VIRTUAL APPRECIATIVE INQUIRY FACILITATION TRAINING PRACTICUM

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INTRODUCTION

This Appreciative Inquiry is set in the context of our Architectural practice. In process of the design of a physical building it is not customary for architects to exercise this level of discovery into a client organization. I believe this approach can bring significant value to our clients.

A building can be a powerful tool to move an organization toward its preferred future, or it can be an expensive distraction. Our work is to help them to create the first possibility. To do this our first steps are to learn about how an organization holds its values and what is fundamentally good and healthy about themselves, that they want more of. It is on this understanding that we begin to build. This process entails learning *who* the client is, both individually and corporately, and what *idea* or *ideas* have infected them to want to change their built environment.

In my work as an architect, I have come to see that *ideas* tend to have a life of their own, and that these *ideas* have the ability to *infect* someone or a group of people. It is not so much that I have an *idea*, rather an *idea* has me. From my observations of client groups, the way that an idea forms is like a mist that hangs over and surrounds a group of people. It is implied, sensed, and ambiguous, waiting for something to cause it to coalesce into an actionable reality. Appreciative Inquiry is a powerful way to bring this coalescence.

CONTEXT - CLIENT ORGANIZATION

The client group chosen for this approach is an orthopedic surgical practice named Proliance Orthopedics and Sports Medicine (POSM). The choice of this group is based on my familiarity with this type of practice, having designed for several similar Orthopedic groups over the last fifteen or so years. With this familiarity we have also developed a fairly standard and familiar process of design. With familiarity of both client type and design process this seemed like an ideal opportunity to try something new.

Orthopedic surgeons are unique in the medical professions. Practices are typically for-profit (and highly profitable). Being physician-owned, their governance is hierarchical, top-down, and autocratic. Orthopedic surgeons are typically white, male, and authoritative. This assessment may seem harsh, but in our interviews with these surgeons their own unsolicited comments bear this out:

- “How a bunch of big, egotistical, selfish surgeons can get along is a mystery sometimes.”
- “The physician group can be over-confident. We need to shut up and listen. We need to get out of our own way.”

- “Our typical structure is very autocratic, centered around a bunch of old guys that make decisions and hand them down.”

POSM, from a first view, is no different. It is a large practice, owned by 19 Physicians; 18 are white and 18 are male. Very homogeneous with little diversity. They oversee a practice that is in three locations and has well over 100 employees. They are also successful and growing.

The traditional design process for a group of this kind is pretty easy. In the past when we needed information or guidance in the design process, we simply ask the physicians. We would always get direct, concise answers. There was no process of build consensus among a diverse group, there was little ambiguity. There was also a high level of trust in our professional judgement, so long as the outcome was on time, on budget with a good-looking building. Using Appreciative Inquiry as the basis of design is a big departure. I was concerned about the outcome of this method and how it would be received. We were delightfully surprised.

METHODOLOGY

Our core team includes Jeri Jacobsen; Project Lead and Interior Designer, Dexter Chin; Project & Technical Architect, and Myself: Social Design Lead and Principal-In-Charge. I took the lead with the 1:1 interviews with Jeri in support. All three of us took part in the group design events.

Our primary work with the client group consisted mostly of two groups:

- Executive team; six physician-owners.
- Patient Flow Advisory Team; Executive Director, Reception Lead, M.A. Lead, Materiel Lead & I.S. Manager.

Other physicians and support staff members were also engaged on an as-needed basis.

For the first steps of Definition, Discovery and Dream we used 1:1 interviews, relying on Zoom, both for convenient and in response to safety concerns about COVID. During the Design and Destiny phases we used a series of group design work sessions. These sessions are generally “hands-on” processes where staff are invited to develop physical design concepts through what we call “paper doll” exercises. We also used physical mock-ups of actual space configurations. In this setting physicians and staff can simulate new and imagined processes together. These are powerful consensus-building tools and results in higher levels of buy-in from all participants.

