A Strengths Based Leadership Approach to Building Patient-Centered Medical Home Teams

Angela Mitchell

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Executive Summary

For the past decade the US health care system has been pressured to change. The United States spends an estimated $2 trillion annually on healthcare, more than any other industrialized nation (Johnson, 2012). On March 23, 2010 the Affordable Care Act (ACA) was signed by President Obama and health care will be dramatically changed as a result. This law involves health insurance reforms across the country that will provide coverage to over 50 million Americans over the next four years. In response to the ACA, Providence Medical Group has undergone a tremendous amount of change to position the organization for the future of health care. This has meant significant budget reductions and transformation into a new model used to care for patients in primary care settings. This transformation also requires changing the culture of the organization. Health care traditionally has been focused on the physician being solely responsible for a patient’s health. The new culture represents a team-based approach to patient care. This capstone study will discuss the challenges associated with this transformation in health care, and test a new team building curriculum using Strengths Based Leadership. Two research questions are addressed: Does having an understanding of individual and team members’ strengths lead to improved Team Development Measures (TDM)?; Will team members find the Strengths Based Leadership training useful? In the study, five Providence Medical Group teams received the new training, and three teams did not. The Team Development Measure (TMD) is used to test whether teams score higher in team development measures following the training. Teams were also evaluated to determine their levels of satisfaction and effectiveness with the new training. The study draws several conclusions related to the research questions and includes several implications for future training and applied research.
A Strengths Based Leadership Approach to Building Patient-Centered Medical Home Teams

Capstone Study

Introduction and Research Questions

For the past decade the US health care system has been pressured to change. The United States spends an estimated $2 trillion annually on healthcare, more than any other industrialized nation (Johnson, 2012). On March 23, 2010 the Affordable Care Act (ACA) was signed by President Obama. This law involves health insurance reforms across the country over the next four years that will provide coverage to over 105 million Americans. In response to the ACA, Providence Medical Group has undergone a tremendous amount of change to position the organization for the future of health care. This has meant significant budget reduction and transformation into a new model used to care for patients in primary care settings.

Providence Medical Group (PMG) is one of the largest employers of primary care services in Oregon. PMG’s Mission is to serve all patients in need of services, especially the poor and vulnerable, and they hold this in high regard during the changes they have been experiencing with health care reform. PMG is part of Providence Health & Services in Oregon and employs Primary Care Doctors, Specialty Doctors, Nurse Practitioners, Pharmacists, Physicians Assistants, Registered Nurses, Medical Assistants, Patient Relations Reps, and all administrative staff needed to run over 110 clinics; primary care and specialty care. When the ACA begins in 2014, PMG will be responsible to care of more than 140,000 new patients.

The Institute of Medicine realized the need for change in health care and called for a new health system for the 21st century that focuses on primary care teams playing a central role in reducing cost by providing preventative care to patients (Institute of Medicine, 2001). On March 2, 2012, in response to the ACA, Governor Kitzhaber signed a law that launched Coordinated Care Organizations (CCOs) to better serve Oregon Health Plan (OHP) patients by improving
health outcomes through a team based approach. This new model in Oregon is called the Patient Centered Primary Care Home (PCPCH). At PMG this new model is called the Patient-Centered Medical Home (PCMH), and represents the same design and function. This model changes primary care practice from being physician-centered to one that engages all members of the clinical care team (Grumbach, 2002). As a result, primary care practices’ are changing around the country. Physicians and other clinic staff are being asked to take on more responsibilities, work in a co-located team-based environment, and transform how they have traditionally been practicing medicine.

The new PCMH model attempts to rebuild the ability to deliver the core components of primary care through teams (Starfield, 2005). While adding evidence–based improvements in chronic and preventive care, there is greater emphasis on quality and safety, and keeping a central focus on patient-centeredness and patient engagement. Traditionally, physicians were trained and responsible to handle majority of the patients care before, during, and after clinic appointments. The PCMH model shifts the responsibility from the physician to other members of the care team. As a result, new responsibilities and roles have been added. One new role is adding a change coach to the clinics who is responsible to assist clinic teams and management during the change process. The coaches are trained in change management and bring knowledge and tools to help clinics achieve success by overcoming inevitable roadblocks that come with change. Another new role is the Clinical Care Coordinator, responsible to make sure that each patient’s chart is reviewed prior to the visit to make sure all paperwork and labs are up to date, and information about the patient’s medical history is shared with other members of the team. Teams are also adding Team Lead positions, elected by members to take a leadership role and facilitate meetings, ensure teams are achieving their goals, and request assistance from the
change coach when needed. Eventually, the goal is for all PCMH teams to be self-directed, relying on their team to problem solve and make decisions without the clinic managers or change coaches assisting them. Overall, the PCMH model spreads the responsibility for taking care of patients from a physician to a team of medical professionals, allowing for more patients to be seen and for care to be improved.

There are many compelling reasons for primary care practices to use the PCMH model. PCMH teams that work well together in primary care lead to higher effectiveness and innovation (Borrill et al. 2001), where improvements in health care delivery are made (Wood, Farrow & Elliot, 1994). One study found that there were increased levels of detection, treatment, and follow-up for hypertension management (Adorion, 1990). Another study in Colorado found that PCMH leads to significant reduction to emergency department visits and hospital admissions, lowering the cost of health care expenses for patients (Harbrecht, 2012). PCMH team levels of cohesiveness were positively associated with better clinical outcome measures and higher patient satisfaction (Grumbach, 2004). Therefore, the PCMH promises improvements to health care delivery and patient health outcomes and levels of satisfaction.

Teams working well together in healthcare also impacts the mental health of the team members (Borrill et al. 2001), with informational and instrumental support reducing stress levels (Himle, Jayaratne & Thyness, 1991), enhancing organizational commitment and job satisfaction (Sundstrom, De Meuse & Futrell 1990; Wood et al. 1994; Cohen, Ledford & Spreitzer 1996; Guzzo & Dickson 1996), and reducing staff turnover and absenteeism (Katzenbach & Smith 1993). Teams that do not work well together lead to issues such as stress, which contribute substantially to staff absenteeism and turnover (Ulleberg & Rundmo 1997). This can have a
negative financial impact on the organization through additional recruiting, retraining and employing staff to cover absentees, and additional workload for other team members.

While many primary care practices in the country are considered PCMHs, this has been accomplished by meeting the National Committee for Quality Assurance (NCQA) requirements without considering the cultural transformation into a team-based model. This has proven to be problematic, as many primary care practices have approached their transformation efforts with a project-oriented, check-the-boxes mentality. “The implementation of the PCMH involves a patient-centered culture shift that can be difficult to embrace by many health care workers” (Dorrance, 2013, pg. 153). Therefore, changes that are made in order to check off a box do not consider the deeper goals of PCMH transformation into a team-based model where responsibilities for patient care are shared.

PCMH transformation can be challenging to implement, both because it causes critical changes to relationships, work flows, and communication patterns, and comes during a time with many competing demands that affect primary care practices today. Primary care practices, including PMG, are experiencing multiple pressures to care for growing numbers of patients, to provide improved care, and often to do so with constrained fee-for-service reimbursement. In order to make this work the teams must learn how to work together. However, many questions still remain regarding the most effective way to help primary care practices transformation from a hierarchical model to one that relies on teams.

Leadership in the public service is experiencing a similar shift in culture, moving away from being seen as an act of individuals, and moving towards a description of a community or a collective act (Avolio, Walumba, & Weber, 2009; Black & Earnest, 2009; Ingraham & Getha Taylor, 2004; McCallum & O’Connell, 2009). Since individuals on PCMH teams are being
asked to take on new roles and act as leaders, investing in their leadership strengths may be an
effective way to build the teams. Literature describes how leadership is developed in people, and
that leadership skills are learnable (Avolio, 2010; Avolio, Walumba,& Weber, 2009; Day &
Harrison, 2007; Day, 2000; Kouzes & Posner, 2007; McCallum & O'Connell, 2009; Solansky,
2010). In the book, Strengths Based Leadership (2008), Tom Rath and Barry Conchie highlight
three keys to being a more effective leader: “knowing your strengths and investing in others’
strengths, getting people with the right strengths on your team, and understanding and meeting
the four basic needs of those who look to you for leadership.” (Rath, 2008, pg. 2). At the end of
the book, readers take an assessment using StrengthsFinder 2.0 to get their top 5 leadership
strengths. “A tool like StrengthsFinder 2.0 can be useful in determining how all team members
can maximize their contribution to the group’s collective goals.” (Rath, 2008, pr. 24). Therefore,
using a Strengths Based Leadership approach to build PCMH teams may lead to higher
functioning teams who have awareness of the leadership strengths they bring to the team, and
how the team can use everyone’s strengths to accomplish their goals.

