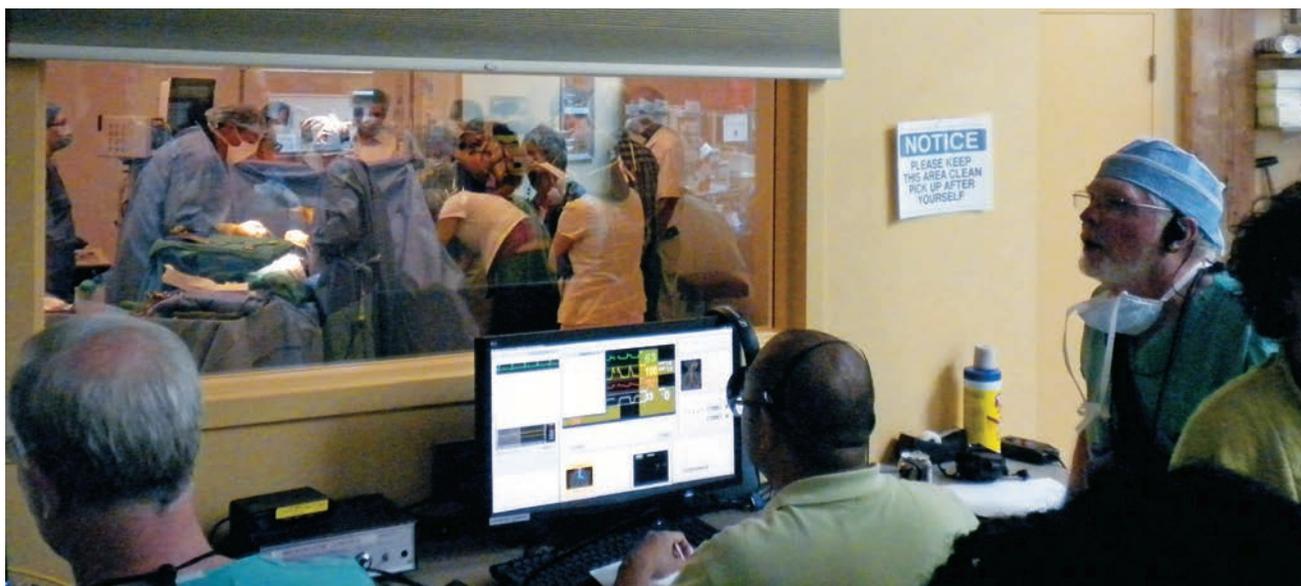
Key attributes for successful facilitation of a Graphic Gameplan with senior managers, managers, frontline staff, and/or mixed teams include:

- ability to assess a team and identify its teamwork performance challenges
- ability to create an environment of safety, learning, and exchange
- ability to facilitate and document group interaction in real time

- ability to manage conflict within and challenge from the project team
- understanding of project management concepts and process
- understanding of teamwork concepts and team development
- willingness to identify and say things that others may not want to discuss
- sincere interest in the team’s or group’s mission and goals, including what they do, why they do it, and how their activities impact patients

If you are considering using the Graphic Gameplan, and your answers to the following questions are “yes,” it may be a very effective process to have in your toolkit.

1. Do I have the passion to make a difference in patient safety?
2. Do I have the basic facilitation skills to lead a use of the tool credibly?
3. Do I have the humility to keep learning and continuously improve?



THE FACILITATOR'S GUIDE

This section discusses the elements of the Healthcare Adventures™ Graphic Gameplan, guides the facilitator through the use of it, and sets out sample language that may be helpful in leading a team through the process.

Overview

The Graphic Gameplan is a visual tool for framing a conversation about a healthcare team's quality improvement project. The graphic provides an overview; the arrow indicates action toward outcomes; and the component parts frame the key elements of the team's work that require planning.

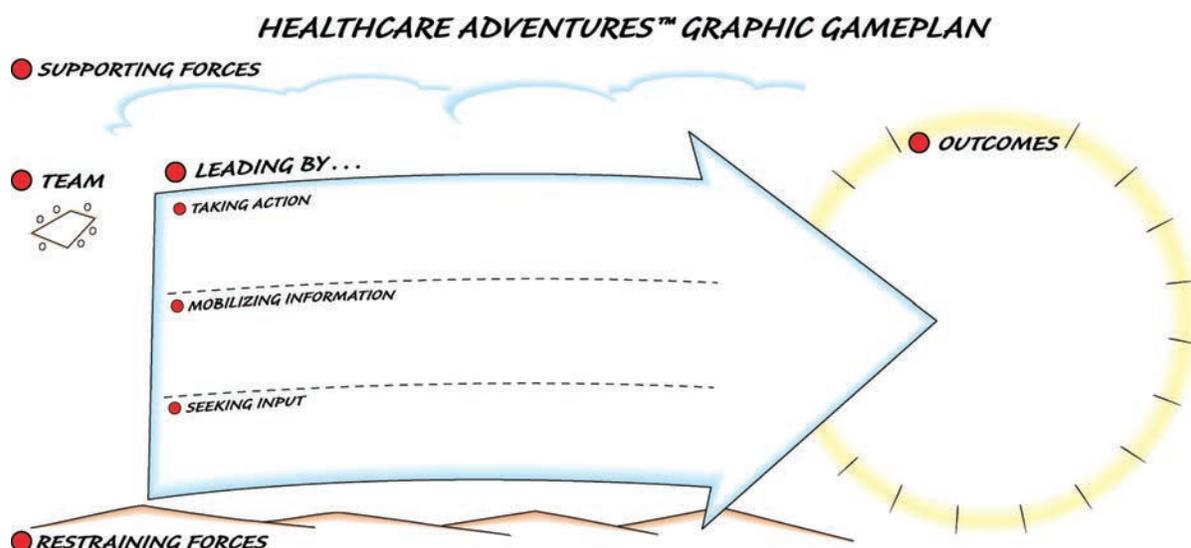
As previously mentioned, The Grove Consultants International of San Francisco created the Graphic Gameplan as a generic tool to help focus project teams. It has been adapted for use as a patient safety leadership training resource, with The Grove Consultants' permission, by the Center for Medical Simulation, the MGH/MGPO (Massachusetts General Hospital/Massachusetts General Physicians

Organization) Center for Quality and Safety, and the Harvard School of Public Health (now the Harvard T.H. Chan School of Public Health). The Graphic Gameplan integrates elements of a new, evidence-based leadership model for organizational learning that identifies seven key elements of successful leadership for improving patient safety culture.