METHOD ONE - 1:1 INTERVIEWS

The positive topic that I chose to investigate is the question of organizational health. POSM has been in existence for many years and has seen a slow transition of physician-owners during that time. It has also grown and captured more of the marketplace for its region. The interview questions are designed to discover what is fundamentally good about organization, its *people* and how they connect. Also, to discover the *ideas* they hold in common as well as the *ideas* that are immerging that might lead them to their desired future.

Using the Encyclopedia of Positive Questions, the following questions were developed:

1. *How many years have you been with POSM?*
2. *What is your sense of the root cause of the ongoing success of POSM? Can you tell a story that illustrates something about how this root cause takes effect?*

3. *When in your work, have you felt most connect to this root cause? What effect did this sense of connection have on the work you are doing?*
4. *What work do you see to be done that will reaffirm this root cause of success? What 3 steps could be taken to start this process?*

The interviews were done in two groups, first with the Executive team of the Physician-Owners, followed after a period, with the Patient Flow Advisory Team. This separation is intentional. Given the hierarchical nature of this organization I was curious to see the degree of alignment between the two. The same questions were asked with both. The interviews took about a half hour each.

Physician Interviews:

These conversations were rich with engaging stories including several origin stories that helped to paint a picture of the organization's culture. Here are words that came to the surface often in these conversations:

- Cohesiveness
- Loyalty
- Phenomenal friendships
- Kindness
- Positive reputation
- Consensus
- Sacrifice
- Good spouses
- Our secret sauce: Partnership behavior
- Relational
- Trust
- Respect
- Fairness

Taken as a whole, they seemed to be describing a fraternal organization, a band of brothers. This connectedness is very important to them, something they intentionally work on. This showed up in their description of the founders, both of whom are now retired, and of their method of recruiting other physicians. Turnover is low, with long tenures. Competitiveness, which is more common in other Orthopedic groups is down-played here. Another unique aspect is the lack of seniority and hierarchy in the physician group. Their Managing Partner is one of their younger physicians. Their decisions-making process is by consensus, played out (as witnessed by our team) as energetic and often comical debates going late into the night. All voices are heard and (mostly) respected. This sense of connectedness and relationship spills over into how they have structured their larger teams and support staff. This will be examined later in this report.

Patient Flow Advisory Team (Support Staff) Interviews:

At our recommendation, this team of support staff was assembled specifically for the process of design of the building. One of the most challenging aspects of designing outpatient clinics is the design of the 'flows' that occur in them. These include the flow of information, supplies, medications, equipment, staff and so on. One of the most significant flows is the movement of

patients, to and from their encounter with the doctor as well as other support services in the clinic. Typically, an orthopedic surgeon will see 25 to 30 patients in an 8-hour day. In this clinic the predicted patient volume is expected to be about 385 patients per day visiting the clinic. A takt time analysis reveals that a new patient will be walking in the front door every 1.25 minutes. It is the work of this Advisory Team to design and oversee this seamless flow without bottlenecks, backups, or confusion.

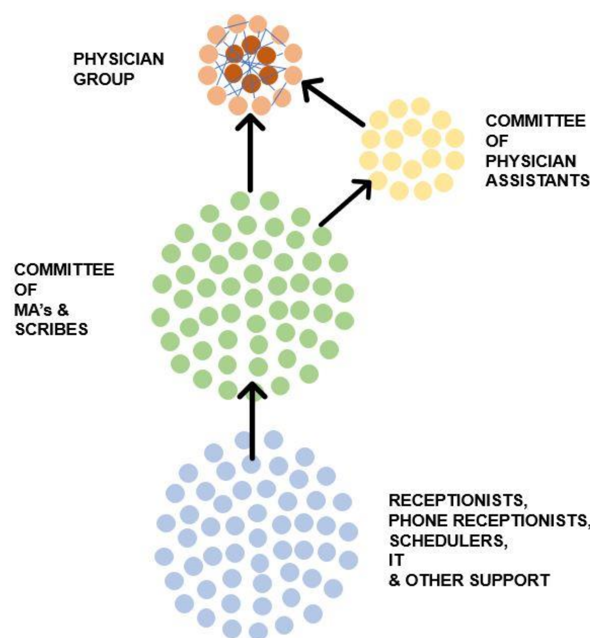
This group is made up of the Leads of various aspects of the patient flow, from Executive Director to Receptionist Lead, Medical Assistant Lead, Materials Manager, and Information Systems Manager. Except for the Executive Director who joined the practice at the beginning of the project, these staff members have been with the practice for a long time, coming up through the organization in an organic way.