The need for these new teams to function is critical if the new model is going to work so
that more patients can be seen. While there is literature on how to create and maintain high-
functioning teams in large organizations and inpatient settings (Dunn, 2007; Flin, 2004; Salas,
2008; Wilson, 2005), little research has been done to determine how to build and develop the
PCMH teams. Knowing what type of training program is useful and effective to build and
develop PCMH teams could help thousands of primary care practices around the country. This
capstone addresses this gap in our practice of building high preforming teams in a patient-
centered medical home context. It addresses two research questions: Does having an
understanding of individual and team members’ strengths lead to improved Team Development Measures (TDM)?; Will team members find the Strengths Based Leadership training useful?

To answer these two questions, this study introduces Strengths Based Leadership training to newly developing PCMH teams that focus on individual’s top 5 strengths, and the collective strengths of the team. Because clinic teams are being asked to take on more responsibility and work together the idea is that learning about their own strengths, and that of their teams, will help them better understand the strengths they bring, learn about other members, and the strengths of their team as a whole. The intent is to explore the effectiveness of a new approach to team building using the Strengths Based Leadership approach.

This study will review literature surrounding the PCMH model and what we know and do not know about building effective PCMH teams, the culture change involved in the PCMH transformation, and team development using Strengths Based Leadership will be reviewed. Following the review, a case study will discuss Providence Medical Groups PCMH transformation project. Four primary care clinics that are transforming into the PCMH model will be examined. Two clinics with five teams will receive Strengths Based Leadership training, while the other two clinics with three teams will not. The TDM will be given to all eight teams six weeks following their initial team training. This study is interested in individual members in teams rating on team cohesion, communication, role clarity, and goals and means clarity, all measures for high functioning teams (Gilley, et al. 2010). Also of interest is whether individuals on teams will find this new training useful to their role and the team, so an evaluation is sent directly following the Strengths Based Leadership trainings. It study will end analyzing and discussing the results, limitations, and recommendations for future studies.
Literature Review

A. Teams in Healthcare Organizations

The PCMH model uses a multidisciplinary team of health care workers to manage patient care (Grumbach, 2002). With increased focus on reducing the cost of health care, and millions of Americans becoming qualified for health care coverage with the Affordable Care Act, the PCMH model transforms tradition primary care practice from one physician managing patient care to a team of multidisciplinary clinical staff. A team can help to expand responsibilities for patient care while demands for preventive care, chronic disease management, and new complaints compete (Jaen, 1994). “The current healthcare context posits team working as essential for the delivery of care and organizational development, but difficult to maintain in the face of instability and multiple team membership.” (Bayley, 2007, pg. 188). This study found that less than a quarter of 400 organizations (primary care, community mental health and secondary health care teams) reported effective communication and team working practices. This literature review will consider four studies related to building teams in the PCMH model. It will also review the culture change component of this transformation, and end discussing team development, and how Strengths Based Leadership can be useful for building teams.

A longitudinal study was conducted in the UK interested in improving individual team member perceptions of team roles, teams functioning, and communication skills. The aim of the study was to implement a new team training program and assess individual’s perceptions post course to see whether it made an impact. Specifically, they were interested in whether team member’s levels of self confidence in their skills, communication skills, and understanding of roles and working styles within the teams would be improved after six months. The training was two days long, delivered to health care professionals working in a PCMH model. They used
three questionnaires developed for the study. Overall, the results from the study show a slight improvement on team functioning and individual approaches to team working after a 3 month period, but no effect after 6 months (Bayley, 2007). There were many limitations observed in the study including the fact that it was not a controlled experiment. Therefore, variations in results could be related to factors beyond the design. They recommend a need for a more robust design. The study concludes that staff development in health care organizations is challenging due to staff time and resources. They recommend future research to include areas of team building beyond goal setting, with assessment made before and after the course. In conclusion, this study found small improvements after a short 3 month period and suggests follow-up intervention between 3-6 months, using a more robust training design.

Another more recent study was conducted introducing interdisciplinary teams into the Patient-Centered Medical Home (PCMH) model in a residency practice. In 2008, the Wayne State University Family Medical Center (FMC) was specifically created to support the new PCMH model and principles. They formed two teams out of six physician faculty members, a behavioral health psychologist, two psychology interns, twenty family medicine residents, a clinical nurse manager, eight nursing staff, and a billing and coding coordinator. Team leadership, revising job descriptions, cross-training staff, communicating clear goals, setting measurable objectives, and publicly praising teams and individual accomplishments were all part of their team training curriculum. They also incorporated daily team huddles and quarterly team meetings with all staff to encourage effective communication. Monthly clinical operations meetings took place to discuss how the teams were measuring on their objectives. Throughout the transformation process there were practice improvement meetings to review the process and procedures. They discovered several contributions to the PCMH transformation work; team-
based care was essential to the PCMH model; requirement of a culture change began with the physicians and all other staff on the team; enhanced responsibility of nursing team leaders was important; the most effective individuals to lead teams did not have the most advanced degrees; effective communication among team members was critical (Markova, 2012). The difficulty they found was accomplishing and sustaining organizational culture change due to lack in individual’s interest. In conclusion, they found that PCMH transformation into a team-based model is an ongoing process and team members need to remain engaged in order for the culture change to occur.

Another helpful article about PCMH teams summarizes findings from the National Demonstration Project (NDP) and makes recommendations for health care organizations interested in creating their own PCMH. The NDP was the first national test using the PCMH model in 2006 working with 36 diverse family practices. They worked with an independent evaluation team that used a multi-method evaluation survey, direct observation, in-depth interviews, email stream, patient record audits, and patient and staff surveys. The summary of findings shows that while it is possible to transform practices into a PCMH it requires immense effort and motivation from the organization and staff, where improved outcomes were found using external support (Crabtree, 2010). Recommendations for health care organizations include investing in additional resources, view it as an evolving model, and that more is needed to figure out how larger health care systems can implement this model (Crabtree, 2010).

In conclusion, this literature review found that PCMH teams made small improvements to team functioning with training focused on goal setting after a short 3 month period, but not after 6 months. Also, when health care organizations transform into the PCMH model, creating teams was essential. Culture change was found to be most effective when it began with the
physicians, and then all other staff on the teams. Also found was individuals most effective to lead teams did not have the most advanced degrees, and how effective communication among team members was critical. Altogether, this literature review found that while it is possible to transform into a PCMH model, it requires attention to building the teams and the culture change of the organization.

B. Culture Change in Healthcare Organizations

Organizational culture has been defined as a set of values, beliefs, and ways of thinking that are embraced by the members of an organization (Denison, D. 1995). A recent study concerned with this aspect of change did a research study with a successfully implemented PCMH clinic at the National Naval Medical Center. They used a semi-structured interview methodology to ask questions related to team cohesion, and what areas of the PCMH model were most challenging. They also asked questions about influences the larger organization and patient population had on the PCMH model. The key findings from this study include cultural tensions in four areas: perceived competing values within PCMH, individual resistance to PCMH values, within-team conflicts threatening the acculturation of PCMH values, and threats to the culture from external stakeholders (Dorrance, 2013). Recommendations from this study include: “value clarification and empowerment, training the teams for socialization, realistic job previews, selective personnel retention, team building and conflict resolution mechanisms, and increased senior managerial support” (Dorrance, 2013, pg. 153).

Another critical aspect of culture change in the PCMH model is the physician’s role. A President’s Column was written by the President of the Society of Teachers of Family Medicine, W. Perry Dickinson, MD. He gives the physician’s perspective on the transformation of health care reform and implications it has on family medicine doctors. He starts the article stating that
becoming a PCMH means more than meeting certification; “A practice may be able to become National Committee for Quality Assurance certified a bit more rapidly, but becoming a true Patient-Centered Medical Home (PCMH) requires major transformation.” (Dickinson, 2010). He goes on to highlight three aspects of the cultural transformation he feels are most important. “First, a consistent finding across multiple projects is that leadership is incredibly important, and the type of change process required for the PCMH necessitates a shift toward a less hierarchical leadership and management style; this can be threatening for the power structure of many practices; second, the PCMH requires team-based patient care and quality improvement processes; third, patient-centered care can be extremely difficult for our practices to accomplish. Physicians tend to think that they are patient-centered in their care, but the reality is that most practices are physician and practice centered, and it requires a major shift for everyone, patients included, to turn this around.” (Dickinson, 2010, pg. 155). He concludes reflecting on the importance of physician leadership supporting the model and leading the way for all staff involved if culture change is going to work. Lastly, he provides his fellow family medicine doctors with a final recommendation, “As the family medicine educators of the future, we need to become comfortable with not being the experts and to being in charge but rather being collaborative learners, facilitative leaders, and good team members.” (Dickinson, P. 2010).