The foremost element—showing you really care—is implicitly communicated whenever managers take the time and energy to advance a safety project by using the Gameplan. The action focus of the Gameplan directly addresses the three patient safety leadership culture elements most relevant to project management:

1. Taking action
2. Mobilizing information
3. Seeking input

However, the process of creating a Gameplan also presents a great opportunity to practice the three other, more-process-oriented elements:



The foremost element—showing you really care—is implicitly communicated whenever managers take the time and energy to advance a safety project by using the Gameplan.

1. Having a welcoming, non-defensive attitude
2. Encouraging speaking up
3. Facilitating communication

Thus, the Gameplan elegantly combines the seven elements in one action.

The two classic teamwork components common to all teams and incorporated in the Gameplan include:

1. Outcomes (goals)
2. Team (roles)

The “[force field analysis](#)” developed by action scientist Kurt Lewin gives the Gameplan its final structural components (Lewin 1951):

1. Supporting forces
2. Restraining forces

The final element is the facilitator, who:

- frames the group’s understanding of the tool
- facilitates the group’s discussion of its project using the tool
- records the group’s discussion of its project as appropriate, using the tool in the least obtrusive way
- feeds back to the group its conclusions so as to build understanding and consensus
- creates an action plan for next steps

Groups complete versions of this exercise in as little as one hour or as much as three hours. We recommend exploring the focus of the Gameplan at a pre-meeting with the group that will lead a specific and significant

patient safety or quality improvement project. We also recommend meeting with the same team six weeks to six months after the initial Gameplan session to follow up on initial implementation of the patient safety project identified during that Gameplan process. (For greater assurance of project completion, more follow-up is advisable, but practically, often difficult to achieve.)

Setting Up the Process

The Graphic Gameplan functions best when the tool is physically large enough to act as a shared visual focus for an extended team conversation. The simplest way to create that focus is to draw the Graphic Gameplan template on a large roll of paper, and post that paper on a flat wall that can be a vertical work surface. A 48” (in width) roll of white paper from an art supply store, unrolled over a space at least 12’ long, or longer, can work well. (Alternately, see page 30 for information on ordering preprinted, 8’ x 4’ color copies of the Healthcare Adventures™ Graphic Gameplan template.) Room seating should be arranged so that everyone can see the Gameplan during the work session.

Although notes can be written directly on the paper template, we recommend writing instead on (3” x 5”) sticky notes so that ideas can be moved, clustered, and replaced as the conversation proceeds. The sticky notes give the facilitator flexibility to record the group’s conversation in a way that is nearly as fluid as the conversation itself. We recommend water-based markers (because they have no noxious scent and won’t stain clothes) that make strokes thick enough to be visible at the back of a small room.

Think of the Graphic Gameplan as a series of important conversations that a team needs to have about an upcoming patient safety project. The intelligence of many past successful team efforts is embedded in the tool.

Introducing the Tool

We typically introduce the Graphic Gameplan as a tool before we dive into the project content. This is language we might typically use:

The Graphic Gameplan is a visual tool for mapping quality improvement projects in teams. It was first developed by The Grove Consultants International of San Francisco. This version is a unique adaptation, by practitioners at the Center for Medical Simulation, Massachusetts General Hospital, and the Harvard T.H. Chan School of Public Health, that incorporates evidence-based components appropriate to our task.

Think of the Graphic Gameplan as a series of important conversations that a team needs to have about an upcoming patient safety project. The intelligence of many past successful team efforts is embedded in the tool. We can walk through the Gameplan methodically, step-by-step, and let it prompt the right conversations. Or we can talk more casually, letting our thinking emerge, and capture our insights where they fit within the framework. Either can work, and we may well end up employing a combination of the two.

Before we begin the discussion, we walk participants through the Graphic Gameplan element by element, describing the role and function of each component of the process:

- *As you can see, the Graphic Gameplan is essentially an arrow, and it moves from left to right, toward its point, where we record our intended*

outcomes. When we are successful, how will we know?

- *The arrow starts on the left with the team itself. Who are the players who will make this project happen? What roles are needed to ensure the project's success?*
- *The three shafts of the arrow are three evidence-based components that lead to goal achievement and to recognition of the leadership required for successful organizational learning.*
- *The first is "taking action." What highly visible action steps can the team take that will achieve the desired outcomes? What leadership is required for these actions to occur?*
- *The second is "mobilizing information." What information—from any source—is needed by the team and others, to inform actions and achieve outcomes? What leadership is required to mobilize this information?*
- *The third is "seeking input." Who else needs to be involved in this change, either to ensure the best possible decisions, or to secure buy-in from key stakeholders? How should these stakeholders be involved, and what leadership is required to obtain this input?*
- *Of course, the team does not work in a vacuum. There are forces present in the environment—which we'll call "supporting forces"—that act like wind in your sails, moving you toward your outcomes. And there are forces present in the environment that hinder or restrain your success, that hold you back from achieving your outcomes. Leadership may be required to activate supporting forces and/or to overcome restraining forces.*



Initiating the Gameplan Experience

Having introduced the Graphic Gameplan, we can now begin the series of conversations that help the group map its project, and in so doing, complete the template. We often choose to start the conversation with some very broad, open-ended questions. Doing this lets group members set the pace, begin where they want to begin, and feel ownership of the process.

We ask questions such as:

Let's start at the beginning with some really basic questions:

- *What is the project you have chosen, in a nutshell?*
- *Why did you choose this project, and not another?*
- *Why do this project now?*
- *Why is this team the right team to do it?*

When we list multiple questions like this, we don't mean to suggest that they all be asked at once. We suggest starting with one, and falling back to the

others if additional prompts are needed. Asking about the project—overall—gets team members talking. Sometimes their outcomes will surface. The facilitator will want to post comments, as they are offered, in the sections of the Gameplan that seem most appropriate. Using sticky notes, the facilitator can always move the comment should she and/or the team change their mind(s) about its proper placement.

The question about why a team chose a particular project often makes overt any supporting forces in the environment that raise this project as a priority. Examples might be a change in insurance reimbursement that promotes or punishes certain outcomes, or the publication of a new, evidence-based, procedure protocol that is winning widespread endorsement.

The question about “why now” may surface supporting forces (e.g., “encouraging developments”) and restraining forces (e.g., “this will be harder later”).

*“I'm just so admiring of this process.
There were so many ‘A ha!’ moments!”*

ANESTHESIA TEAM MEMBER

The question about “why this team” begins to identify who is likely to be involved in the project, and what those individuals’ capabilities are.

As indicated before, we let the group share their answers to these questions while we, with little fanfare, record their comments on sticky notes and place them wherever they most belong. Sometimes this initial conversation can be lengthy and productive, generating many sticky notes that populate the entire range of the Gameplan’s specific elements, while in many other cases, it is brief, and only serves as an introduction.