Their response to the interview questions revealed a high level of alignment with those of the Executive Team but described in a slightly different way. The terms we heard here include “family”, “family-oriented”, “work/life balance”, “social gatherings” and “Mom & Pop organization”. These values came up often as they described their present challenges. The Covid Pandemic has made these connections much more difficult. Also, the prospect of growth has threatened the “Mom & Pop” feel of the practice. How would this be maintained?

The interviews of both groups reveal a strong message of what they want more of. A highly connected, relational organization, originating in the fellowship of the physician group that would continue to expand into their support staff and patient community.

Their history

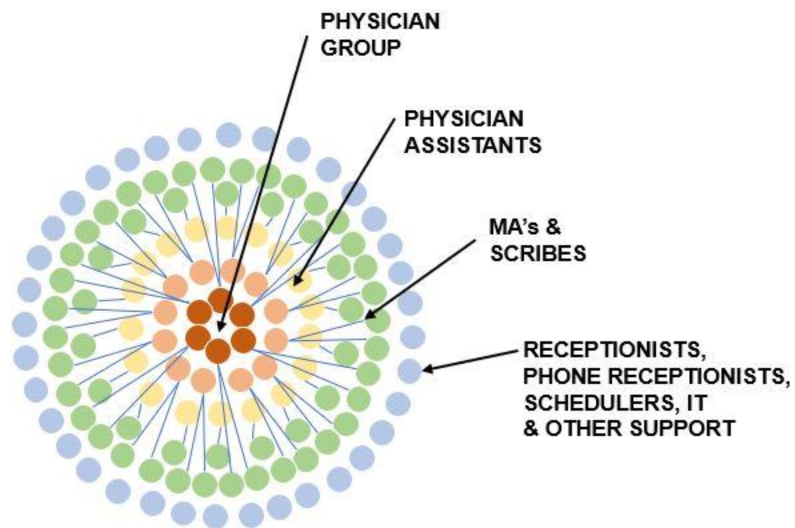
The following diagrams further describes the evolution of this practice over the years. These are not so much organization charts as they are connection diagrams, showing how the individuals and groups connect and relate to one another during their daily work processes:



TRADITIONAL RELATIONAL CONFIGURATION

For a practice of this size, this configuration is typical. When in clinic, a Physician works with a team that is made up of one or more Medical Assistants (MA), a Physician Assistant (PA) and perhaps a Scribe. Orthopedic Physicians typically spend one or two days a week in surgery, on those days support staff are assigned to other Physicians. So, Physicians, MA's, PA's, and Scribes establish and train standardized processes and protocols for patient visits. This turns staff members into 'interchangeable parts' borrowing from manufacturing processes. In this model any MA, Scribe or Physician Assistant should be able to work with any Physician at any time. From a staff resource model this approach should be very efficient, driving waste out of the system if we think in terms of Lean processes. This model has been growing in recent years to drive down the cost of healthcare.