Altogether, this literature review highlights how some practices around the country may be certified as PCMHs based on national or state qualification standards, but to achieve true change the culture of primary care has to change as well. Transforming into a team-based model is one of the most challenging and critical parts to becoming a PCMH because it requires a culture change (Bayley, 2007). It takes resources, time, continuous quality improvement, and most important, clinical staff that are motivated, accepting of the new model, and can work
effectively together on a team. The last section of this review will discuss team development and how Strengths Based Leadership can help build PCMH teams and allow culture change to take place.

C. Teams and Strengths Based Leadership

There are many definitions of teams. Researchers who are experts in this field define them as a small number of people with complementary skills who have the same commitment and purpose, establish goals, and hold themselves mutually accountable (Clutterbuck, 2007; Katzenbach and Smith, 2003). A more simple definition comes from Gibson et al (2009), who defines teams as a social type of work group that consists of two or more individuals, responsible for achieving one or more goals or objectives.

Team development begins when the group is formed. In a study that evaluated several models for building effective teams they found team building to be the first phase that is most critical (Gilley, 2010). “Team building is an important component in building effective teams because it requires performance improvement of team members, ensures self-development, promotes positive communication, encourages effective leadership, and enhances employees’ ability to work closely together to solve problems” (Gilley, 2010). In addition, team building leads to improved work environments where employees have a more enjoyable experience, are more motivated to work in teams, acquire self-regulation strategies, and identify and utilize the strengths of team members (Buckingham & Coffman, 1999). In the change process, team building can lead to quick and effective response times: “Team building is important when there is a need to quickly respond to change (agility and flexibility); decision making and problem solving are better handled by teams, when people develop a sense of belonging, and products/services can be produced at the highest quality and lowest cost and most efficiently”
(Gibson, 2009). Altogether, team building allows members to get to know each other and better understand the various strengths and talents they bring to the team. This is why using Strengths Based Leadership for team building can be effective for PCMH teams. Each member gets share their strengths, learn about other member’s strengths, and ways they can work together to achieve their goals.

Capitalizing on strengths and talents of individuals was Donald O. Clifton’s passion, an educational psychologist for more than 30 years. “A tool like StrengthsFinder 2.0 can be useful in determining how all team members can maximize their contribution to the group’s collective goals.” (Rath, 2008, pr. 24). He developed and refined an assessment of over 5,000 elements into a 177 element questionnaire that identifies the talents that serve as the basis for strengths development. Similar to typology testing, the Clifton StrengthsFinder 2.0 assessment measures raw talents that become a foundation for strengths that can be applied to achieve success. The outcome of the assessment gives the participant five talent themes, or “strengths”, out of 34 total themes. There are four categories these talents fall into: executing, influencing, relationship building, and strategic thinking. A detailed description for ways individuals use their strengths is provided, along with suggestions for how to use yours strengths more effectively, and ways to work with others who have different strengths.

In conclusion, each PCMH team is made up of two or more providers (physicians, nurse practitioners, and physician assistants), two or more medical assistants, and at least one patient relations representative. With a better understanding of their own strengths and talents it can help individuals gain more insight into the value they bring to the team, provide them with an understanding of the various strengths and talents their team members bring, and how they can all work effectively together. The idea is that Strengths Based Leadership team building will.


allow teams to gain a better understanding and appreciation of the various strengths and talents each member brings, which will lead to higher functioning teams overtime.

Methodology and Research Design

A. Brief History

At Providence Medical Group (PMG) the Mission is to serve all patients in need of services, especially the poor and vulnerable. When the ACA begins in Oregon in 2014, PMG’s goal is to provide high quality, low cost care, and produce healthier patient outcomes using the PCMH model. The PMG primary care clinics employ Medical Doctors, Physician Assistants, Nurse Practitioners, Medical Assistants, Patient Relations Reps, and administrative staff who are all part of this change. PMG has been preparing 37 primary care clinics for PCMHs State of Oregon and Federal certification for the past six years. However, the work of transforming the culture in the clinics and creating teams started in 2010.

PCMH teams are made up of health care professionals that come from different backgrounds, both professionally and educationally (see Figure 1 for the Patient Centered Medical Home image):

- **Patient Relations Representative:** Responsible to answer phone calls and emails related to patient concerns and scheduling. They oversee the front desk at the primary care clinics, and make sure patients receive the required information needed for the visit. These positions required an education level of at least high school level.

- **Medical Assistants:** A medical assistant is a multi-skilled professional. They are an integral part of the healthcare team assisting in patient care management. They perform several functions. They update medical records, file insurance forms,
arrange and organize clinic exam rooms, room patients, take vitals, and help with laboratory services. They are required to be a “CMA”, Certified Medical Assistant, which takes about one year to complete.

- **Clinical Care Coordinator:** Key liaison between the patient and their Patient-Centered Medical Home. They work to ensure safety, best practices, and high quality standards are maintained for the patient across the health care continuum. They are required to be a “CMA”, Certified Medical Assistant, with five or more years of experience.

- **Provider:** This can be an MD or DO (Medical Doctor or Doctor of Osteopathy), Physician’s Assistant (PA), or Nurse Practitioner (NP). All require licensure and schooling of 4-8 years beyond a Bachelor’s degree. They are in charge of managing patient’s health care needs.

Cindy Klug, Director for PMG Education, started working on the PCMH transformation work in 2010. “As a result of the Affordable Care Act our health care organization has had to think outside of the box of a new way to deliver care to patients; we needed a new model of health care where teams worked together to provide higher quality, more affordable care that produces healthier patient outcomes.” (C. Klug, January 3, 2013). For the past two years, PMG has been developing this new health care delivery model called Patient Centered Medical Home (PCMH) using six pilot clinics. All of the clinics met certification measures for PCMH, but none had transformed into a team-based model.

Initially, when Cindy Klug was asked to lead the new health care model transformation project she viewed this challenge as an opportunity to find solutions to problems PMG had been experiencing for years, and to get all staff in the clinics involved. This leadership method of
envisioning the future and remaining positive has been proven effective when leading people (Kouzes & Posner, 2007). Cindy decided to give the primary care clinic directors and clinic managers a choice to either comply with a new model created by the executive team, or come up with a model they create themselves. She inspired staff by explaining how over time the new model would produce higher quality care, lower costs, and result in healthier outcomes for patients. She realized that all clinic staff agreed on one thing: helping patients in need. This leadership style of inspiring a vision for the future through finding a common purpose with positive outcomes for patients was very effective. “What truly pulls people forward, especially in the more difficult times, is the exciting possibility that what they are doing can make a profound difference.” (Kousez and Posner, 2007).

Cindy realized she needed resources to help her beyond the clinic managers and hired four new positions: three change coaches and a program manager for primary care redesign. The change coaches are trained in change management and have experience leading teams through major change initiatives. The program manager is responsible to oversee the project operations and ensured all of the key stakeholders involved in the project were involved and kept informed.

The next step Cindy took was forming a PCMH Committee who met monthly throughout the pilot project. “The success of their leadership hinges on an ability to turn ‘you’ into ‘us’” (Nye, 2008). Cindy felt that creating a team environment was critical to the success of the project. “Creating self-directed teams leads to higher functioning and more success and satisfied employees” (C. Klug, January 3, 2012). Cindy used minimal hard power with majority soft power to support the development and success of the PCMH Committee, another leadership strategy found to be effective (Nye, 2008). Using hard power she presented the PCMH Committee with patient population numbers and financial cuts in reimbursements in health care
reform. This reality of hard facts and numbers showed the group how the current health care model needs to change. Therefore, there was no choice in changing if PMG was to continue serving all patients in need of health care services. She used soft power by communicating using persuasive words and symbols that connected the purpose of the transformation to the Mission and Core Values of the organization. “In order to serve all of our patients and live up to our Mission and Core Values we must act and look at this as an opportunity to come up with solutions to create a health care model where all of our patients receive high quality care at lower costs with better outcomes.” (C. Klug, January 3, 2013). She worked with the marketing team to come up with a symbol that represents the new Patient Centered Medical Home model of care (Figure 1). Another soft power technique she used was working with the group the first couple of meetings to come up with a shared vision. After the first couple of meetings, this was the shared vision the PCMH Committee created:

“By building a care team for each patient and engaging the patient’s voice in every care team, our Providence Medical Home will understand and respond to the needs of our patients and act to continuously improve the health of our communities.”