Summarizing

After this initial conversation has run its course and we sense a pause in the conversation, we often take this opportunity to do a quick recap of major comments, showing how they fit with the components of the Graphic Gameplan.

- *Before we dive into the Gameplan in earnest, let me take a moment and briefly recap what I heard, so you can see how the game is played.*
- *For example, in the category of supporting forces, I heard . . .*
- *In the category of restraining forces, I heard . . .*
- *In the category of outcomes, I heard . . .*
- *Is that a fair summary of what was just said?*
- *No doubt there are others, as well, which we can capture as we go.*
- *Now let’s now walk through the Gameplan, section by section, and get your more specific ideas.*

The Gameplan Elements

Next, we move through each section, letting each element serve to prompt key conversations, about the project, that need to happen.



OUTCOMES

We “begin with the end in mind,” as productivity expert and author Stephen Covey has written (Covey 1989).

Let’s start with outcomes.

- *When your project is successful, how will you know?*
- *What would indicate success?*
- *What aims are you hoping to bring about?*

We record these thoughts about outcomes. If, at any point, comments surface that relate to other components of the Graphic Gameplan, we record those, as well, before bringing the conversation back to outcomes. This gives the participants the sense that they are having a casual, free-flowing conversation. The facilitator follows the team (by recording) so as not to lose members’ spontaneous contributions, but also leads the team (by intervening) back to the task at hand.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the outcomes you are aiming for are . . .*
- *Anything else?*
- *Any ways to make these outcomes more measurable?*

You will notice that periodically we pause the group for reviews that summarize, synthesize, and mirror back the work that has been done up to that point. This consolidates the group’s understanding of the work it has done so as to build on it more effectively during the rest of the exercise. It does slow the completion of the plan, but we find it useful in maintaining focus. The maxim “go slow to go fast” reminds us that—to be most effective in generating new thinking—people need time to reflect and to integrate.

SUPPORTING FORCES

Then we continue with the supporting forces component.

- *What forces in the culture and in the environment will act like wind in your sails, or tides lifting your boats, generally making it easier and more likely that you will succeed?*
- *What leadership by whom is required to ensure that these supporting forces are activated?*

If necessary, stimulate the conversation with a comment.

Think broadly about this. Supporting forces can be anything from an organizational culture that supports experimentation, to patients who have been greatly helped by the unit mounting the project and who might have resources to support the current effort.

Record the supporting forces that emerge. Notice whether the team seems more enlivened or energetic during this conversation, perhaps pleasantly surprised by the range of resources available to support its success. This may be worth noting, because that optimism is an asset to the team when the going gets tough.

If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to supporting forces.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the forces supporting your success are . . .*
- *Anything else?*

RESTRAINING FORCES

Next we move on to the restraining forces component.

- *What forces in the culture and in the environment will act like weights, holding you back and making it less likely that you will succeed?*
- *What leadership by whom is required to overcome these restraining forces?*

Record the restraining forces that are identified. Notice whether the team seems drained or subdued by this conversation. Sometimes the apparent lack of time, money, or leadership support for a project can be profoundly discouraging. Be wary of indulging too much in this negativity; ultimately, great things happen because of commitment and positive energy. Constraints can release team creativity, rather than restrict it. Though it may seem paradoxical, once limits

are acknowledged and accepted, remarkable human creativity often comes pouring out. Awareness of limits can actually help teams focus on areas in which their efforts can have the greatest impact. It is important to note these restraining forces in a clear-eyed way, and it's important not to get lost in them.

If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to restraining forces.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the forces hindering your success are . . .*
- *Anything else?*

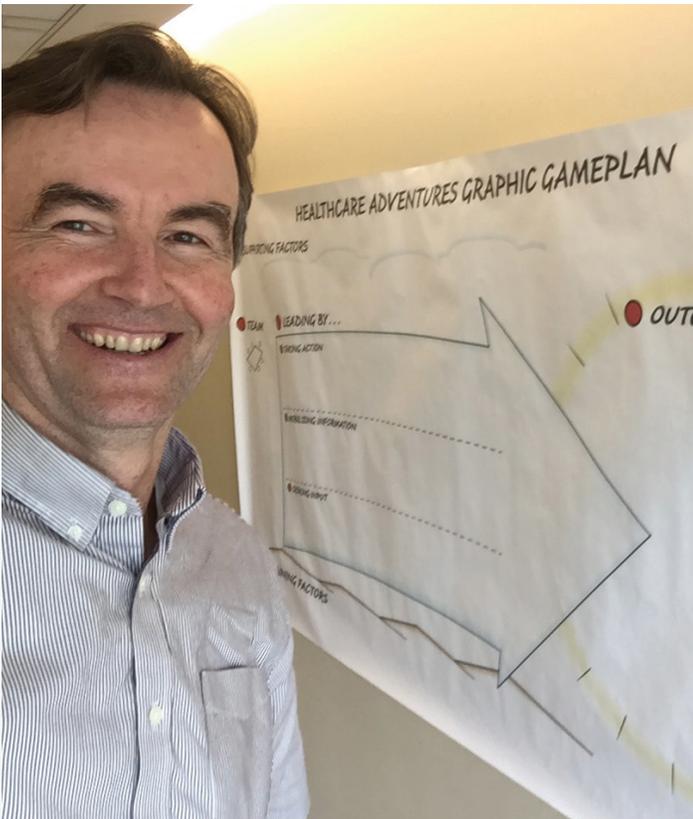
THE TEAM

Then we move on to the team segment.

- *If there's nothing else, let's move on to the team. Some group needs to be responsible for making all this happen. Who will that be?*
- *Often a team has content experts, who may not be regular members of the team, on whom it relies for specialized expertise. Does this team have such resources? Who would that be?*

It may be helpful to record not only names, but also the roles or areas of expertise that individuals bring to the project. Note that there are instances in which teams find it easier to identify the roles needed to accomplish their objectives than to identify immediately the specific individuals who can fulfill these roles.

- *Teams need leadership. Team leaders can be appointed by managers, they can be selected by the team themselves, and they can rotate.*
- *How does this team plan on managing its leadership function?*



If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to taking action.

- *Often a team has an executive sponsor who runs interference for the team, or works to create bridges across boundaries. Does this team have such an ally? Who would that be?*

Record these team notes. If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to the team.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the team you envision is . . .*
- *Anything else?*

TAKING ACTION

We continue with the taking action segment.

- *We now have a team dedicated to these outcomes. What actions does this team need to take to achieve those outcomes?*
- *What actions are within your power to initiate?*
- *What actions are outside your power to initiate, but which you might influence?*
- *What actions do you know this team can accomplish regardless of any obstacles it might face?*
- *What leadership by whom is required to execute desired actions?*
- *Are all of these actions necessary to achieve your outcomes?*
- *Are all of them, together, sufficient to achieve your outcomes?*
- *If not, what is missing?*

Record the identified actions. In suggesting actions necessary to accomplish project aims, participants may recommend actions in no particular chronological order. When posting actions on the Graphic Gameplan, try to place sticky notes into a rough chronology, from left to right.