Several years ago, the Physicians began to recognize that this system compromised the quality of care they were giving to their patients. Physician care is not standardized. Each has unique ways they care for their patients through personal approach, training, and different subspecialties in the practice. Hand Surgeons, Spine Surgeons and Sport Medicine Doctors all engage their patients differently. This standardized method also ran counter to the relational bias described earlier in this report. So, in a counterintuitive move they reconfigured themselves:



<u>POSM RELATIONAL CONFIGURATION</u>

In this new model each Physician has a dedicated team when they are in clinic. When that Physician is in surgery or out of office, they have developed other tasks that the team member can do, keeping stable employment. A typical day in clinic is high energy and fast moving when seeing volumes of 25 to 30 patients. The relational connections within the team develops its own efficiencies with the ability to communicate vital information with few or no words. Roles are clearly defined and little wrinkles in process are quickly smoothed out. Another counterintuitive move is the inclusion of Scribes in the team. Increasingly, with the advent of Electronic Medical Records the Physician is expected to input and gather medical information at a computer station during the visit.   While this has increased the efficiency of healthcare, it has also challenged the personal connection between Provider and Patient when the Provider is focused on a computer screen.   So, they have gone back to the older model of including a Scribe in the team. This approach also has a secondary positive effect: Many MAs' become

Scribes as part of their training to become Physician Assistants. The role of Scribe provides a wider career path for many of the support staff.

In his interview the MA Lead said this; "My fundamental responsibility as an MA is to increase the face-time between the Doctor and the Patient". This in a nutshell perfectly describes the intention of this major shift in team configuration, to enhance Doctor / Patient connection.

Offering this history helps to describe the evolutionary arc of this organization. The fundamental need to develop and keep relational connections both within the organization and with the patients they serve is, what they are about and what they want more of as they continue to grow.

The Challenge

The development of this new building has highlighted a challenge to the practice. The POSM RELATION CONFIGURATION diagram above reveals a weakness in the relational connections of the organization. The outer ring of support staff including Receptionists, Phone Receptionists, Schedulers, and others are not part of the web of daily relational connections in the same way as Physicians, MA's, PA's and Scribes. This group includes the lowest paid, least skilled and has the highest turn-over. Recently, they experienced 36% turn-over among receptionists within a 6-week period. This was further aggravated by the attempted integration of the electronic medical record system with the practice management system, both of which are necessary for the check in / check out process for each patient. Two years ago, they introduced a new software package that promised to integrate these systems. This integration failed resulting in a series of workarounds requiring a hodgepodge of tools including electronic records, paper records, a light signal system and phones to complete the check-in task. Redundant information is collected and entered twice into two systems while the patient is checking in. This resulted in long queueing lines and high levels of patient dissatisfaction. Since the receptionist is not dedicated to specific physicians, they must also be familiar with all the variant pieces of information required by each physician that must be collected from the patient at time of check in.

This challenge came into sharp focus during work sessions with both the Physicians and the Patient Flow work force. When initial analysis revealed a potential patient flow of 385 patients per day the Receptionist Lead observed that in their largest clinic, they had been able to process 240 patients on one day, requiring six receptionist and resulting in long queuing lines. She describes the day as "stressful and exhausting". To accommodate a patient flow of 385 using present check-in protocols, at least 9 receptionists would be needed, as well as room for extended queuing lines. This much space is not available in the new facility.

This challenge came up in a joint meeting of Physicians and support staff. There is a general understanding that a big part of the solution must be a better integrated software package, but such a conversion could not be realistically done in time for the opening of the new clinic. This was followed by an hour-long discussion, dominated by the physicians who opined on the various options and concluded that there was no easy solution to the problem, and the existing 'work-around protocols' must be carried forward. The managing physician partner directed this question to members of the Patient Flow Advisory Team; "Do you believe there is a way to reduce the workload at the reception desk to address this?" receiving affirmative responses, he asked them to "figure it out".