Through Cindy’s use of minimal hard power and mostly soft power she was able to develop a group or team who together developed a shared vision that guided their way throughout the transformation process. Altogether, Cindy Klug was the leader who started the PCMH transformation work and used effective leadership throughout the transformation pilot process including honesty, forward-looking, inspiration, competency, and minimal hard power with
majority soft power; all effective leadership strategies during change (Kousez and Posner, 2007; Nye, 2008).

B. CAP Analysis of PMGs PCMH Transformation Project

The PCMH Committee tried various versions of the PCMH model before they came up with one that worked for all six pilot clinics. The pilot ended on January 1st, 2013 and PMG is beginning to spread the PCMH model to the rest of the primary care clinics in Oregon. On January 15th, 2013, Cindy Klug, the three change coaches and program manager were interviewed and asked:

“What was most challenging during the pilot to be aware of as the PCMH model spreads to the rest of the primary care clinics in Oregon?”

All responses to this question related to PCMH team’s level of functioning and ability to work together; even after the two year pilot some teams were still not working well together. Using the Change Acceleration Process (CAP) (Figure 8), this study conducted an analysis of the pilot project to determine why some of the teams were not developing well together. CAP is a tool Providence Medical Group uses that helps prepare for and adapt to change. There are five stages tool related to change: creating a shared need, shaping a vision, mobilizing commitment, making change last, and monitoring progress. During each phase there are tools to involve and empower employees and stakeholders during the change process. It considers the cultural, technical, political and human factors involved in organizational change.

The first stage in CAP is creating a shared need. This is important because it forces any resistance or apathy to be addressed up front, clarifies what the change is about, develops shared recognition by everyone involved, and the ability to frame the need for change as both a threat and opportunity (CAP, 2006). Cindy and the change coaches used tools in CAP to assist clinics
and teams during this phase to create a shared need. Specifically, teams in the pilot met with the change coaches to better understand why the PCMH transformation project was happening in the first place. Change coaches used tools to brainstorm with the teams about concerns they had with the new model, and what barriers may be involved during the change. For example, two tools were used during in this process: Three D’s matrix and Threat vs. Opportunity matrix. In the three D’s matrix the teams brainstormed answers to questions related to data/diagnosis (what data do we have or need?), demonstrate (Show me! Where is it working/not working?), and demand (Who or what is driving it?). The answers were put into two categories, ideas and actions. The threat vs. opportunity matrix the teams brainstormed on short and long term treats and opportunities to PCMH transformation. Overall, teams were provided with ample support during this phase of the change process. After the shared need was developed the change coaches helped the teams move into shaping a vision.

During the shaping a vision teams envision what the organization will look like once the change is successfully implemented; the changes on the entire organization, and to patients who receive their services. This is an important step because it gives the teams a clear path ahead and focuses on the results of the change as they relate to individual behavior, rather than the organization. One tool the change coaches used during this phase was the consumer focus alignment. During this exercise they answered the question, “What are the 3 – 5 most important things we want this team and/or project to be known for by our key stakeholders?” This is critical to have a team come to a consensus on, and can also bring to the table individuals who have differing options about what the end will look like. It is important to have a clear understanding of the end in order to keep everyone on the same page and in full support of the change. Change coaches used other tools during this phase and established the team goals.
Altogether, the teams seemed to get a lot of support surrounding shaping their vision, which leads to the next phase of mobilizing commitment.

During the mobilizing commitment phase teams develop strategies for how to begin the change process. Rather than getting the entire clinic staff to change all at once, the change coaches worked with the individual teams to pilot the new PCMH model. This allowed opportunity to learn from the mistakes and successes that occurred prior to rolling it out to the rest of the primary care clinics. The teams started discussing their roles and how the team-based would work. The training curriculum used for the teams during this phase focused a lot on what the change process is, but little was provided focusing on team building. This raised concern and presented an area, or gap, that could be the cause for some of the teams to not be developing as well together.

Starting in 2013, nine primary care clinics began their transformation into the PCMH team-based model. This presented an opportunity to test the new Strengths Based Leadership team building training. Initially, all eight teams were given an introduction to the PCMH model, called a “kick-off” meeting, and discussed why the PCMH model is important to position PMG for health care reform, and what the future state will look like once their clinics go through the change process. Following the kick off meetings the teams were formed and co-located. They moved from independent work stations to new spaces were teams work side by side. Once this step was complete they had their first team meeting. This is when the Strengths Based Leadership team building training was introduced to five out of the eight teams. The three teams who did not receive the new training were given the same team training the pilots received.
C. Strengths Based Leadership Training Curriculum

1. At least five days prior to the Strengths Based Leadership training each team member received a *Strengths Based Leadership* book with instructions on how to take the StrengthsFinder 2.0 assessment (Figure 1.0).

2. Team members were also asked to complete a Team Activity form after completing the assessment and bring it with them to the training (Figure 2.0) to encourage discussion about their reaction to the assessment.

3. During the training each member wrote their top 5 strengths on sticky notes and placed them on a map (Figure 3.0) for the entire team to see.

4. While placing their strengths on the map the facilitator asked that they reflect on how they see their number one strength contributing to the team.

5. Once everyone was finished, there was an open discussion on their reaction to the test and their teams strength map.

6. After they completed this training the team strengths map (example in Figure 4.0) was made into an electronic version and sent to the teams with an evaluation (Results in Table 3).

7. Throughout the process, quality and process improvement meetings occurred with the Director, change coaches, and facilitator. Planning was completed with the Change coaches to continue using the individual and team strengths throughout the teams development should results prove effective.

Six weeks following their initial team training all 8 teams (n=57), 5 with Strengths Based Leadership (n=36), and 3 teams without (n=21), were given the TDM in paper format with a one
week deadline to return it to their clinic manager. Teams who received the Strengths Based Leadership training were asked to complete a Team Evaluation Questionnaire through an online secure Providence intranet site within 24 hours of the training.

D. Team Development Measure (TDM)

The TDM is a 31-item self-report survey created to measure team development and promote team quality improvement in the healthcare setting. It has been used in over 150 teams by more than 1000 individual members. It has been tested in teams of 3-4 persons as well as teams of > 40 persons.

Method: Simple summated score

The 31-item survey has a scaled 4-response set:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Step 1: Each response for every item was coded and given a score based on a subject’s response, assigned to each item as follows:

Strongly Disagree = 1
Disagree = 2
Agree = 3
Strongly Agree = 4

There are 4 items that are reverse scored (Items #3,15,16,27) so that a score assigned to these items are as follows:

Strongly Disagree = 4
Disagree = 3
Agree = 2
Mitchell, A Strengths Based Leadership Approach to Building Patient-Centered Medical Home Teams

Strongly Agree = 1

Step 2: A summary for each teams mean scores are shown in Table 1 and 2. The score range is 31-124 and was converted to a 0-100 linear measure using the TDM score table (Appendix 1).

Step 3: An overall team score was calculated by summing all individual scores (after converting to a 0-100 linear scale) and obtaining a mean. In team development, it is of greater value to have a team that has a similar perspective of the “teamness” within the group, e.g., a narrower range of distribution.

Appendix 1: Team Development Measure Score Table

<table>
<thead>
<tr>
<th>Stage</th>
<th>Score Range</th>
<th>Components Present*</th>
<th>Solidification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Team</td>
<td>0 - 36</td>
<td>None to Building Cohesiveness</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>37 - 46</td>
<td>Cohesiveness</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>47 - 54</td>
<td>Communication</td>
<td>In Place</td>
</tr>
<tr>
<td>3</td>
<td>55 - 57</td>
<td>Role Clarity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>58 - 63</td>
<td>Goals &amp; Means Clarity</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>64 - 69</td>
<td>Cohesiveness</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>70 - 77</td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>78 - 80</td>
<td>Role Clarity</td>
<td>Firmly In Place</td>
</tr>
<tr>
<td>8</td>
<td>81 - 86</td>
<td>Goals &amp; Means Clarity</td>
<td></td>
</tr>
<tr>
<td>Fully Developed</td>
<td>87 - 100</td>
<td>Everything</td>
<td></td>
</tr>
</tbody>
</table>

Team Development Score Table has four components and two levels of solidification form eight stages of team development. These stages were empirically found in the Rasch analysis of team development (Mahoney & Turkovich, 2008). The central feature of Rasch analysis is that it captures how respondents to the survey see the world. Therefore, what the TDM results describe
is not the invention of the researchers, but what the individual team members feel about their team.