If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to taking action.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the actions you plan to take are . . .*
- *Anything else?*

MOBILIZING INFORMATION

Next we move to the segment on mobilizing information, i.e., finding and using existing information that can be useful for the project. Information can highlight content (e.g., a description of a similar program in another unit of the hospital) or process (e.g., the best way to present ideas to a particularly busy audience). The maxim offered by management expert Ken Blanchard—“Feedback is the breakfast of champions”—reminds us that information on our performance is critical to our ability to improve it (Blanchard 2009).

- *We now have a team dedicated to these outcomes, and to taking these actions. What information does this team need to mobilize to support these actions and achieve its outcomes?*

- *Is this information available, or does it have to be gathered? If the latter, how would that happen?*
- *Do baseline data exist, or would they have to be gathered? If the latter, how would that happen?*
- *Does the need to have this information suggest additional actions that must be taken?*
- *What leadership by whom is required to access this information?*
- *Who would use this information, and how would it be shared?*
- *What best practices exist in this area, and how can you access them?*

Record these ways of mobilizing information. If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to mobilizing information.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the information you need is . . .*
- *Anything else?*

SEEKING INPUT

We continue on to the seeking input segment. Input serves two main purposes: (1) generating more creative ideas, and (2) ensuring buy-in and support from key stakeholders.

- *We now have a team dedicated to these outcomes, taking these actions, and mobilizing this information. We now turn to input, which serves two main purposes: (1) generating more creative ideas and better decisions, and (2) ensuring buy-in and support from key stakeholders.*
- *What input do you need before you initiate these changes, and from whom?*
- *What input do you need during these changes, and from whom?*
- *What input do you need after making these changes, and from whom?*

- *Think about input from superiors.*
- *Think about input from peers.*
- *Think about input from subordinates.*
- *Think about input from experts.*
- *What leadership by whom is required to secure this input?*
- *What managers need to receive this input, and what is required to ensure they receive it?*

Record these opportunities to seek input. If, at any point, comments surface that relate to other components of the Graphic Gameplan, record those, as well, before bringing the conversation back to seeking input.

Last, summarize briefly, and test for closure before moving on.

- *So just to review, the input you need is . . .*
- *Anything else?*

Concluding

We have now led the group through the entire Graphic Gameplan. Sometimes it is useful to give the group a chance to take stock and catch its collective breath.

We've now walked through the whole Gameplan once.

- *What do you think?*
- *What was that like?*
- *Has this been helpful? How?*

Having acquired the perspective of the whole process, participants will sometimes want to revisit individual components. This is especially important for groups that considered questions only superficially the first time through.

Now that we have mapped out the whole project, let's take one additional look at our outcomes.

- *Are they attainable?*
- *Are they too ambitious?*
- *Are they not ambitious enough?*

*“We needed this chance to be together,
to become a team and to reflect on the project.”*

ORTHOPEDIC SURGERY TEAM MEMBER

The final step is making plans for next steps. Some groups like to post the actual Graphic Gameplan on a team room wall for ready reference; others like to transfer it to a digital version; and some like to translate it into project management software.

- *What are the best next steps for the team to take to make maximum use of the Gameplan?*
- *Who is going to make that happen?*
- *Exactly who is going to take responsibility to do what?*
- *When do you think you are most likely to revisit the Gameplan again, for review and revision?*

Of course, we end by thanking the participants, and wishing them success. If our relationship is ongoing, we pledge our support and specify our next steps.

A Sample (Completed) Graphic Gameplan

The most interesting Graphic Gameplans are the ones you complete for a project you care deeply about. Nevertheless, it can be useful to see a completed sample Gameplan, which shows how a real, live team used the tool to map out a patient safety improvement project that they cared about. The sample, available through the link below, addresses a topic area of concern to many hospitals—infection control. This Graphic Gameplan was developed by a team aiming to decrease MRSA (methicillin-resistant *Staphylococcus aureus*) rates. (Note that identifying details have been changed to protect the team’s privacy.)

To download this sample Graphic Gameplan, click on the link and follow the instructions.

https://harvardmedsim.org/_media/pdfs/HCA-Graphic-Gameplan.pdf

Sample Timing Frameworks for Graphic Gameplan Sessions

A Three-Hour Session	
Minutes	Task
10	Introducing the tool
25	Opening questions
15	Defining outcomes
15	Identifying supporting forces
15	Identifying restraining forces
15	Break
15	Defining the team
15	Identifying actions
15	Mobilizing information
15	Seeking input
25	Closing questions

A Two-Hour Session	
Minutes	Task
05	Introducing the tool
10	Opening questions
15	Defining outcomes
10	Identifying supporting forces
10	Identifying restraining forces
15	Defining the team
15	Identifying actions
15	Mobilizing information
15	Seeking input
10	Closing questions

APPENDIX

AUTHOR BIOGRAPHIES



Jay W. Vogt is an organizational development consultant with 30 years' experience in working with nonprofit organizations, corporations, government, and small businesses. In 1982, he founded Peoplesworth, a private practice in strategic planning and change management.

He holds an MA in counseling from Antioch University New England, and a BA from Hampshire College.

Jay is an accomplished facilitator, mediator, trainer, management consultant, and coach. He is a master at facilitating large groups, having led hundreds of events averaging 100 or more participants. His clients have included: corporations such as Fidelity and NSTAR; small businesses such as Stonyfield Farm and Applegate Farms; state agencies such as the Massachusetts Water Resources Authority and the Massachusetts Rehabilitation Commission; colleges such as Harvard University and Bunker Hill Community College; national trade associations such as the Organic Trade Association and the Social Venture Network; foundations such as The Boston Foundation and Two Ten Footwear Foundation; and nonprofit organizations such as the Massachusetts Horticultural Society and the Massachusetts Audubon Society.

Jay's healthcare clients include the Massachusetts Medical Society, Partners HealthCare, Partners Community Healthcare Inc., Partners HealthCare International, Physician Health Services (of the Massachusetts Medical Society), Massachusetts Health Council, Massachusetts General Hospital, The Society for Simulation in Healthcare, CRICO, Massachusetts Society for Medical Research, University of Massachusetts Medical School, UMass Memorial Health Care, and others. His collaborative work with clinicians has been published in

journals such as *Health Care Management Review*, *Simulation in Healthcare*, and *Reflections*.