METHOD TWO – GROUP DESIGN WORK SESSIONS

Here was an opportunity to 'Flip and Frame' the situation from a problem to opportunity to move toward their preferred future. This was followed by two group work sessions with the Patient Flow Advisory Team. The first work session started with a method called 'Climate Setting' we learned from our Synectics training. It begins the meeting with a compelling question and time for each participant to give a thoughtful response. This approach has two benefits: 1) it allows each person to establish their voice in the engagement, and 2) it invites them to begin to think differently. The question is *"How, when and where do you daydream?"* All had answers and several delightful stories showed up. In this work session our goal to help the team look at a familiar problem or circumstance from unfamiliar perspectives to stimulate curiosity, imagination, and allegorical possibilities. "What if a queuing line could be an interesting and colorful journey? Think of such lines at Disney Land venues."

One of the keys to seeing a familiar thing from an unfamiliar viewpoint is to use different methods of looking. The most common method in a group setting is through language and dialogue, however many of us have strengths of thought and feeling that are not word-based. It is here that we can introduce form, imagery and graphics allowing us to "*think with our hands"* to open new doorways to discovery. In the second work session we used a 'paper doll' exercise to explore the experience of check-in.

This hands-on gaming approach creates a sense of play just like a game of Monopoly. You can make wild and daring investments in real estate because Monopoly money is just play money, there is no risk. While the actual challenge of high-volume patient flow is scary, turning it into a game opens the conversation about outlandish, humorous, and crazy moves that have within them seeds of real possibility. This hands-on approach also opens the conversation about the preferred futures that showed up in the interviews. In what ways might these configurations and processes help to tighten the engagements between the Receptionist and the Clinical Teams? What is the experience of the patient? How do these kinds of flows show up in other settings that make them a positive experience? It is the role of the A.I. Facilitator to ask these sorts of questions while encouraging to team to try another option, followed up with the question; "Why do you like this?". Judgement and the choice of a single solutions is deferred until all the insights and implications are made visible.

CONCLUSION

At the time of this writing the project is continuing in the *DESIGN* phase and will be moving into the *DESTINY* phase in the coming year as the facility and its new operational models continue into design and construction. This new facility will be 'going live' in September 2022.

In this application, the value of Appreciative Inquiry is in its ability to reveal the foundational health in the organization, upon which their preferred future could be built. The 1:1 interviews drew out stories that described this health in many ways. Here is a defining quote from one of the physicians.

"My goal is to surround myself with good people and to take good care of them."

It describes the essence of their history, to have a very relational organization that draws the best out of everyone, both individually and collectively. The interviews also revealed the seeds of a preferred future. An interview with the support staff has this comment:

"When I started here it was still sort of a 'Mom & Pop' organization. Now it's grown and the Physicians have worked very hard to hold on to that 'Mom & Pop' quality, it's very intentional."

This reveals the provocative proposition; How do we scale up and at the same time, enhance these important relational connections, both with our staff and our patients? It is provocative in that it runs contrary to larger corporate trends, to build efficiency at the expense of relational connections.

As described earlier in this report, by the very nature of this kind of medical practice, the power differential across the organization is large. The physician-owners, with high levels of specialty training along with professional and ownership liability exposure hold much more power and influence than the majority support staff. Yet they have worked hard to nurture and grow their staff, in so doing minimize this barrier. The value of this is it increases the organizational ability to explore and develop ideas necessary to actualize their provocative proposition.

An idea, is a mental and emotional construct, drawn from imagination with the intent to be realized. The inherent value of this organization is that it is peopled with those that have mental, emotional, and imaginative capacity. Our next challenge is to continue to draw out this capacity as *Design* and *Destiny* continues.

For me personally, one of the most profound aspects of this experience is the element of surprise. In more traditional architectural approaches of discovery, tools such as surveys, data searches and questionnaires tend to start with qualified inquiries that would inform the end product of a building. These tools are presorted and presuppose a defined viewpoint. Appreciative Inquiry on the other hand has the potential to reveal things that could not be predicted.

Stories cause the suspension of our inclination to sort things into categories.

Stories have the power to engage the imagination in the way that diagnostic discussions cannot.

(From A.I. Training Material)

It is this element of surprise that opens the most interesting possibilities.