The TDM measures teams based on two developmental processes:

1. Presence of Components: How many of the components of team development are present in the team and
2. Solidification of Components: How firmly those components are in place in the team.

If a team is fully developed all of the components of development are solidified. This also means that teams become resilient, where disruptive events from either within or outside of the team are taken in stride as the team continues to move forward in its work (Mahoney & Turkovich, 2008). This level of development is the ultimate goal for PCMH teams.

**E. Team Evaluation Questionnaire**

This measure was only given teams who received the Strengths Based Leadership training. The Team Evaluation Questionnaire (Appendix 2) was sent via email within 24 hours of the training and was anonymous. There are eight questions related to levels of satisfaction and how useful individuals felt the training was for their role and the team. Scoring was done using a 5-point liker scale to rank responses to questions [strongly disagree=1; neutral=3; strongly agree=5]. For non-responses no value was given. After the questionnaire was completed, an overall mean was also calculated based on team position and question.
Appendix 2: Team Evaluation Questionnaire

### Strengths Based Team Training

<table>
<thead>
<tr>
<th>Select the button that represents your rating</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, I was satisfied with this training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All of the stated learning objectives were met.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The activities and materials supported my learning.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this session to others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Application to my Work

<table>
<thead>
<tr>
<th>What I learned in this training will be useful to me in my role on the team.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>After completing this training, I have a better understanding of my own strengths.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After completing this training, I have a better understanding of my team member’s strengths.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, this training and information was useful for my team’s development.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Findings

#### Table 1: Teams who received the Strengths Based Leadership training

<table>
<thead>
<tr>
<th>North Portland</th>
<th>TDM Mean Score</th>
<th>Stage of Team Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team A</td>
<td>62</td>
<td>Stage 4</td>
</tr>
<tr>
<td>Team B</td>
<td>65</td>
<td>Stage 5</td>
</tr>
<tr>
<td>Team C</td>
<td>64</td>
<td>Stage 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Happy Valley</th>
<th>TDM Mean Score</th>
<th>Stage of Team Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team A</td>
<td>56</td>
<td>Stage 3</td>
</tr>
<tr>
<td>Team B</td>
<td>55</td>
<td>Stage 3</td>
</tr>
</tbody>
</table>
Table 2: Teams who did not received the Strengths Based Team training

<table>
<thead>
<tr>
<th></th>
<th>TDM Mean Score</th>
<th>Stage of Team Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercantile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team A</td>
<td>59</td>
<td>Stage 4</td>
</tr>
<tr>
<td>Team B</td>
<td>62</td>
<td>Stage 4</td>
</tr>
<tr>
<td>Glisan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team A</td>
<td>40</td>
<td>Stage 1</td>
</tr>
</tbody>
</table>

Table 3: Team Evaluation; Average scores for 35 team members who received training

<table>
<thead>
<tr>
<th>Satisfied</th>
<th>Objectives</th>
<th>Activities</th>
<th>Recommend</th>
<th>Useful 2 Role</th>
<th>Own Strength Understanding</th>
<th>Team Strength Understanding</th>
<th>Team Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.09</td>
<td>4.03</td>
<td>4.09</td>
<td>4.14</td>
<td>4.14</td>
<td>4.17</td>
<td>4.31</td>
<td>4.23</td>
</tr>
<tr>
<td>Physicians/PA/NP</td>
<td>Medical Assistants/CCC</td>
<td>Patient Relations Reps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.04</td>
<td>4.04</td>
<td>4.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discussion

Research Question 1:

Does having an understanding of individual and team members’ strengths lead to improved Team Development Measures (TDM)?

Happy Valley and North Portland clinic teams received the Strengths Based Leadership training; Mercantile and Glisan clinic teams did not. The mean scores for each team is shown in the 2nd column of each table; at the 3rd column shows the developmental stage of each team.

At the Happy Valley clinic, team A had a mean score of 55, while team B had a mean score of 56. That puts these team in stage 3 on the TDM scale, where the presence of cohesiveness, communication, and role clarity are perceived my individual members to be in
place, though goals and means clarity is still not present. Based on the TDM measure these teams are still developing and have not reached the solidification stages.

At the North Portland clinic, team A scored 62, team B scored 65, and team C scored 64. This means team A is in stage 4 in their development, so all four stages of cohesiveness, communication, role clarity and goals and means clarity are present and they are moving into solidifying those components of their team. Teams B and C are farther ahead in their development, scoring in stage 5 of development. This means that the individuals on the team are moving into the solidifying stages of their development.

Mercantile and Glisan clinics did not receive the Strengths Based Leadership training. Mercantile team A and B scored 59 and 62, which is stage 4 on the TDM score table. This is the same stage as team A from the North Portland clinic. Therefore, although these teams did not receive the Strengths Based Leadership training they ended up in the same developmental stage as teams who did. The Glisan team scored 40, putting them in the very first level of team development when teams first are formed. This was significantly lower than any team that was measured in this study.

Overall, the average score for teams who received the Strengths Based Leadership training was 60.4, ending up in stages 3-5 on the TDM Score Table for level of team development. For teams who did not receive the training, their average score was 53.7, 6.7 points below. Mercantile teams average score was 60.5 while the Glisan team scored 40. Teams who received the Strengths Based Leadership training ended up in stages 3, 4 and 5 on the TDM score table, while the teams who did not receive the training ended up in stage 4 and 1.

**Research Question 2:**

Will team members find the Strengths Based Leadership training useful?
The teams who received the Strengths Based Leadership training also received an evaluation within 24 hours of taking the course. A summary of their responses is in Table 3. The mean score overall was 4.14 with 5 being most useful. The two highest ratings came from the last two questions, where individuals felt they had a better understanding of their own strengths and of their team member’s strengths.

**Conclusions**

These findings partially support research question 1. Teams who received the Strengths Based Leadership team building training ended up with an average score on the TDM of 60.4 compared to 53.7 for teams who did not. As mentioned above, Mercantile did not receive the training and scored an average of 60.5. This puts them at stage 4 in their development, the same or close to teams who received the training. Mercantile teams scored higher than the Happy Valley teams, who received the training. However, the Glisan team ended up with a score of 40, putting them in the very first stage of development. Since Mercantile and Glisan have both had the same amount of support and information during their “kick-off” meeting this implies that other factors may be present that are affecting the teams level of development.

This research did find support for research question 2, with an average overall score of 4.15 out of 5 on the team evaluation. Scores for questions 6 and 7 relate to better understanding of individual strengths and that of team members were the highest, with 4.17 and 4.31. Each question scored above 4 out of 5. This level of satisfaction in the training and usefulness to roles and the team presents the opportunity to continue using the Strengths Based Leadership approach to building future PCMH teams and incorporating strengths based leadership in other professional and team development program.
Limitations

Time was a limiting factor of this study. The TDM was given to teams six weeks following the training. Allowing more time for the teams to develop may have shown increased levels of development compared to teams who did not receive this training. Also, this study was not a controlled experiment so there could have been confounding factors that influenced the team’s level of development beyond the design of this study. Also, this study only used self-reports from individual team members. Having a more robust design, over a longer period of time, could include more process evaluation in each clinic and team, and more objective measures of team functioning.

While the TDM is proven to be useful in measuring teams level of development having qualitative data would have been useful. Change coaches could have observed the teams and taken notes on areas where Strengths Based Leadership was used by the teams. Clinic managers could have been interviewed on the before and after state of the teams. Overall, having more qualitative data would have given more information to the teams levels of development and the usefulness of the Strengths Based Leadership training. This observational and interview data may have been useful for explaining why the teams who did not receive the training ended up with such drastically different scores.

Recommendations
The leadership style used by Cindy Klug was effective to get the pilot PCMH Committee formed and the model developed. Further evaluation into the leadership styles used in the clinics would be important to understand. Teams are being led during significant change processes so the leadership styles and techniques is an important contributing factor to whether the project and teams are successful. Also recommended is a more in depth evaluation of the power and culture structures in the clinics. This can help to better understand why teams are not functioning well and ways to support them. Another recommendation is with so many more clinics needing to transform into PCMH model, more change coaches should be hired and use the change management tool, CAP. This can be used to help the clinics and teams get through the change process successfully, and determine any gaps that may be causing the teams to not develop well together. Lastly, a Strengths Based Leadership training program is recommended. Since the teams scored so high on the training, a program for using strengths overtime with individuals, teams, clinic managers and medical directors is offered.