Jay is the author of *Recharge Your Team: The Grounded Visioning Approach*, a recent book by Praeger on his visioning work with clients. Jay is also the author of *Board Roles to Board Goals: Creating an Annual Board Workplan*, by Peoplesworth Press. Learn more about Jay at www.peoplesworth.com. See his TEDx talk on "The Art of Facilitation: Changing the Way the World Meets" at <http://bit.ly/JayWVogtTEDx>.



Michael Sales, EdD, is a coach, program designer, teacher, and facilitator who combines detailed knowledge of personal, group, and organizational change technologies with a broad background in business, entrepreneurship, and education. Michael has extensive knowledge

of the challenges of participatory management, the introduction of technologies into organizations, and the dynamics of life in family-owned businesses. He has helped many individuals, teams, and organizations achieve their objectives. His expertise is in the mobilization of energy and talent in support of results.

Michael's doctoral work at the Harvard Graduate School of Education (supervised by Chris Argyris) focused on the interpersonal skills required by participative management. His Bachelor's degree is from the University of Pennsylvania's Wharton School; his Master's program (in Broadcast Communication Arts from California State, San Francisco) explored institutional resistance to new technologies. Michael also has training certificates from the National Training Laboratories Institute for Applied Behavioral Science, and from Global Foresight Associates, where he was trained in scenario construction. He has served for

25 years as a senior associate of Barry Oshry's Power + Systems Training (the developers of The Organization Workshop), and of the Power + Systems Training Power and Leadership Conference. Michael was a founding principal of New Context Consulting, which provides customized experiential education for organizational learning and change.

Michael's engagements as a strategy and leadership consultant have spanned a broad range of economic sectors. Since 2004, he has increasingly honed in on futurism as the key question confronting leaders. In an era that stresses short-term thinking, it is uncommon to find executives, managers, and/or line workers who want to focus on the future in a disciplined, yet creative, way. But it is exactly these sorts of visionary leaders, wherever they might exist in the organizational or social hierarchy, with whom Michael wants to work. Toward that end, he has co-founded Art of the Future (a strategy consulting firm) with co-visionary Anika Schriefer. They published *Life Sustaining Organizations: A Design Guide* in 2011.

Michael was a contributing writer to the World Future Society's Future Survey. His authority on the dynamics of closely held corporations is reflected in his publications on the subject. Michael co-authored an article, on the management of mature workers, that was selected by Prentice Hall in 2001 as one of the pre-eminent publications in the training literature. He is Co-Chair of the Society for Organizational Learning, North America, and a professional member of the World Future Society.



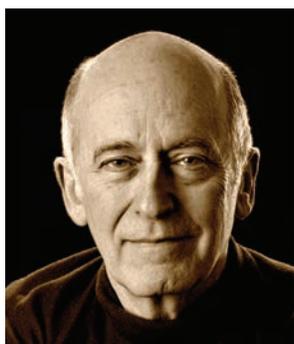
Sara J. Singer, MBA, PhD, is an Associate Professor of Health Care Management and Policy at the Harvard T.H. Chan School of Public Health, and a faculty member in the Department of Medicine at Harvard Medical School in the Mongan Institute for Health Policy,

Massachusetts General Hospital. Her research in the field of healthcare management and policy focuses on how organizational leadership and culture impact efforts to implement health delivery innovations, integrate patient care, and improve performance of healthcare organizations. A key feature of this research is the development of survey instruments that measure provider and patient perspectives on key interpersonal and organizational factors, enabling benchmarking, rapid and reliable feedback about the effectiveness and comparative effectiveness of delivery system innovations, and broader dissemination of more-successful interventions.

Dr. Singer acts as: Co-Chair of the Harvard PhD in Health Policy Program Management Track (2013–present); Implementation Research Director for the Safe Surgery 2015 initiative (2010–present); Evaluation Co-Chair for the Massachusetts Department of Public Health's Proactive Reduction in Outpatient Malpractice: Improving Safety Efficiency and Satisfaction (PROMISES) program (2010–present); and Evaluation Team member for the Harvard Center for Primary Care's Academic Innovations Collaborative: Comprehensive, Accessible, Reliable, Exceptional and Safe (CARES) Collaborative (2012–present). She also co-founded and served as Executive Director for the Center for Health Policy at Stanford, where she was also a Senior Research Scholar and Lecturer (1993–2003). Dr. Singer served as Staff Director for the California Managed Care Improvement Task Force (1997–98), a Senior Legislative Assistant for Health Policy in the U.S. House of Representative (1994), and Health Policy Analyst at the U.S. Office of Management and Budget (1992).

Dr. Singer has published more than 70 articles in academic journals, and books on healthcare management, health policy, and health system reform. Her publications have won numerous awards, including Best Paper awards from the Academy of Management's Health Care Division in three consecutive years—2009, 2010, and 2011. She is the recipient of the 2013 Avedis Donabedian Healthcare Quality Award from the American Public Health Association, and the 2014 Teaching Citation Award from the Harvard

School of Public Health. Dr. Singer has conducted numerous studies—for the Agency for Healthcare Research and Quality, Veterans Administration Health Services Research & Development Service, and private foundations—related to measuring and improving organizational culture, learning, teamwork, patient safety, integrated patient care, and the financing and delivery of healthcare. She holds an AB in English from Princeton University, an MBA with a Certificate in Public Management from Stanford University, and a PhD from Harvard University in Health Policy/Management, with a concentration in organizational behavior.



Jeffrey B. Cooper, PhD, is the Founder and Executive Director of the Center for Medical Simulation (CMS), which is dedicated to the use of simulation in healthcare as a means to improve the process of education and training, and to avoid risk to patients. He is also Professor

of Anaesthesia at Harvard Medical School. He received his BS in Chemical Engineering and MS in Biomedical Engineering from Drexel University in 1968 and 1970, respectively, and completed a PhD in Chemical Engineering at the University of Missouri in 1972. Starting soon thereafter with the Bioengineering Unit in the Department of Anesthesia at Massachusetts General Hospital, he led the team that conducted seminal studies of critical incidents and human error in anesthesia.

During the same period, he led a team that developed one of the first microprocessor-based medical technologies, the Boston Anesthesia System, aimed at integrating functions for the ultimate purpose of reducing human and system errors. Both of these efforts have catalyzed changes in anesthesia practice in the ensuing years. In April 2009, Dr. Cooper retired as Director of Biomedical Engineering for the Partners HealthCare System, Inc., a technology development and service department that he organized and led for 15 years.

Dr. Cooper was a lead member of the group that created the first safety-related standards for anesthesia, equivalent versions of which have since been adopted in the U.S. and throughout the world. He is a Co-Founder of the Anesthesia Patient Safety Foundation (APSF), serving continuously on its Executive Committee and for 13 years as Chair of its Committee on Scientific Evaluation. He is now an APSF Executive Vice President. He serves on the Board of Governors of the National Patient Safety Foundation and founded its Research Program, which he chaired for seven years.

