Jennifer L. Tomasik

Building a Shared Language

How administrative and clinical leaders can improve performance and productivity.

Physicians are being asked to take on more formal leadership positions in healthcare organizations. As chief medical officers, chief quality officers and department chiefs and other senior positions, physicians face a complex array of challenges, including cost constraints, improving operational performance across silos, and the pressure to improve quality while reducing medical error. These challenges require more than an individual leader's time and attention—they demand a team-based approach that brings together the best of clinical and managerial expertise. Ironically, because their training inculcates values of autonomy learned from experience and professional distance, physicians often treat the team or managerial approach as foreign.

As a result, physician leaders must find new ways to work with administrative colleagues—applying sophisticated organizational and managerial skills that improve communication, contribute to the performance and productivity of teams and enable physicians to see their role in contributing to the organization's overall success. Building a shared language and approach to communication and collaboration creates the possibility of linking clinical and business knowledge to meet the challenges of leading modern healthcare organizations.

Improving Collaboration With a Common Language

High-quality patient care is the result of a sustained effort by numerous players on the healthcare delivery team, both clinical and administrative alike. These players are called upon to work together to make numerous decisions on an ongoing basis. The challenge is the makeup of these teams, which changes depending on patient needs and the time of day. When the decision-making process is unclear or critical data is missing, the possibility for error can increase. Decision charting is a tool that helps people understand their role in this process and can exponentially improve team collaboration and performance.

Decision charting lays out critical decisions for a team and assigns the following roles to the individuals that comprise the team:

A – **approve** a decision
R – be **responsible** for informing the decision
C – **consult** to a decision
I – be **informed** about a decision after it is made

Team members complete charts that lay out decisions on the left side and each role across the top. Team members fill in how they believe each team member is currently involved in a decision and how they should be involved in the future. The data is used to evaluate agreements and discrepancies among team members. This process also establishes a common vocabulary for making decisions. It sharpens delegation, ensures accountability and increases effective communication among individuals and team members.

In one organization, we worked with a mix of clinical and administrative leaders to identify specific cases where confusion existed about important patient care issues. Physician, nurse and administrative leaders came together to improve discharge planning by learning how each of the players were involved. Analysis of the data revealed great confusion about roles and how it contributed to duplication of effort, causing critical tasks to fall through the cracks. Applying decision charting to real-work processes enabled the teams to clarify who should be involved in which decisions and the ways a shared language can be developed. Over time, senior leaders in the organization also learned to use this language, which increased teamwork and improved overall communication.

In another project, we used decision charting to identify significant differences in assumptions about roles among attendings, chief residents, residents and nurse practitioners in

adapting a surgical service to the 80-hour work week. The tool clarified how to assemble teams to meet patient needs and helped team members understand their individual roles and how they related to the teams' overall success. The work resulted in improved team performance and increased patient satisfaction, goals of equal importance to the individuals and to the organization.

Linking Clinical and Business Skills

Another method to build a shared language among team members is to apply traditional business concepts to critical quality and safety work. We worked with three hospitals in a large health system to help executives advance their clinical quality goals. The work focused on creating a unit-based clinical leadership model to improve relationships among physicians, nurses and administrators. Physicians, nurses and dedicated quality coordinators met together on a weekly basis to establish unit and organizational quality priorities. During these meetings they reviewed performance metrics, identified challenges and developed short- and long-term projects. These teams are now trained to link quality goals to improved clinical and financial performance, and the concept of return on investment has become part of their vocabulary. This model also resulted in improved physician-nurse interaction scores, staff turnover rates, nurse appreciation scores and reduced infection rates.

Like decision charting, the clinical leadership model is successful because it is built around shared goals and a common way of thinking and communicating. These examples are some of the many ways that physicians can partner with other clinical and administrative leaders to build a shared language to support decision making and collaboration. After all, delivering on the clinical mission depends on operating a successful business enterprise. ▲

Jennifer L. Tomasik is a principal at the Center for Applied Research Inc. and co-leader of the firm's Health and Hospital Systems practice in Cambridge, Mass. She can be reached at jtomasik@cfar.com or (617) 301-8245.