**Clinic Leadership Development**

In looking forward, recommendations for leadership strategies are to continue using the techniques Cindy Klug demonstrated of inspiring a vision, incentivizing with currencies related to personal values, using minimal hard power with majority soft power, and model the way for others. All clinic managers should create a climate of trust, facilitate relationships, and provide reflection and action. These are all strategies proven effective during challenging times (Kouzes and Posner, 2007). Managers can foster collaboration by discussing the importance of team-based care at meetings, and how it is critical to work together as every role on the team is important and valued. “‘You can’t do it alone’ is the mantra of exemplary leaders – and for good reason.” (Kouzes and Posner, 2007). Relationships can be formed using the new team-based
approach with clinic managers creating an environment that supports relationship building. For example, at most clinics the physicians have their own office, separate from the other clinic staff. In creating an open office environment, where all member of the team work together it can enhance communication and relationship building. Clinic managers should also check in with staff one on one to ask what has been working, and what could use improvement. This will create an environment of trust with staff knowing that there is an open door policy and their managers really care about making sure they have what they need to be successful. Finally, clinic managers should continually reflect with their staff on what has worked, what has not, and what has been changed as a result. “Your (leadership) job is not to give advice and win arguments; it’s to pay attention to what others want and need” (Kouzes and Posner, 2007). Finally, clinic managers should continue to use leadership techniques that inspire the teams to move forward and enable them to transform into high-functioning teams. Although the future of health care has many challenges ahead and change is constant, the leadership techniques used is critical in creating an environment that allows change to occur successfully.

A. Political and Cultural Considerations

Another important factor not covered in this study is the evaluation of the larger organization of PMG. An image used to analyze how organizations function is the political image; “By attempting to understand organizations as systems of government and by attempting to unravel the detailed politics of organizational life, we are able to grasp important qualities of organization that are often glossed over or ignored.” (Morgan, G. 2006). Viewing an organization through a political image means learning how organizations make decisions when everyone has different points of view, and how power is exercised. Conflict within these dimensions is an important consideration. Using the political image means viewing organizations
as governing structures. Morgan describes six types of governing structures: autocracy (power held by one person), bureaucracy (power in written word), technocracy (expert power), codetermination (opposing parties combine in joint management of mutual interests), representative democracy (rule through election of officers), and direct democracy (everyone has equal right to rule). PMG has a hierarchical structure where decisions are made at the top, executive level. Using this image will explore how conflict in power may be a cause to the problem. Doctors, with their technical expertise, may not follow instruction from the top because they are experts in their field. Therefore, their individual interests may be getting in the way. Morgan discusses three types of interests that can help explain the politics of an organization; task interests (work one preforms), career interests (aspirations and visions of future), and extramural interests (personalities, private attitudes, values, preferences, and beliefs). Whether these interests overlap with one another, or how much they overlap, can explain the political environment of an organization and how decisions are made. Since standardization of the PCMH is the problem of this study, which comes from the techno structure of the organization, getting the operating core of doctors, or experts, may be part of the problem. Therefore, using the political image would show the power structures at each clinic and whether the doctor’s personal interests may be part of the reason PCMH teams are struggling. This can help determine ways to work more closely with the physicians in those clinics to assist in the change process.

Another recommendation is to evaluate differences between PMG’s human/cultural considerations compared to the clinics. “There is a growing literature of relevance to understanding how organizations can be understood as a cultural phenomenon” (Morgan, pg. 386). PMG is a large organization that has been in operation for over 35 years. It provides orientation and trainings on the mission and core values of Providence Health & Services (larger
health care system) which has a rich history of serving patients in communities since 1858. All PMG administrative staff work in the same office filled with cubicles. Conference rooms are constantly filled with meeting among members of various teams working to manage the clinics and uphold to the mission and vision of the organization. Some of the clinics run by PMG used to function independently for 30+ years. Not being part of PMG from its creation could be a factor affecting the PCMH transformation work. Clinics have their own unique ways of organizing and managing that could be much different than PMGs. Using the culture frame to view the PCMH transformation project could mean understanding why some of the teams are struggling and work more closely with those clinics to overcome the obstacles and determine ways to create sustain PCMH teams based on what works for the individuals clinics.

B. Change Acceleration Process

With so many more clinics transforming into the PCMH model, more change coaches should be hired and use the change management tool, Change Acceleration Process (CAP). The CAP model is designed to help people prepare for and adapt to change within an organization. It uses transitional organization development strategies throughout the process by considering the humanistic side to the problem. It follows an action plan throughout, views the solution to the problem starting at the end, includes social considerations in every phase, and uses multiple frames to evaluate the problem. Using the various brainstorming and problem solving tools the teams will be more encouraged to think outside of traditional problem solving strategies to come up with solutions that are innovative and consider each person involved. The following are the seven components to CAP and recommendations for ways to use this model during the PCMH transformation process.
**Leading Change:** Initially, it is critical to have a change facilitator who is trained in CAP and responsible to support the team throughout the process. They act as a change facilitator and do not play a formal role in decision making on the team. The next important step is having committed members who are clear about what the problem is, the need to use CAP to assist in solving the problem, and the important role they play throughout the process. There are tools in this step the team uses to ensure they are prepared to be a part of the CAP team. For example, there is CAP self-assessment that asks questions related to leading change where individuals rate themselves on a scale from almost always to almost never. One question in this assessment is, “Finds opportunities in change rather than excuses for avoiding change”. This is an opportunity for team members to check in on how they rate themselves and how committed they are to successfully implementing a change in the organization.

During this phase of CAP, a change coach who would meet with the clinic managers, director, and supervisors. They would each complete the leadership self-assessment and share their results with the group. This is an opportunity for everyone to be aware of their commitment to transforming into a PCMH. It also creates expectations for each team member. If people score low they may not be a good fit to help lead through the change process.

**Creating a Shared Need:** Once the CAP team is in place in the clinic the next step is to create a shared need among staff. During this process the goal is for the team to realize the need to solve the problem outweighs the resistance to change. Reasons for change are developed that emphasize the importance and appeal to not only leadership driving the change, but all stakeholders involved. It is critical to develop the shared need and reasons for changing in the beginning of the CAP process and refer back to them when the team faces challenges.
**Shaping a Vision:** Linking the vision to the PCMH teams and patients is important. In this phase the CAP team envisions what the organization will look like once the change is successfully implemented; the changes to the entire organization, and the patients who receive services. This is a key step that gives the group a clear path ahead and focuses on the results of the change as they relate to individual behavior, rather than business.

**Mobilizing Commitment:** Now that the CAP team is in full support of the need for change and what is will look like once it is complete, the group develops strategies for how to begin the change process and who should be involved. Rather than getting the entire clinic to begin to change, they leverage a smaller more manageable group that can start the process and be adaptable. This creates an opportunity to learn from the mistakes that occur prior to rolling it out to all of the teams. The group then discusses how individuals are linked to each other, and draws lines on a map to indicate an influence link using an arrow to show who influences whom. This is useful in determining how to best rollout communication to certain staff to ensure the message is coming from a position of respect and authority. For PMG this would mean discussing the various constituents involved in the PCMH work (doctors, nurses, medical assistants, patients, PMG leadership, Operations Team, Providence leadership, patient educators). Through identifying and labeling key clusters of stakeholders and their level of interest/involvement in the change effort it will help the team be aware of who is affected and to what extent.

Another important tool during this phase of the change process is the Technical-Political-Cultural analysis. This would mean an opportunity for the CAP team to dive deeper into doctors possible reasons for resistance related to technical, political and cultural factors. With PMG this might mean discussing how some doctors follow along with the PCMH team based model, and why some do not. For example, some reasons might be related to their clinics culture (i.e. they
function as a separate clinic versus part of the larger organization), or their individual interests (i.e. doctors feel they are capable to take care of patients using their own strategies), as discussed earlier. This would present ideas for potential causes to resistance using multiple frames.

Finally, the last tool used during this phase is developing an Action Plan (WWW). The group would consider the stakeholders involved, what they need to do, who each are, and when their tasks should be completed. This holds the team accountable and creates tasks the group decides are manageable and realistic to accomplish. For an organization as large as PMG this would mean involving clinics as pilots (i.e. maybe 7 clinics), and selecting staff within each to participate. When the team members approach the staff they must communicate the vision and shared need developed by the group to be sure staff are in support of the project.