Dr. Cooper is one of the pioneers in diffusion and innovation in healthcare simulation. He has led CMS to become one of the premier simulation programs in the world. Among the more-innovative programs he has created or co-developed are the Institute for Medical Simulation live, interactive simulation video-conferencing, and the novel Healthcare Adventures™ (a program for training healthcare administrators and leaders in teamwork via realistic simulation). He has mentored the faculty of CMS since its inception and has stimulated, participated in, and advised on various research projects.

Dr. Cooper has been awarded several honors for his work in patient safety, including the 2003 John M. Eisenberg Award for Individual Lifetime Achievement in Patient Safety from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, and the 2004 Lifetime Achievement Award from the American Academy of Clinical Engineering. In 2013 he received the Distinguished Service Award, the highest honor bestowed by the American Society of Anesthesiologists, and awarded for the first time to a non-physician. In 2010, the Department of Anesthesia, Critical Care and Pain Medicine at Massachusetts General Hospital established the Jeffrey B. Cooper Patient Safety award in his honor.

ADDITIONAL HEALTHCARE ADVENTURE™ PUBLICATIONS

Making Time for Learning-Oriented Leadership in Multidisciplinary Hospital Management Groups

Sara Singer, MBA, PhD; Jennifer Hayes, MEd; Garry Gray, PhD; and Mathew Kiang, MPH
Health Care Management Review, published online ahead of print, July 15, 2014: http://journals.lww.com/hcmrjournal/Abstract/publishahead/Making_time_for_learning_oriented_leadership_in.99853.aspx

Background: Although the clinical requirements of healthcare delivery imply the need for interdisciplinary management teams to work together to promote front-line learning, such interdisciplinary, learning-oriented leadership is atypical.

Purpose: We designed this study to identify behaviors enabling groups of diverse managers to perform as learning-oriented leadership teams on behalf of quality and safety.

Methods: We randomly selected 12 of 24 intact groups of hospital managers from one hospital to participate in a Safety Leadership Team Training program. We collected primary data from March 2008 to February 2010, including pre- and post-program staff surveys, multiple interviews, observations, and archival data from management groups. We examined the level and trend in frontline perceptions of managers' learning-oriented leadership following the training, and ability of management groups to achieve objectives on targeted improvement projects. Among the 12 intervention groups, we identified higher- and lower-performing

groups and behaviors that enabled higher performers to work together more successfully.

Findings: Management groups that achieved more of their performance goals, and whose staff perceived more and greater improvement in their learning-oriented leadership after participation in Safety Leadership Team Training, invested in structures that created learning capacity and conscientiously practiced prescribed learning-oriented management and problem-solving behaviors. They made the time to do these things because they envisioned the benefits of learning, valued the opportunity to learn, and maintained an environment of mutual respect and psychological safety within their group.

Practice Implications: Learning in management groups requires vision about what learning can accomplish; the will to explore, practice, and build learning capacity; and mutual respect that sustains a learning environment.

A Case for Safety Leadership Team Training for Hospital Managers

S.J. Singer, J. Hayes, J.B. Cooper, J.W. Vogt, M. Sales, A. Aristidou, G.C. Gray, M.V. Kiang, and G.S. Meyer
Health Care Management Review (2011) 36(2): 188–200

Background: Delivering safe patient care remains an elusive goal. Resolving problems in complex organizations like hospitals requires managers to work together.

“That creaking sound you heard was us thinking about taking an approach that is not blame focused but learning focused.”

PEDIATRICS TEAM MEMBER

Safety leadership training that encourages managers to exercise learning-oriented, team-based leadership behaviors could promote systemic problem solving and enhance patient safety. Despite the need for such training, few programs teach multidisciplinary groups of managers about specific behaviors that can enhance their functioning as leadership teams in the realm of patient safety.

Purpose: The aims of this study were to describe a learning-oriented, team-based, safety leadership training program composed of reinforcing exercises; to provide evidence confirming the need for such training; and to demonstrate behavior change among management groups after training.

Methods: Twelve groups of managers from an academic medical center based in the Northeast U.S. were randomly selected to participate in the program and exposed to its customized, experience-based, integrated, multimodal curriculum. Data—about the need for the training in these groups, and change in participants' awareness, professional behaviors, and group activity—were extracted from transcripts of four training sessions, over 15 months, with groups of managers.

Findings: Training transcripts confirmed the need for safety leadership team training and provided evidence of the potential for training to increase targeted behaviors. The training increased awareness and use of leadership behaviors among many managers and led to new routines and coordinated effort among most management groups. Enhanced learning-oriented leadership often helped promote a learning orientation in managers' work areas.

Practice Implications: Team-based training that promotes specific learning-oriented leader behaviors can promote behavioral change among multidisciplinary groups of hospital managers.

From Automatic Defensive Routines to Automatic Learning Routines: The Journey to Patient Safety

M. Sales, J.W. Vogt, S.J. Singer, and J.B. Cooper
Reflections, The SoL Journal on Knowledge, Learning, and Change (2013) 13(1):31–42

Patient safety in hospital settings is a major public health problem. Several distinctive challenges combine to create a high-risk environment for patients that can result in grave—and costly—personal and organizational consequences. The authors hypothesize that defensive behaviors among hospital leaders, managers, and staff aggravate the dangers implicit in these settings. The authors describe a multidimensional training program, Healthcare Adventures™, in which the exploration of so-called “automatic defensive routines” figures as an important focus. The subject intervention combines a simulation of a traumatic patient safety event with structured reflection. Taken together, these kinds of learning opportunities support collaborative inquiry and appreciative engagement, which can improve outcomes for patients.

Design and Evaluation of Simulation Scenarios for a Program Introducing Patient Safety, Teamwork, Safety Leadership, and Simulation to Healthcare Leaders and Managers

J.B. Cooper, S.J. Singer, J. Hayes, M. Sales, J.W. Vogt, D. Raemer, and G.S. Meyer
Simulation in Healthcare (2011) 6:231–38

Background: We developed a training program to introduce managers and informal leaders of healthcare organizations to key concepts of teamwork, safety leadership, and simulation, and thus, motivate them to act as leaders to improve safety within their spheres of influence.

Purpose: This report describes the simulation scenario and debriefing that are core elements of that program.

