Teaming to Innovate

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Health system leaders operate in an environment characterized by the acronym VUCA: volatile, uncertain, complex, and ambiguous. Facing rapid changes and large up-and-down swings (volatility), difficult-to-predict events (uncertainty), multiple and interconnected elements (complexity), and unclear signals (ambiguity), these leaders struggle with how to work effectively.

Success through On-the-Fly Teaming (Not Stable Teams)

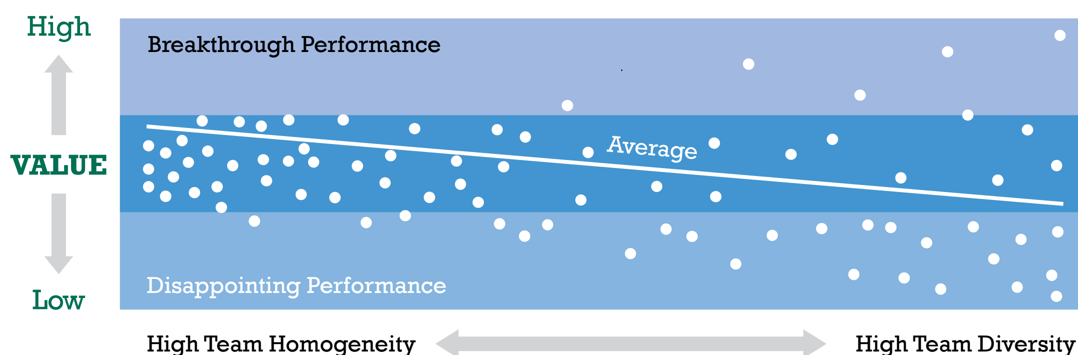
The key to succeeding in a VUCA environment lies in mastering the art of "teaming." Traditional teams are bounded, reasonably stable groups of interdependent individuals focused on achieving a shared goal. As with a sports team, dance troupe, or singing group, individual members get to know each other's strengths and weaknesses and learn to work effectively over time, through practice. By contrast, teaming at work is like a pickup game in the park, where people who don't know each other well collaborate with little or no stability. Teaming has long been a part of healthcare—in medical emergencies, for example, people who may not even know each other's name routinely come together from different parts of the hospital to collaborate and coordinate on a real-time basis to save lives. Teaming regularly occurs in many disciplines outside healthcare as well. In computer animation, for example, teaming has led to the creation of amazing films like *Toy Story*. While they may seem quite different, the teaming required in a medical emergency and in creating *Toy Story* has many similarities, including the presence of unknowns, a need

for different expertise at different times, a lack of fixed deliverables and roles, and the need to learn by doing things that have not been done before.

Teaming is teamwork on the fly, coordinating and collaborating across boundaries without the luxury of stable team structures. While critical to the healthy functioning of the kinds of partnerships needed in healthcare, teaming is neither natural nor easy. To understand why, consider the results from a survey of 8,000 individuals in various roles in 250 global companies. The survey found that most people struggle with the kind of horizontal coordination and collaboration needed for effective teaming—whether to bring new products and services to market or simply deliver high-quality care in a hospital. In fact, only 59 percent reported that they can rely on people in other units all or most of the time to follow through on what they have promised to do, compared to 84 percent reporting they can rely on people up and down the chain of command.[1]

The power of teaming lies in the ability to bring together people from across silos to problem-solve and innovate in a synergistic manner. It can be difficult, however, to get diverse, on-the-fly teams to perform well. One study found that, on average, with all else being equal, homogenous teams slightly outperform diverse teams.[2] As shown in **Exhibit 1**, homogeneous teams tend to be more consistent, while diverse teams exhibit greater variability in performance, with some doing very well and others "crashing and burning." In other words, diverse teams have enormous potential but often do not reach it.

Exhibit 1: Leading Diverse Teams



1 Donald Sull, Rebecca Homkes, and Charles Sull, "Why Strategy Execution Unravels—and What to Do About It," *Harvard Business Review*, March 2015.

2 Ruth Wageman, "Critical Success Factors for Creating Superb Self-Managing Teams," *Organizational Dynamics*, 1997.

Overcoming Barriers to Effective Teaming

Fortunately, strategies exist to overcome the major barriers to effective teaming, as discussed below.

Instill an Enterprise Mindset

Competing priorities and a competitive mindset often get in the way of effective teaming. Consider a professor who tells first-year law students on the first day of class to look to their left and right, and says "One of you wont be here next year." Perhaps intended to motivate his students to work hard, the message contains an implicit message of scarcity—encouraging students to adopt a competitive mindset in which "winning" is the main priority. A competitive mindset views success as a zero-sum game and fosters an unhealthy focus on one's self, and how one compares to others. By contrast, effective teaming requires purposeful adoption and promotion of an *enterprise mindset*, with success seen as shared and expansive and the focus being on the work and the fostering of relationships with others. An enterprise mindset leads one to ask what is best for the organization and engages people in a shared mission. Rather than seeing those to the left or right as competitors, they are viewed as a source of potentially great ideas.