**Making Change Last:** During this phase, and the two that follow, the CAP group starts to focus on how to make the changes permanent. The team learns from the mistakes and celebrates the successes. Together, they develop a plan for rolling the PCMH model out to the rest of the teams and prepare to compete with other change initiatives. Throughout this process the CAP team continually monitors what is helping and hindering the change initiative.

**Monitoring Process:** This is an important phase of the CAP process that it critical to motivating people to continue moving forward. Similar to the action plan in the 4th step, there is a project plan the CAP group develops. This holds people, tasks and dates accountable to the successful completion of the change. It also creates an opportunity to celebrate when benchmarks are met, which is an important step. People are held accountable when the benchmarks are not met and explore reasons why the task was not completed on time.

**Changing Systems and Structures:** During this phase of CAP the underlying systems and structures of the organization are considered. If they are not changed along with the initiative
then the likelihood of them working against the change is high. The leadership team must identify how the organizations systems influence the behavior desired to change, and adjust them appropriately. This is critical because in order for the change to last, the organization systems must change along with it to support and sustain it.

Overall, hiring more change coaches who are trained in CAP could help the PCMH teams develop more effectively. CAP considers each position, reasons for the problem, and evaluates the problem using different frames (political, cultural, technical). This would allow teams to consider possible solutions to problems that otherwise would not be considered. It uses transitional organization development strategies throughout the process; considers the humanistic side to the problem and everyone involved; follows an action plan throughout; views the solution to the problem starting at the end; includes social considerations in every phase; and uses multiple frames to evaluate the problem. And lastly, it evaluates the organizations systems and structures to ensure that the clinics change with the initiatives, or PCMH model.

C. Strengths Based Leadership Program

The last recommendation is using developing a Strengths Based Leadership program for the teams, clinic managers, and medical directors that can be used for ongoing team building and individual professional development. Employees scored high on the training and found value in it for their own level of development and for their teams. However, if Strengths Based Leadership is going to be effective overtime it needs to be used often with the teams. Figure 6 shows the steps PMG change coaches can use to implement the Strengths Based Leadership program overtime with PCMH teams. The first step is to continue training the teams beyond the initial training is using the Team Strengths Map during team meetings while teams continue to develop through stages together, and learn how to use each other’s strengths to manage through
the various challenges they face. This will keep the focus on the positive aspects of the teams and encourage them to see beyond the problem they are facing. Individuals on teams can also use their results from the StrengthsFinder 2.0 assessment to encourage their team members to use and be aware of their talents. This can be during times when added responsibilities occur, or during a time when a problem needs to be solved. The team lead and change coach can also use the Team Strengths Map to keep the teams focused on their strengths and see opportunities for overcoming challenges, versus focusing on the problem itself.

Another way the Strengths Based Leadership program can be used with teams moving forward is to have the initial training reintroduced to the team when new members are introduced. This will allow for current team members to openly discuss their top 5 strengths with their teams so that the new member gains a better understanding of the roles each member plays on the team, and how to work best with them. The new members will also bring their StrengthsFinder 2.0 results and discuss their top 5 strengths and how they see them being useful for the team.

Lastly, the Strengths Based Leadership training program can be useful for clinic managers and medical directors who are responsible to oversee the employees in the clinics. Each clinic manager will get the Team Strengths Map. This will be helpful for them to visually see the strengths each team represents. The map can also be helpful during one on one meeting with staff to help provide a positive aid while discussing issues related to conflict management. For example, if an employee scores mostly in the executing category and is having a hard time working with a team member who scores mostly in relationship building, the clinic manager can use the map to point out how that employees role is critical to the success of the team, and how to be aware of how to balance with those on the team who bring strengths that are different.
Clinic managers and medical directors will also receive each employee’s StrengthsFinder 2.0 results, which they can use during professional development planning to encourage staff to continue working on building their strengths, and working well with others on their team.

Overall, if Strengths Based Leadership is going to be used and effective overtime it needs to be used continually with the teams. Individual team members can use the Team Strengths Map to better understand their team members and how to work best with them. They can also use the results to encourage new roles and responsibilities on their team. Clinic managers and medical directors can also use the Team Strengths Map and individual strengths of each employee to encourage problem solving and professional development. Altogether, the Strengths Based Leadership program can be a change agent that keeps the clinics and teams focused on the strengths each individual brings, and provide an opportunity to see beyond the challenges that are inevitably coming with health care reform.

Capstone Reflection: Contributions to my Leadership Role

- Leading from where I sit
- Facilitating and leading teams through change
- Working closely with leadership to encourage focus on individual strengths and conflict management strategies using strengths
- Better utilizing my own strengths
- How individual’s strengths balance with each other
- Leadership development goals using my own strengths and areas to grow

**Foster Collaboration:** As leadership is a team effort I will continue to build relationships both within and outside of my organization to enhance overall outcomes. In healthcare there are many challenges ahead that I view as opportunities, and with collaborative relationships with other healthcare organizations in the community we can share best practices and work together to provide high quality health care to all members in the community.

**Search for Opportunities:** I will look for opportunities within and outside of my organization to help improve services and outcomes for the patient population. I plan to do this through meeting with leadership in my organization and in the community to determine current initiatives, and open up doors for collaboration. Through becoming more aware of the initiatives going on inside and outside of Providence I can begin to foster collaboration and develop new initiatives to improve health care in the community.

**Envision the Future:** I envision a future of improved healthcare for all patients at Providence and in the community as a whole. I will keep a running list of goals I would like to achieve, and make sure to review them every quarter to stay on track. I will share my professional goals with
my director to get feedback. I will also share my goals with co-workers and collaborate on ways we plan to work together to achieve our goals. The Affordable Care Act is coming to Oregon in 2014 and the increase in patient numbers, combined with a significant decline in reimbursement is overwhelming. When thinking about the future I will keep an optimistic view and realize that with every challenge has opportunity for change that can result in more efficient and effective programs and outcomes. Through sharing my personal vision of the future I hope to inspire others and move forward in my professional leadership role, being open to feedback, flexible to change, and optimistic of what lies ahead.

**Institutional Thinking:** In order to overcome all of the challenges public administrators face, leadership must have the knowledge and understanding of the history, balance demands, and have the ability to move forward and take risks to maintain civil liberty. “Public Service leadership requires leaders to size up the constellation of contending forces at play in the community and to assess the range of plausible approaches for engaging citizens and officials in developing institutional responses.” (Morgan et al, 1998, pg. 706). Having the technical knowledge, combined with the history of our governance institutions, and the ability to work effectively with people at every level is a core competency all leadership need. Hugh Heclo, author of “On Thinking Institutionally” discusses this type of leadership as someone who can think institutionally, about the entire system of governance rather than the place one works: “To gain a more rounded view of the subject, and one of greater relevance for our lives, we have to move beyond thinking about institutions and consider what it is to think as moral agents within a framework of institutional values” (Heclo H., 1998, pg. 79). This style of leadership takes
someone who has the ability to think beyond themselves, and look at the entire system to find solutions to problems.

**Relationship Building:** Public administrators need to work with all public institutions, including non-profits and the private sector, in order to sustain liberty and promote resolutions to problems in a civil and respectful manor. Leadership who is able to develop and maintain relationships within and outside of their organization can problem solve together and improve outcomes for public services. This relates directly with my leadership goal in fostering collaboration, viewing leadership as team based rather than an individual venture. I have experienced working “for leadership” without a genuine relationship, and working “with leadership” having a great relationship. Needless to say, the work and skills I developed was much more productive and meaningful to the organization with having good relationships. I think this is critical for leadership in the public sector because it creates an environment of team, and allows people to work to their highest potential. It also creates an environment where people enjoy their work more, and are more likely to stay in their positions longer, and move up in the company with the vast knowledge and skills that are critical. Another key component to this leadership style is that it creates opportunity for collaboration outside of the organization as well as inside. The future of public service must start to work together, and with leadership that emphasizes the importance of relationships, it can happen.

**Model the Way:** Another significant core competency is in modeling the way for others in “The Leadership Challenge” by Kouzes and Posner. This involves being aware of what is important to the followers: trust, compassion, stability and hope. Creating an environment where follower’s
needs are being met, they will move forward even during challenging times. This leadership style is in line with the American Society of Public Administration Code of Ethics through demonstrating personal integrity, promoting an ethical organization, and in striving for professional excellence. All of these concepts are critical to successful leadership and to modeling the way for the future of public service. With the changes we face today, and will face in the future, being a model for people is important in order to keep them motivated and moving forward together.