Methods: Twelve teams of clinician and non-clinician managers were selected, from a larger set of volunteers, to participate in a one-day, multi-element training program. Two simulation exercises were developed: one for teams of non-clinicians and the other for clinicians or mixed groups. The scenarios represented two different clinical situations, each designed to engage participants in discussions, immediately after the experience, of their safety leadership and teamwork issues. In the scenarios for non-clinicians, participants conducted an anesthetic induction and then managed an ethical situation. The scenario for clinicians simulated an emergency room consulting visit that evolved into a problem-solving challenge. Participants in this scenario had a limited amount of time in which to prepare

advice for hospital leadership on how to improve observed safety and cultural deficiencies. Debriefings after both types of scenarios were conducted using principles of “debriefing with good judgment.” We assessed the relevance and impact of the program by analyzing participant reactions to the simulation through transcript data and facilitator observations, as well as a post-program questionnaire.

Findings: The teams generally reported positive perceptions of the relevance and quality of the simulation, with varying types and degrees of impacts on their leadership and teamwork behaviors.

Practice Implications: These kinds of clinical simulation exercises can be used to teach healthcare leaders and managers safety leadership, and teamwork skills and behaviors.

“This helps each of us frame the project in our own minds better. The project is much clearer now.”

ACUTE CARE MEDICAL TEAM MEMBER

THE CENTER FOR MEDICAL SIMULATION

The Vision

“Experiential healthcare learning that never puts a patient at risk”

The Mission

“Using simulation to improve safety, quality, and education in healthcare”

The Center for Medical Simulation (CMS) believes that healthcare simulation is most effective when techniques are drawn from multiple disciplines and are tailored to the level and background of each group.

Our elite team of more than 25 professional faculty members has expertise in medicine, patient safety, biomedical engineering, organizational behavior, and adult learning. The combined healthcare simulation experience of the CMS team is unsurpassed, ensuring that each simulation session is customized and uniquely effective.

Two Decades of Simulation Training to Improve Quality of Care

Founded in 1993, CMS was one of the world’s first healthcare simulation centers and continues to be a global leader in the field.

Simulation training at CMS gives healthcare providers a new and enlightening perspective on how to handle real medical situations. Through high-fidelity scenarios that simulate genuine crisis management situations, the CMS experience can open new chapters in the level of healthcare quality that participants provide.

At CMS the focus is on communication, collaboration, and crisis management in order to develop skills and teamwork behaviors that are best learned actively, under realistic conditions. Since 1993, CMS has conducted more than 2,000 courses and trained thousands of participants, using its innovative and challenging scenarios. CMS is proud to feature:

- multidisciplinary, expert staff affiliated with some of the world’s most well-known and well-respected hospitals, medical universities, and colleges
- exceptionally high-quality and innovative programs in full-environment facilities
- broad course offerings

The Center for Medical Simulation has been a leader in the healthcare simulation field since putting its first mannequin simulator into service in 1994. It has developed courses for clinicians, healthcare educators, administrators and managers; conducted research on a spectrum of topics; and helped manufacturers conduct human factors trials of their technologies; it also continues to innovate an array of healthcare simulation activities.



FURTHER LEARNING WITH THE CENTER FOR MEDICAL SIMULATION

Healthcare Adventures™ Leadership and Management Training Workshops for Leadership and Management Teams (Non-Clinicians or Mixed Groups)

Healthcare Adventures™ (HCA) are customized, intensive team-training workshops for leadership and management teams across the healthcare spectrum. Designed to improve individual and team performance by developing collaboration and communication, the HCA workshops use a simulated patient experience in a highly realistic clinical environment to highlight a team's dynamics in a powerful, but non-threatening, fashion. Even non-clinicians get the chance to care for a patient and experience real-life issues first-hand, and clinicians are challenged to think like healthcare administrators and executives. It's an eye-opener!

CMS faculty and professional facilitators work with the team before the simulation, discussing objectives and expectations, and again after the simulation, identifying important interactions, key learnings, and actionable strategies. This allows the group to turn learning into action immediately, by working on a real-world project with the help and support of the CMS facilitators. Depending on their needs, teams can draw on a variety of follow-up support mechanisms and training to advance their learning and performance. Workshop topics include teamwork, effective communication, resource management, performance enhancement, and patient safety.

Optimal team size for the greatest benefit from the HCA workshop is 6–10 people.

The HCA Workshop includes:

- pre-workshop consultation between the team leader and a CMS facilitator
- pre-training team briefing on simulation objectives and strategies
- customized team challenge in the simulated clinical environment
- debriefing and discussion to identify important interactions and develop actionable strategies for implementation
- facilitated workshop session to apply effective group processes to an existing team project challenge (e.g., closing a budget gap, designing a new service, or building a charter for a new team)
- post-workshop report from the CMS facilitator
- follow-up between the CMS facilitator and the team leader

Tuition: USD \$12,000 per team (6–10 people); includes one-day workshop, pre-workshop consultation, and post-workshop follow-up

For more information and/or to schedule a workshop, please contact: Gary M. Rossi, COO at grossi@harvardmedsim.org or 1.617.726.3041.

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REFERENCES

- Ancona, D.G. and D.F. Caldwell. 1992. "Bridging the Boundary: External Activity and Performance in Organizational Teams." *Administrative Science Quarterly* 37(4): 634.
- Argyris, C. 1985. *Strategy, Change, and Defensive Routines*. New York: Harper Business.
- Auerbach, A., C. Landefeld, and K. Shojania. 2007. "The Tension Between Needing to Improve Care and Knowing How to Do It." *The New England Journal of Medicine* 357: 608–13.
- Batalden, P. and P. Stoltz. 1993. "A Framework for the Continual Improvement of Health Care: Building and Applying Professional and Improvement Knowledge to Test Changes in Daily Work." *The Joint Commission Journal on Quality Improvement* 19(10): 424–47.
- Blanchard, K. 2009. "Feedback Is the Breakfast of Champions." *How We Lead: Conversations on Leadership with Ken Blanchard*, August 17, 2009. <http://howwelead.org/2009/08/17/feedback-is-the-breakfast-of-champions>.
- Blumenthal, D. and C. Kilo. 1998. "A Report Card on Continuous Quality Improvement." *The Milbank Memorial Fund Quarterly* 76(7): 625–46.
- Burke, Dennis W. 2002. *Basic Facilitation Skills*. Milwaukee, WI: Human Leadership and Development Division of the American Society for Quality, the Association for Quality and Participation, and the International Association of Facilitators. <http://discrcs.org/sites/default/files/2002BasicFacilitationPrimer.pdf>.
- Carman, J.M., et al. 1996. "Keys for Successful Implementation of Total Quality Management in Hospitals." *Health Care Management Review* 21(1): 48.
- Carroll, J.S., S. Hatakenaka, and J.W. Rudolph. 2006. "Naturalistic Decision Making and Organizational Learning in Nuclear Power Plants: Negotiating Meaning Between Managers and Problem Investigation Teams." *Organization Studies* 27(7): 1037.
- Clarke, J.R., J.C. Lerner, and W. Marella. 2007. "The Role for Leaders of Health Care Organizations in Patient Safety." *American Journal of Medical Quality* 22(5): 311–8.
- Covey, S. 1989. *The Seven Habits of Highly Effective People*. London: Simon Schuster Ltd. UK. Also, http://en.wikipedia.org/wiki/The_Seven_Habits_of_Highly_Effective_People.
- Edmondson, A.C. 1996. "Learning from Mistakes Is Easier Said Than Done: Group and Organizational Influences on the Detection and Correction of Human Error." *The Journal of Applied Behavioral Science* 32(1): 5.
- . 1999. "Psychological Safety and Learning Behavior in Work Teams." *Administrative Science Quarterly*. 44(2): 350–83.
- . 2003. "Managing the Risk of Learning: Psychological Safety in Work Teams." In *International Handbook of Organizational Teamwork and Cooperative Working*. Edited by M. West, D. Tjosvold, and K. Smith. London: John Wiley & Sons, Ltd.
- . 2003. "Speaking Up in the Operating Room: How Team Leaders Promote Learning in Interdisciplinary Action Teams." *The Journal of Management Studies* 40(6): 1419–52.
- Edmondson, A.C., R.M. Bohmer, and G.P. Pisano. 2001. "Disrupted Routines: Team Learning and New Technology Implementation in Hospitals." *Administrative Science Quarterly* 46(4): 685–716.
- Garvin, D.A. 2000. *Learning in Action: A Guide to Putting the Learning Organization to Work*. Boston: Harvard Business School Press.
- Hackman, J.R. 2002. *Leading Teams: Setting the Stage for Great Performances*. Boston: Harvard Business School Press.
- Husted, K. and S. Michailova. 2002. "Diagnosing and Fighting Knowledge-Sharing Hostility." *Organizational Dynamics* 31(1): 60–73.
- Institute for Healthcare Improvement. "How to Improve." www.ihl.org/resources/Pages/HowtoImprove/default.aspx. Accessed 3.25.15.
- Institute for Healthcare Improvement. 2005. White Paper: "Going Lean in Health Care." www.ihl.org/resources/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx. Accessed 3.25.15.
- International Association of Facilitators. 2003. "Core Facilitator Competencies." https://iaf-world.org/site/sites/default/files/IAF%20Core%20Competencies_1.pdf. Accessed 3.25.15.

Janis, I.L. 1982. *Groupthink*. Second edition. Boston: Houghton Mifflin.

Kabcenell, A., T.W. Nolan, L.A. Martin, and Y. Gill. 2010. Institute for Healthcare Improvement White Paper: "The Pursuing Perfection Initiative: Lessons on Transforming Health Care." www.ihl.org/resources/Pages/IHIWhitePapers/PursuingPerfectionInitiativeWhitePaper.aspx. Accessed 3.25.15.

Landon, B., et al. 2004. "Effects of a Quality Improvement Collaborative on the Outcome of Care of Patients with HIV Infection: The EQHIV Study." *Annals of Internal Medicine* 140: 887–96.

Landon, B., et al. 2007. "Improving the Management of Chronic Disease at Community Health Centers." *The New England Journal of Medicine* 356: 921–34.

Leape, L.L. and D.M. Berwick. 2005. "Five Years After To Err Is Human: What Have We Learned?" *The Journal of the American Medical Association* 299(19): 2384–90.

Lewin, K. 1951. *Field Theory in Social Science*. New York: Harper and Row. Also, http://en.wikipedia.org/wiki/Force-field_analysis. Accessed 3.25.15.

McGlynn, E.A., et al. 2003. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine* 348: 2635–45.

Mittman, B. 2004. "Creating the Evidence Base for Quality Improvement Collaboratives." *Annals of Internal Medicine* 140: 897–901.

Nembhard, I.M. and A.C. Edmondson. 2006. "Making it Safe: The Effects of Leader Inclusiveness and Professional Status on Psychological Safety and Improvement Efforts in Health Care Teams." *Journal of Organizational Behavior* 27(7): 941.

Podolny, J.M., R. Khurana, and M. Hill-Popper. 2005. "Revisiting the Meaning of Leadership." *Research in Organizational Behavior* 26: 1–31.

Senge, P.M. 1990. *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday.

Shojania, K. and J. Grimshaw. 2005. "Evidence-Based Quality Improvement: The State of the Science." *Health Affairs* 24: 138–50.

Shortell, S., et al. 1995. "Assessing the Evidence on CQI: Is the Glass Half Empty or Half Full?" *Hospital and Health Services Administration* 40(1): 4–24. [Note: this journal is out of publication. The article can be accessed via subscription at: www.proquest.com/products-services/abi_inform_complete.html. Academic or municipal libraries may maintain subscriptions to this service.]

Shortell, S. and S. Singer. 2008. "Improving Patient Safety by Taking Systems Seriously." *The Journal of the American Medical Association* 299(4): 445–7.

Tucker, A.L. and A.C. Edmondson. 2003. "Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics That Inhibit System Change." *California Management Review* 45(2): 55–72.

Tucker, A.L., et al. 2008. "Front-Line Staff Perspectives on Opportunities for Improving the Safety and Efficiency of Hospital Work Systems." *Health Services Research* 43 (5, pt. 2): 1807–29; published online ahead of print.

Weick, K.E. and K.H. Roberts. 1993. "Collective Mind in Organizations: Heedful Interrelating on Flight Decks." *Administrative Science Quarterly* 38(3): 357.

Weiner, B.J., S.M. Shortell, and J.A. Alexander. 1997. "Promoting Clinical Involvement in Hospital Quality Improvement Efforts: The Effects of Top Management, Board, and Physician Leadership." *Health Services Research* 32(4): 491.

Westphal, J.D., R. Gulati, and S.M. Shortell. 1997. "Customization or Conformity? An Institutional and Network Perspective on the Content and Consequences of TQM Adoption." *Administrative Science Quarterly* 42(2): 366.

W.K. Kellogg Foundation. 2004. "Logic Model Development Guide." www.epa.gov/evaluate/pdf/eval-guides/logic-model-development-guide.pdf. Accessed 3.25.15.

“This gives us an appreciation for how complex this is. I thought we had this whole project worked out and ready to go. Now, we see it’s not. I see why leadership needs to be engaged enough so frontline staff get the support they need to do this.”

PEDIATRICS TEAM MEMBER

FACILITATOR’S GUIDE

The Healthcare Adventures™ Graphic Gameplan For Patient Safety

JAY W. VOGT • MICHAEL SALES • SARA J. SINGER • JEFFREY B. COOPER



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