Embrace and Promote Intelligent Failure

While the term "intelligent failure" might seem like an oxymoron, some failures can in fact be good for an organization, even if others clearly are not. Three distinct types of failure occur within organizations. The first involves preventable failures—i.e., situations where the right way to do something is known but not executed. These clearly are not useful and should be avoided. The second consists of complex failures, where complicated internal and/or external factors combine in novel ways to produce failures in reasonably familiar environments. These too are to be avoided whenever possible, although they can lead to valuable learnings. The third type of failure is known as intelligent failures, where undesired results come out of thoughtful forays into novel territory. These failures are worthy of celebration because they generate new ideas and information on what may be possible.

Elements of Intelligent Failures

- ✔ The opportunity to be explored is significant.
- ✔ The outcome will be informative.
- ✔ The cost and scope are relatively small.
- ✔ Key assumptions are explicitly articulated.
- ✔ A plan exists to test those assumptions.
- ✔ The risks of failing are understood by all and mitigated to the extent possible.

With proper planning, moreover, preventable failures can be avoided and instead turned into intelligent ones. For example, many years ago Telco, an excellent provider of local and long-distance telephone service, launched a new DSL service in a large urban market. The decision to launch was based on the recommendation of the marketing department, which saw a large profit opportunity, and despite the objections of operations personnel, who felt that the company was not ready to provide DSL at scale. The launch ended up being a colossal service failure, with frequent outages and only a 13 percent customer satisfaction rate—well below the 90 percent-plus ratings the company routinely enjoyed. While Telco had conducted a pilot test, it was done in idealized conditions that did not match the requirements of the broader rollout. In other words, the pilot test had been designed to succeed. Instead, it should have been designed as a stress test for the company to see if and when failure would occur. Had this been the case, the pilot would have yielded valuable learnings that could have been fixed in a small, controlled environment in advance of the broader rollout. Unfortunately, Telco's leaders did not embrace the opportunity to learn through intelligent failure, and instead suffered a massive preventable failure that hurt the entire organization.[3]

> "As leaders, your job is to help your organizations fail well. The goal should be to reduce preventable failures to near zero, to anticipate and mitigate complex failures, and to promote intelligent, small-scale failures."
>
> —*Amy Edmondson*

Key Questions to Consider When Designing Pilot Tests

- ✔ Is the pilot program being tested under typical circumstances instead of optimal conditions?
- ✔ Is the goal of the pilot to learn as much as possible, rather than to demonstrate to senior managers the value of the new system?
- ✔ Is it clear that compensation and performance ratings are not based on a successful pilot?
- ✔ Will explicit changes be made based on the pilot?

3 See Chapter 7 in Amy C. Edmondson, *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy*, Jossey-Bass, 2011.

Build Psychological Safety

Organizational leaders need to offer a safe culture where everyone knows that his or her voice is welcome. Yet too often that type of culture does not exist. Instead, people instinctively avoid taking risks, since no one wants to appear ignorant, incompetent, intrusive, or negative. Rather than speaking up, most people seek to manage other people's impression of them. They do not ask questions, admit weaknesses or mistakes, offer ideas, or criticize the status quo. This type of "impression management" is second nature, with most people doing it without even thinking.

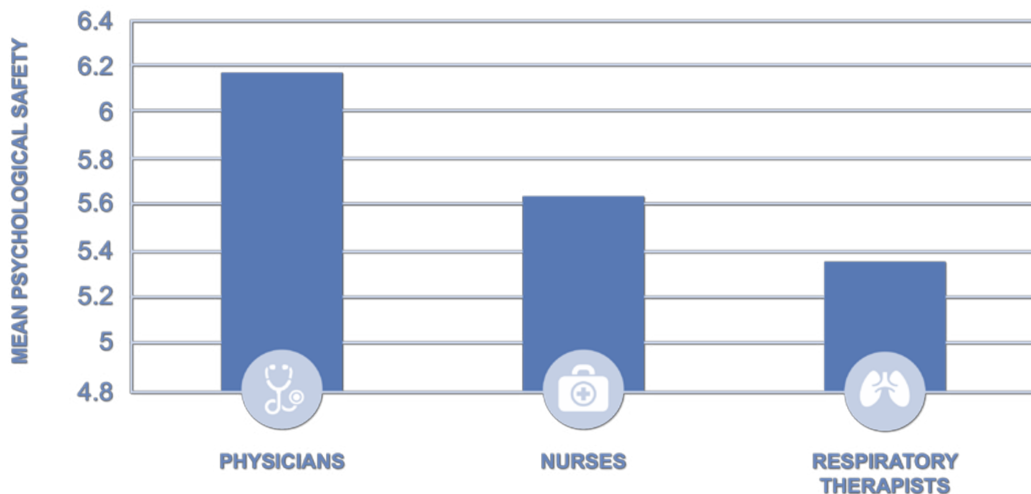
> "How comfortable are you relying on courage or duty as a means of ensuring safety in your organization? You must make it easy for people to speak up. You have to invite it and encourage it."
>
> *—Amy Edmondson*

Leaders, therefore, need to create an environment of psychological safety that inspires people to routinely do the unnatural. Psychological safety has been achieved when people believe they will not be punished or humiliated for speaking up with ideas, questions, and concerns, or for admitting mistakes. It should be thought of as "giving permission for candor" and it can literally save lives. One of the best examples of the ramifications of not creating psychological safety can be seen in the tragedy surrounding the Columbia shuttle spacecraft, which blew up upon re-entry to the earth's atmosphere on February 1, 2003, killing all seven astronauts onboard. Rodney Rocha, a NASA engineer, saw something that concerned him on a grainy video during the shuttle's takeoff days earlier. He feared that a large foam piece of the rocket booster might have dislodged and caused considerable damage to the shuttle that could cause problems on re-entry. He made several requests to investigate further that were shut down by his bosses. On day eight of the mission, Mr. Rocha did not speak up during a team meeting when the agenda item related to foam strikes came up for discussion. He later explained that he did not feel he could speak up, believing he was "too low" in the organization and that his bosses had already made it clear that his thoughts and ideas were not welcome or valued. An investigation later determined that a large foam strike had indeed occurred and caused the accident. The Columbia flight director later tried to pin the blame on Mr. Rocha, suggesting that he was "duty bound as a member of the team to voice his concerns."

Among other lessons, the Columbia story highlights the dangers that occur when hierarchy has deep roots in the psyche of organizations. While necessary, hierarchy must be carefully managed. It must be clear that everyone's voice is valued, regardless of level in the organization, and that there will never be negative repercussions for speaking up.

Studies suggest that hierarchy can have an impact on perceptions of psychological safety. As shown in **Exhibit 2**, statistically significant differences in psychological safety exist across neonatal intensive care unit (NICU) physicians, nurses, and respiratory therapists in terms of how comfortable they feel speaking up and the degree to which they feel their voice is welcome. Speaking up, moreover, can literally save lives. In follow-up studies, researchers found an 18 percent difference in mortality across NICUs, with fewer deaths in units where medical directors went out of their way to ask for input and hence promote psychological safety.

Exhibit 2: Psychological Safety and Hierarchy



N=1,100 clinicians

Ingrid Nembhard and Amy C. Edmondson, "Making It Safe: The Effects of Leader Inclusiveness and Professional Status on Psychological Safety and Improvement Efforts in Healthcare Teams," *Journal of Organizational Behavior*, 2006.

Psychological safety is important not just on the front lines of care, but also in the C-suite and boardroom. Without it, people will generally vote "yes" with the boss even when they have significant reservations or concerns. Promoting psychological safety is not about being nice, but rather about creating room for behaviors needed in complex, uncertain, and interdependent work. Middle managers are particularly important to promoting it, be they medical directors, bank branch managers, or restaurant managers in a chain. Psychological safety enables learning behaviors to occur, including robust error reporting, creativity, and implementation of quality improvement initiatives.

Most importantly, psychological safety need not require any sacrifice in performance standards. Leaders must inspire high standards and create psychological safety. Doing so lands them in the "learning zone" depicted in **Exhibit 3**, while doing neither well lands them in the "apathy zone." Rodney Rocha can be seen as in the "anxiety zone." He was motivated, smart, and capable, but lacked psychological safety. As a result, he was unable to speak up. The NICU study found that some nurses and respiratory therapists felt much the same way.

Exhibit 3: No Tradeoffs between High Standards and Psychological Safety

Building psychological safety is a three-step process, as outlined below:

- ✔ **Set the stage**: Leaders must create cognitive frames that shape how people make sense of a situation and influence how they act and respond. These frames need to highlight dissent and disagreement as being welcome and the right type of failure as something to be accepted and celebrated. Alfred P. Sloan, the head of General Motors, recognized the need for disagreement as far back as 1946. More recently, David Kelly, CEO of IDEO, explicitly framed small, intelligent failures as "mission critical" to ultimate success. Effective leaders remind their teams of the importance of speaking up on a regular basis.
- ✔ **Invite engagement**: Leaders should acknowledge their own limits and regularly ask if they might be "missing something." They should ask what others are seeing, invite careful thought, and give everyone in the room an opportunity to respond. The goal is to ask good questions that broaden and deepen the discussion. Examples include:
    - What do you think?
    - What are we missing?
    - What other options should we consider?
    - Does anyone have a different perspective?
    - What leads you to think so?
    - What's the concern that you have about that?
    - Can you give us an example?
    - Can you explain that further?
    - What do you think might happen if we did "x"?

- ✔ **Respond appreciatively**: Providing honest feedback should be a positive experience that is clearly welcomed. In addition, innovative organizations celebrate such feedback along with intelligent failures. Eli Lilly, for example, hosts "failure parties," and a growing number of organizations have created awards to recognize those who fail smart and who speak up. (NASA started these sorts of programs after the Columbia accident.)[4]

4 More information on creating psychological safety can be found in Ms. Edmondson's book, *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth.*