**Communication:** I scored highest in communication in the StrengthsFinder 2.0 assessment. Communication is critical to good leadership through having the skill to deliver to groups the mission and vision of the organization, and influence them to move forward with you. In my leadership goals having strong communication skills is critical to all three: fostering collaboration, searching for opportunities, envisioning the future. Being able to adjust your communication style and method to best reach various stakeholders and diverse community members is an important part of this core competence.

**Inspire a Vision:** Not just as an individual, but as a team. In my experience having a shared vision allows for people to grow and succeed together. Being mindful of what the vision is produces results that reflect this shared vision and motivate people to keep moving forward together. “Leaders have to make sure that what they see is also something that others can see.” (Kouzes & Posner, 2007, pg. 105). Being a good leader means that you must include your team on creating the vision, and in revising it as you move forward.
Inclusiveness: “Leadership is not a solo act, it’s a team effort. (Kouzes & Posner, 2007, pg. 223). In my leadership roles I always strived to engage members of the team, and foster a sense of collaboration. I strongly feel that everyone brings talents and experience that differs from one another, and if leadership can foster those differences and create an environment that allows for everyone to collaborate together in a respectful way, the results are much richer. For example, the list of the top ten public leadership values was a combination of each students ideas about what it takes to be an effective leader in the field of public service. If we would have been given a list from Dr. Ingle, and told to use it as we assess our core values, I don’t think the exercise would have been as effective or meaningful.

Integrity: To me it means being consistent in behaviors and actions that reflect all of my core values. Others will not trust or view you as a leader if you do not show and model your core values consistently and effectively. A leader will not be successful if those they are leading do not trust in their core values. This aligns with the last core value I scored highest in: ethical. In my experience in being a leader and having worked with great leaders, this value is critical in the field of public service because it aligns with the moral values you have to serve and better the community. It is reflected in every interaction and relationship you have, and is necessary to be an effective leader.

Closing Remark

In the article, “Leadership can be Taught”, Xiaomei Wang summarizes Sharon Daloz Parks approach to teaching leadership called “case in point”. This style of teaching leadership
“transcends the general case study models by using the individuals' own experiences and the classroom environment itself as a living laboratory for leadership learning.” (Xiaomei, W. 2010). Her main belief was that leadership is something that is shaped over time with a deliberate effort, as we discussed in the first class of EMPA 517. “True leadership involves interactive presence between individuals of a team that motivates everyone to face adaptive challenges.” (Xiaomei, 2010). This capstone study introduced a new training to the PCMH teams using Strengths Based Leadership based on this concept of leadership as a collective or team effort. The PCMH teams face challenges every day in managing patient care needs to ensure healthy outcomes. With health care reform comes the new team-based approach and with that a need to build and develop these teams to be high functioning. Having an understanding of the strengths each team member has will mean more developed team building that will carry the teams through developmental stages with ease.

With all of the changes that we face in the field of public service today, and with what lies ahead, working on high functioning teams that are able to adapt to change will mean improved outcomes. I look forward to leading more teams in my future career and continuing to learn and grow based on what my team members teach me. In the EMPA program I have learned and grown because of the various strengths and talents of other cohort members. I knew going into the program they each had experience and were talented in their field, though the learning and relationships I have gained superseded my expectations. I know moving forward that no matter what challenge I face I have a team of talents leaders I can ask for advice. The EMPA program gave me the tools and knowledge and humility to know that true leadership is not a singular act, and I will carry this with me forever.
Figure 1: Patient-Centered Medical Home Image
Figure 2: Instructions for Strengths Based Leadership Team Training
Welcome to the Strengths Based Leadership Team Training! A critical part of a high functioning Patient Centered Medical Home is the team’s level of effectiveness. This training will focus on the strengths you and each member brings to the team, and help move you all forward in your journey to becoming a Patient Centered Medical Home.

Enclosed:

**Strengths Based Leadership book:** You do not have to read this book before the training but are encouraged to at some point during your transformation.

**Team Activity Form:** This will be used during the training as an ice breaker at the beginning of your training.

**Before the training:**

- Complete the Strengths Finder 2.0 assessment:
  - Open the silver pocket at the end of the book and scratch off box to get the access code
  - Go to, strengths.gallup.com, to take the assessment and get your results

**Bring to the training:**

- Bring a copy of your Strengths Finder 2.0 Assessment results with you to the training
- Bring your completed Team Activity Form with you to the training
Figure 3: Team Activity Form

Team Activity

Please complete this form after you take your strengths finder assessment and bring it with you to the training.

1. What was your first reaction to the Strengths Finder results?

2. What theme did you think you would see “at the top” but didn’t?

3. Have you shared your Signature Themes Report with anyone? What was their reaction?
Figure 4: Team Strengths Map

```
<table>
<thead>
<tr>
<th>Name of Team</th>
<th>Executing</th>
<th>Influencing</th>
<th>Relationship Building</th>
<th>Strategic Thinking</th>
</tr>
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Figure 5: Example of a Team Strengths Map
Team Name: Team C – North Portland

Team Strengths Map

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<thead>
<tr>
<th>Executing</th>
<th>Influencing</th>
<th>Relationship Building</th>
<th>Strategic Thinking</th>
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<td>Activator</td>
<td>Adaptability</td>
<td>Analytical</td>
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<td>Danielle Schrauth, PRR</td>
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<td>Monique Gedenk, MD</td>
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<td>Laura Rojas, MA</td>
<td>Communication</td>
<td>Developer</td>
<td>Input</td>
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<td>Kawana Vincent-Young, MA, Care Coordinator</td>
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<td>Tammy Skaggs-Patterson, MA</td>
<td>Laura Rojas, MA (1)</td>
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<td>Harmony</td>
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<tr>
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<td>Includer</td>
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<tr>
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<td>Responsibility</td>
<td>Kawana Vincent-Young, MA, Care Coordinator</td>
<td>Matthew Breeze, MD</td>
</tr>
</tbody>
</table>

Figure 6: Strengths Based Leadership Program
Mitchell, A Strengths Based Leadership Approach to Building Patient-Centered Medical Home Teams

**Strengths Based Leadership**
**PCMH Team Development Program**

1st Team Meeting
- StrengthsFinder 2.0 Training: Each member's top 5 strengths are put on the Team Strengths Map
- Open discussion: Each team member shares how they see their strengths working on the team; balance of strengths among team
- Team establishes ground rules

Future Team Meetings
- Team Strengths Map is used during meetings as an objective tool for teams to use while problem solving and overcoming conflict
- Individual strengths are considered when changing roles on the team
- Team Lead and Change Coach use the Team Strengths Map and other team development tools during meetings to assist as they develop through stages

Introducing New Team Members
- StrengthsFinder 2.0 Training is reintroduced to team with Team Strengths Map so that new team members can learn about others' strengths on the team and share their top 5 strengths
- Open discussion: Each team member shares how they see their strengths working on the team; balance of strengths among team
- Team reintroduces and revises ground rules, if necessary

Professional Development
- Managers and Directors can use individual strengths during professional development meetings to develop plans that encourage building on strengths
- During coaching sessions, problem solving is encouraged using individual strengths and how they can work better with team members who have different strengths

Ongoing Evaluation: To ensure the Strengths Based Leadership continues to be useful to PCMH teams, evaluations will be sent out asking for feedback on the program, with suggestions for improvement.
Figure 7

**Strengths Based Leadership Training: Facilitators Guide**

**Knowledge:**

Today we are going to have you each tell your team what your top 5 strengths are and how you see them being effective for your team’s level of functioning.

**Exercise:**

1. Everyone is given the Strengths Based Leadership book with instructions on how to take the StrengthsFinder 2.0 assessment. They are also instructed to bring their results with them to the meeting, along with their team activity forms.

2. With post-it notes and a pen each member is asked to write each strength on separate sticky notes with the number (1-5) each strength ranked. They are also asked to put their names on the back so that the information can be entered into an electronic map with their teams strengths.

3. Ask for a volunteer who is willing to go first.

4. Have each team member individually place their strengths on the Team Talent Map.

5. Read their #1 strength definition out loud using the “Clifton Strengths Finder Quick Reference Card”, and have the member tell one way they will use this strength on the team.

6. Once everyone has gone, change coach leads an open discussion using these questions…

   - What do you think this means about your team?
   - Is there anything you think your team will do well on?
   - Is there anything your team will need support with?

**Closing Item:**
Finally, given that we have talked about your individual strengths and have a visual map for your teams strengths we will provide you with an electronic copy and bring these results to your co-location are and to future team meetings.

Figure 8: Change Acceleration Process (CAP)
References


Leadership Theory and Practice: A Harvard Business School Centennial Colloquium
Mahoney & Turkovich, (2008). Team Development Measure:


