

Leading Healthcare Integration

A Change Leadership
Guide for Mental Health
and Primary Care Services
Integration

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Introduction

This guide is designed to provide practical information for the healthcare leader preparing to, or involved in, primary and behavioral healthcare services integration at the administrative, supervisory or clinical staff levels. It is assumed the reader has basic knowledge about integrated healthcare. The reader will find useful tips for engaging stakeholders, strategic planning and execution of primary care and behavioral health services integration. Behavioral health and primary care provider staff as well as consumer stakeholders contributed to this guide, ensuring that a variety of perspectives and experiences are afforded to the reader.

The guide begins with an overview of Change Leadership concepts. The basic principles and steps for approaching organizational change are then presented, providing a conceptual foundation for the sections that follow. Step One examines the importance of approaching change from the personal perspective of each staff person engaged in the process. Step Two describes the important task of identifying and dismantling the structures behind barriers to change that may be built into current practices, external conditions and organizational cultures. Identifying and gaining commitment to follow through on barrier dismantling is the topic of Step Three. Step Four explains what it means to be a coach, and the important distinction between coaching and managing staff. Step Five provides practical approaches to coaching staff on commitment follow-through.

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Definitions

1. **Change Leadership:** The process of engaging staff at all levels to initiate a grassroots change process and energizing it on an ongoing basis while taking steps to remove barriers and accelerate the pace of change.
2. **Coaching:** The facilitation of learning and development with the purpose of improving performance and enhancing effective action, goal achievement and personal satisfaction. It invariably involves growth and change whether that is in perspective, attitude or behavior.¹
3. **Commitment:** Promising to oneself and others a future course of action. **Current Reality:** The present state of the organization both from the standpoint of operations, individual beliefs and cultural norms, and of invisible assumptions/premises that define reality and limit options.
4. **Learning Organization:** Organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to learn together.
5. **Management:** The process of gaining promises from people for specific actions or results and holding people accountable for the promises they have made.
6. **Personal Vision:** The mission or purpose of an individual's life; The source of power a person uses to commit to a course of action.
7. **Urgency:** Action which is alert, fast moving, focused externally on the important issues, relentless, and continuously purging irrelevant activity to provide time for the important, and to prevent activities that lead to burnout.²
8. **Shared Vision:** The logical and emotional linking or integrating of one's personal vision with that of others.

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Overview

General Principles for Change Leadership

“People will support that which they help to create.”

Mary Kay Ash

“The central issue is never strategy, structure, culture, or systems. The core of the matter is always about changing the behavior of people. Behavior change happens mostly by speaking to people’s feelings.” John P. Kotter

The reasons why people and organizations do or do not change are many and varied. This guide focuses on how to effectively lead organizational change. It tackles the difficult topic of organizational change by providing a leadership method designed to instill a sense of focused urgency in each staff member. The method you will learn can be used in nonprofit, public, or for-profit organizations. In this guide the focus will be on applying the method in order to integrate mental health and physical healthcare services. Throughout the manual you will find case study examples describing how the method has been used in the process of integrating a community mental health center (CMHC) and a community health center (CHC).

In this section we will focus on the basic principles and conceptual framework behind change leadership, and specific actions any staff person can take to effect organizational change.

Today community health centers and community mental health centers are engaged in challenges that are driving historic changes in how people with serious mental illnesses and co-occurring physical health conditions receive healthcare services. Staff at all levels of these organizations are being called on to rethink their approaches to healthcare service provision to meet the physical and mental healthcare needs of a population of people who are dying prematurely due to lack of better care.³

If you have ever been involved in a systems-change effort, or even a policy or procedural change having to do with one aspect of service provision, you are familiar with some variation of the following typical course of activities. First, senior management spells out a charge or charter that a group of staff are assigned to complete as part of a larger strategic plan. Second, a committee or workgroup leader is chosen and a meeting is convened with key stakeholders. Third, a needs assessment is conducted with the stakeholders, solutions are identified and a work plan is created detailing objectives, resource needs, timelines and accountability structures. Finally, the group engages in the work plan execution. The “Plan-Do-Check-Act” cycle of quality improvement is commonly used to describe this process.

As a staff person involved in the process, it can be difficult to become passionate about engaging in these change efforts. This is understandable if the processes either have a perceived loose association with the work you

do, or if the changes seem so all encompassing that you do not know where to begin. Additionally, some organizations (perhaps yours?) have a history of lackluster success when it comes to managing change or completing projects. This can cloud enthusiasm and any sense of urgency to move forward. A leading indicator of change not occurring at the organizational level is a lack of sustained enthusiasm as contrasted with a sense of urgency. Urgency is action which is alert, fast-moving, focused externally on the important issues, relentless, and continuously purging irrelevant activity to provide time for the important and to prevent activities that lead to burnout.²

So how does one invoke a sense of urgency that drives creative thinking, collaboration, commitment and ultimately follow-through from each member in the organization? The first step is not foreign to great leaders of the past or present. It involves telling a compelling story about what could be. In the mind's eye of the individuals hearing the story, a picture materializes that stirs emotion. The emotion is akin to an "ah-ha" experience where the person is able to see something that they had not seen before. This realization is followed by a sense of anticipation for what will come next. Once such a story is clearly articulated, people will either be compelled to individualize the vision and take ownership, or not. The role of a change leader is to create a compelling vision that others can see as their own. In effect, the person assimilates the vision into their own personal vision.

A personal vision is the mission or purpose of an individual's life; the source of power a person uses to commit to a course of action. When people come together and share their individual visions, a shared vision emerges. The

sharing of personal visions is a force multiplier that instills commitment to action through creation of urgency.

Step Two uses the positive energy generated from the shared vision to drive an investigation into the current reality. What is currently in place that will facilitate reaching the vision and what needs to be changed? This step requires a thorough understanding of organizational culture and how current practices, policies and funding structures function. Simply put, barriers to change are identified and solutions generated.

Step Three is a clarification of what quantifiable actions need to be taken, by whom, and by when. People make promises to themselves and others to do the work necessary to move the current reality toward the vision. In other words, people take ownership of their part of the solution.

Steps Four and Five are focused on the practice of coaching. Step Four calls on people to seek out and give support to one another as they engage in their work. The Fifth and final step is staying vigilant to where each member of the team is, including oneself, in their commitment to follow through. This is done in the spirit of teamwork rather than one of criticism.

These final two steps help create the framework for what Senge describes as a Learning Organization, *“Organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to learn together”*.⁴

The five **5 Steps for Effective Change Management** can be described as follows.⁵

Step One: Generate a compelling Future Vision

- Leadership is the art of generating a vivid and compelling view of the future that another can identify with and be inspired to act on.

Step Two: Reveal the Current Reality

- Develop an aligned view of the current reality with barriers, solutions and opportunities clearly delineated.

Step Three: Secure Promises for Action

- Promises create a “contract” that specifies quantifiable deliverables to fulfill a commitment.

Step Four: Support/Coach

- The job of a coach is to insure that each person has the resources needed to succeed.

Step Five: Follow-up on Promises

- Acting as a support rather than the “promise police” will create trusting relationships that will allow for an innovation-driven climate in which change becomes a strategic enabler for personal and organizational growth.

These steps can be taken in any sequence that fits the circumstance. Often a return to Step One can reinvigorate a team or team member through generating clarity of purpose. Sometimes the current reality can change, resulting in a need to revisit everyone’s understanding of it in order to develop and align new commitments for action.⁵

Step One

Painting a Picture of What Will Be: Creating the Shared Vision

“First, I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the Moon and returning him safely to the Earth.” John F Kennedy, *A Special Address to Congress On The Importance of Space*; May 25, 1961

Creating a focus that all staff involved in a change endeavor can see and believe in is the purpose of creating a shared vision. President Kennedy in his address to Congress on the importance of space exploration did not mince his words into vague or flowery language that could be interpreted differently by people. Landing a man on the moon within ten years and returning him safely to earth describes a vision of the future in clear terms that form easily into pictures for the listener. This is what creating a compelling shared vision of the future is all about. Much like the impact of a punch line to a joke, the person realizes the impact of what is being said, and it elicits a rush of emotion.

Granted, few of us have a public stage from which to cast our visions, or a speechwriter to help us craft the language. Nevertheless, within our own spheres of influence we can try to bring more clearly into focus the picture of what we are working to create in the world. Often organizations spend a great deal of time creating “the vision statement”.. Time is spent choosing the right combination of words that

will succinctly express the highest ideal of the organization. Unfortunately, while this may seem to make sense, two of the most important points of a vision are missed in this process. First a vision is personal. An employee, to truly internalize and work toward the vision of an organization, must see how it fits with their own personal life vision. If developed correctly, an organization's vision is shared and becomes an effective driving force because people are truly committed to it. A vision is not a set of words on a paper, but an imagined picture in people's minds. The art of creating shared vision begins by understanding that your medium is the imagination of the people you are seeking to influence. A vision is only a vision when it is being spoken. It is at that moment that it appears in the mind of both the speaker and the listener. At that moment people become "enrolled" in the vision. They can see how it reflects to some degree their own person vision. It makes sense on an intellectual and emotional level. Now, few of us have a ready answer for the question, "what is your personal life vision?" That does not mean that we don't have one. It simply means we have not spent the time to consider what it looks like. The second missed point is that the vision is important, not only for what it stands for, but for what it does.⁶ A vision is best expressed through dialogue, planning, and execution.

In the next section we will discuss what to do with the energy created from the generation of a shared vision. If you as a leader are not energized by the prospect of the change your organization is embarking on then it will be helpful to spend time clarifying your personal vision. Leadership is the ability to describe a vision of what can be that others can see as their own. Reflect on a time when a

leader compelled you. Think back to a speech you have heard, whether it was Martin Luther King, Jr.'s "I have a dream" speech, or a mentor's reframing of your concerns that opened the doors to possibilities you had not seen. It is the welling of emotion, the chill down your spine you feel at that moment when clarity of purpose is realized.

Shying away from this first step because it is a bit daunting, idealistic or yes, even hokey, is the fatal flaw in most change initiatives. These five steps do work and this first step is the most critical to generating the buy-in and energy required to make a lasting change a reality. If you are doubtful we ask that you suspend your disbelief long enough to give this process a sincere try. The following case study shows one example of how a pair of healthcare providers developed a powerful shared vision.

Case Study Example;

Jim, the CEO of a CMHC, sat with the senior management teams from his center and the neighboring CHC to discuss developing a draft strategic plan for integrating their services. For several weeks he was in discussions with his board and with Susan, the CEO of the CHC, about integrating services. The boards from both organizations gave the CEOs the green light to develop a draft strategic plan for services integration. The senior management teams knew the discussions were happening between the CEOs and their boards, but they did not know to what extent. Jim knew that with all the changes occurring at his center related to the implementation of a new electronic health record, his managers would not be eager to take on another change effort at this time.

After facilitating brief introductions, Jim and Susan began by giving a short history of their respective centers and described the populations they serve. Jim explained that the boards had approved the development of a draft strategic plan to integrate services. Several of the staff looked confused; a few just looked down at their notepads in silent resignation. Jim asked the group if he could share what he understood this integration effort to mean by describing his vision for what it could look like. Staff looked up and over at him. Some gently nodded their heads in approval.

“It’s easiest if I just describe what integrated health services looks like to me”, he said, “I see a person who is new to our system coming to our CMHC for their intake meeting. They walk into our clinic and meet w/ a health aide who helps the person complete a brief biopsychosocial questionnaire. The questionnaire gathers mental health and physical health information as well as a description of the person’s diet and exercise regime. The person is then introduced to a mental health professional and a nurse who complete a thorough assessment with the person about what they need and want from our services. The discussion results in the development of person-centered goals for the person’s mental and physical health needs.” At this point he pauses and says, “How am I doing so far, is this making sense?” The clinical director of his agency says, “I can see the health aide you mentioned being a peer support person.” Jim says, “That makes sense. What do others think?” The clinical director from the CHC says, “It would be really nice if we had a gym or some kind of workout center our patients could use and get support with their diet and exercise.” Susan pipes up and asked how the CHC clinical director

came up with that idea. “I got into healthcare to help people develop healthy lifestyles and to treat medical conditions. I see us doing more of the treating part and less of the healthy lifestyle education and monitoring,” the CHC clinical director replies. Soon the staff is comparing snapshots of the ideal picture of an integrated mental health and physical health facility. Each staff adds a little more color to the picture, almost upping the ante on each other by further coloring the picture with a new twist on how best to provide the services. What emerges is a shared vision of how the services could be integrated. In a matter of thirty minutes the group had formed a shared vision. Jim and Susan looked at each other knowing they had set something important in motion. After a brief lull in the discussion the CHC medical director speaks up and says, “Jim, is this what you had in mind?” Jim smiles and says, “You all have created something bigger and better than what I could have envisioned. Now we need to figure out how to make this a reality.”

Step Two

Tackling the Current Reality Barriers

“I know it's hard when you're up to your armpits in alligators to remember you came here to drain the swamp.” Ronald Regan, February 10, 1982.

The importance of taking the time to clarify the shared vision becomes readily apparent as you enter into a discussion about how to actually make the shared vision a reality. During Step Two the momentum and optimism generated from articulating the shared vision is used to delve into the inner workings of how the organization(s) operate(s), warts and all. Each area of operations is assessed to determine how well-positioned the organization is to becoming the organization that is envisioned. The gap that exists between the current reality and the future vision can be used to leverage the needed change. Senge's *Creative Tension Model* interpretation of problem solving turns the problem into an opportunity. Instead of seeing a problem as (shared vision – current reality = problem) he suggests seeing it more proactively as the (shared vision – current reality = creative tension)⁴. It is this creative tension that brings about the urgency that drives staff to accomplish breakthrough results.

Like a stretched rubber band, the current reality should be tied to the vision via a strategically designed work plan. The tension between “the way things are” and “the way things could be” (the vision) can provide the energy needed to move in the direction of the vision. This is accomplished by not letting the current reality cloud the vision. Regular reminders of what the vision looks like will help propel the group in the right direction. Choosing is a courageous act, and having people *choose* between the current reality and the future vision can be difficult for staff to fully accept. Coaching staff through this process is critically important.

Clinical and operational areas typically covered when conducting this strategic gap analysis include:

- Access Services
- Clinical Services
- Funding
- Governance
- Promising and Evidence-Based Practices
- Information/Data management

Some organizations considering services integration have never worked together. Others have partnered and may have begun work to integrate on one level or another. Integration between organizations can be described as existing on a continuum, with organizations that have merged services and operations on one end. On the other end of the continuum are organizations that are completely separate and just beginning the process of integration. Typically organizations are somewhere in between these poles. Reynolds has adapted a matrix designed by Doherty and Baird (see Appendix A) that describes this continuum.

The matrix can be used to establish a baseline description of the current reality for organizations in the process of integrating or just considering integrating.

Full integration is not always the goal. Organizations can work to integrate on some levels and not on others. Where organizations are able to integrate, and to what degree, depends on the unique circumstances of the organizations involved.

Organizational strengths and opportunity areas begin to emerge as the current reality is exposed. These findings are used to develop a strategic plan and associated work plans targeting the individual objectives. As a part of the work plan, timelines are defined, and assignments of responsibility for accomplishing certain tasks are made. The level of commitment staff have to following through on work-plan assignments is of critical importance. If staff are not committed to following through with the work-plan tasks, movement toward the objectives, and therefore the vision, will be stymied or led off course. Clarifying commitments is the focus of Step Three.

Case Study Example:

Jim and Susan, our CEOs from the first example, realizing they have strong momentum from the senior management teams call the group back together soon after their shared vision discussion. They ask each team to rate the current reality of their agency using the Reynolds, Doherty and Baird continuum (see Appendix A). Once both teams are able to describe the current reality of their organization on the continuum and where they want to be, they are ready to move forward.

Jim and Susan lead the teams through a discussion of what they should target during year one of the strategic plan, given the existing shared vision and continuum descriptors. This first step toward uncovering the current reality goes smoothly, but as they dig deeper, the group is reminded of the extent to which mental health and physical health services exist in separate “silos” (e.g., separate funding streams and cultures). The present state of the tangible aspects of the organizations seems clear (e.g., where funding comes from, what kind of data reports are available, and to whom they are reported) but from the perspective of individual beliefs, cultural norms and invisible assumptions/premises that contribute to everyday decisions things are less clear.

Jim and Susan know that failure to discuss this aspect will limit options for moving forward. They know that in order for this strategic plan to be successfully implemented it is going to take significant commitment on the part of each team member to evaluating their own mental models in order to achieve the chosen objectives. So they spend time asking each other questions that expose the different cultural and philosophical approaches to care. Susan asks the group to compare and contrast how different mental models (i.e. beliefs or ways of conceptualizing care) could impact their discussion. She draws this chart to exemplify the point she is trying to get across.

	Field	
	Behavioral Health	Primary Care
Who is provided the care?	Consumers	Patients
How long is the typical visit?	30 minutes	15 minutes
Where are services most likely to be provided?	Community	Office-based
Dominant treatment model?	Biopsychosocial model of care	Medical model of care

The team members spend time discussing the implications of differences like these, and how their staff will need to be aware of the confusion that can be created if these differences are not factored into their work together. Susan points out the benefit of involving people who have “fresh eyes” to see how practices might be improved.

Step Three

Generating Commitment to Implement Solutions on the Ground

“If a man knows not what harbor he seeks, any wind is the right wind.” Seneca

On average, people genuinely intend to complete the work they commit to doing. Sometimes, however, the best of intentions are derailed when the rest of one’s personal and work life comes into focus. Other commitments can begin to crowd the days, and progress can be slowed or stopped. During Step Two staff spent time defining the current reality and how best to link it with the shared vision. The next step is to develop a work plan to answer the “who, what, when and how” questions related to bring about the changes needed. Each staff person will be asked to commit to doing their part in bringing about systems change.

A helpful technique is to break down the commitment into component parts. The SMART acronym describes the components necessary to develop an actionable commitment⁷. Each commitment made by staff to completing part of the work plan should include these components.

Specific

Tasks to be completed should be written with as much detail as possible. There should be no ambiguity about what will be done.

Measurable

Progress and results should be tracked using quantitative measures. If you are having a difficult time figuring out how to measure the task, it is probably not specific enough.

Attainable

It is imperative that the person have the actual tools, time, ability and senior management support to accomplish the task. Progress should be regularly monitored especially if the task is a stretch goal. Stretch goals push the person to the limits of their abilities and are particularly challenging.

Realistic

The practical requirements to accomplish the goal must be in place. Given the proper resources such as time, funding, and senior management support the person must believe they can accomplish the goal. If the goal is attainable and realistic the person is both able and willing to achieve it.

Timed

The steps along the path to completing the tasks must include timelines. Timelines create a productive sense of urgency. If the person is unclear about when they will be

able to accomplish all or part of a goal, the prior SMART principles have probably not been thoroughly vetted.

For some leaders, asking people to make specific (SMART) promises for action can seem overly demanding or confrontational. It is, however, the foundational step to creating a culture of integrity – where people can be counted on to do what they promise. When done as part of effective leadership, this is neither demanding nor confrontational. After all, the promises being asked of people should line up with each individual's personal vision. Completing the requests not only moves the shared vision of the agency forward, but more importantly to the staff person, moves their personal vision forward.

A crucial element of asking for promises is making sure that people understand that they have permission to decline. Without the ability to decline a promise, people say yes to everything, whether they think they can do it or not. The ability of a leader to negotiate promises is crucial to developing a culture of integrity.

Case Study Example:

Susan's and Jim's team members create the following objectives (see Appendix B for the completed work plan and Appendix C for a blank template). They have brief weekly team meetings focused on the integration effort, and at the end of each meeting each team member clarifies exactly what they have committed to doing. In addition, each staff person includes their involvement in the integrated health project on their overall employment work plan. Often a staff person's supervisor is not involved in all the projects to which their staff are assigned. By requiring staff to include this project on their work plan it allows for progress to be

reviewed monthly during staff supervision. Additionally, it allows for the staff person's supervisor to evaluate staff workloads, and to provide coaching regarding commitment prioritization. In our experience this is a common problem staff and their supervisors run into. Over commitment to the "project of the week (or month)" leads to the subsequent erosion of a staff person's time and ultimately their ability to follow through on commitments.

Step Four

Being a Coach

“Empowerment is not something you give me or I give you: we co-construct it between us by the actions each of us takes.”

Paul Jackson & Mark Mc Kernow

Once the work plan is drawn up it is useful to discuss what it means to coach one another in the execution of the work plan. The change leader should offer coaching and let people know that they may be asking for it themselves. As a leader it is helpful to model the behavior by asking for coaching in team meetings. This is especially useful if the team members tend to work independently, and only talk with each other when there is a significant concern or during regular meeting times. “Being the change” you would like to see happen is part of being a coach.

Coaching is the facilitation of learning and development with the purpose of improving performance and enhancing effective action, goal achievement and personal satisfaction. It invariably involves growth and change in perspective, attitude or behavior. The most effective coaching is ontological, that is, it is about who people are being, not just what they are doing. Ontological coaching is focused on assisting people in first being aware of the context of their actions, then of the actions that will most effectively accomplish their goals.

We all operate with an unconscious commitment to staying in our comfort zones. We are all comfortable responding to

our environments and emotions by operating in familiar and habitual ways. These habits help constitute our personality and were formed early on in life because they helped us achieve our goals and deal with an ever changing environment.. As humans we are absolutely committed to being comfortable because relying on these comfortable strategies seems to be a way to reduce the risks in life.

The problem is that when these strategies don't work, we continue to employ them. We are not even conscious that we are choosing the strategy, and therefore cannot choose an alternate strategy. This is the job of a coach; to help people see how their unconscious comfort zone is thwarting their commitment.

Mc Dermott and Jago define coaching as "*a conversational yet focused discipline that supports people in the learning of how to lead and manage themselves more effectively in relation to their issues, their resources, their contexts and their potential.*"¹ In most organizations the word "coaching" will need to be defined and explained so everyone has the same understand of what it is and is not. Talking about the definition of coaching is best done while wrapping up the work plan during Step Two. Defining coaching, however, is a poor substitute for explaining what it means to be a coach. In this section we will attempt to describe just what coaching is intended to mean.

Coaching provides two people the opportunity to examine, in the context of a collegial work environment, what is being done regarding commitments made. Coaching creates a forum to process and understand how best to follow through on a commitment. As people become more comfortable with sharing and learning from each other,

coaching becomes a regular approach to sharing insights and learning self-improvement skills.

In a coaching role, staff will make specific and nonspecific requests, so if there is any uncertainty, be sure to ask for clarification. It is good to know if the staff person is looking for coaching or just wants to vent. After it is agreed that coaching is being requested, the coach most commonly asks open-ended questions that elicit self-reflection and ultimately personal responsibility for actions taken or planned. This allows for even the most difficult of topics to be discussed, because the impetus for the discussion is a product of the request itself.

As the discussion progresses, open-ended questions begin to funnel the discussion in the direction of what the person requesting the input can do. Closed-ended questions are used to clarify or highlight a point of particular import, such as what exactly the person did or did not commit to. Understanding exactly what commitments were made and kept (or not kept) is important to have on the table, and often best put there with closed-ended questions.

Core competencies of coaching include the ability to establish a trusting relationship. The content of a coaching interaction should be confidential unless both parties agree otherwise. Speaking about lessons learned from a coaching interaction is appropriate as long as the other party remains anonymous. Active listening skills are particularly important as a means to elicit self-reflection on the part of the person being coached. Absent from the listener's mind is their own opinion of the person, of what the person should do, or of a solution to the problem. The coach's attention should be focused on hearing what the person believes, feels, wants and needs. To listen creatively one must train oneself to

hear, not just the words spoken, but the intention behind the words and ultimately the commitment to a course of action. Active listening provides the opportunity for the person to truly reflect on the situation, their role in it, and ultimately, their responsibility for following through on a previous or new commitment. Once the problem has been elicited, a coach must be able to facilitate goal-setting and quantification. These are the skills we discussed in Step Three.

Remember that coaching much more about “skills for being” than it is about “techniques for doing.” It is based on some fundamental assumptions and competencies that drive the coach’s behavior.

Coaching Assumptions:

- People are committed to a higher purpose; a personal vision that is about contributing to a purpose they see as meaningful.
- When people are not being effective it is usually because their comfort zone is in conflict with their higher commitment and they are not aware of it.
- People are resourceful and are most successful when regarded with wonder and respect.
- People are better able to understand and self-direct when invited to explore with curiosity and without judgment.
- Powerful questions stimulate internal search.
- The key to getting “outside of the box” or expanding a myopic perspective is the ability to self-reflect which requires a safe and respectful environment.
- Techniques are useful tools which should be employed in the right circumstances at the right time.

Coaching Competencies:¹

- The ability to establish trust and intimacy in relationships through being honest, open, trustworthy and respectful.
- The ability to ask powerful open-ended questions that has positive impact.
- The ability to hold people accountable for their commitments and actions.
- The ability to create and monitor measurable goals.

Coaching behaviors include:¹

- Regularly communicating a compelling vision and the need for change from the current reality that generates excitement, enthusiasm, and a commitment to the process.
- Providing resources to implement change initiatives. Helping others to see their role in the change process, thereby facilitating the feeling of ownership.
- Clearly communicating performance targets and offering support to achieve them.
- Identifying and enlisting the support of key individuals and groups to move the change forward.
- Serving as a personal model for the change that one expects from others by demonstrating commitment to innovation and continuous improvement oneself.

What about the staff person who doesn't ask for coaching or does not follow through on their commitments? The one who just doesn't seem to care about this stuff? Staff must be accountable for their promises/commitments and actions. They are employed to do a job, and sometimes that job would not be their first choice of things to do.

Unfortunately, there are certain staff who need to be managed. Management involves telling the person what they must do and following through with consequences if the job is not completed to specification. Coaching is challenging especially when morale is low or a staff person's personal vision is disconnected from the shared vision of the organization. Focusing on the person's personal vision for their life and work is a good place to start when a staff person is struggling with their work.

Commitment to achieving the shared vision requires that all team members be willing to coach and be coached by one another. This is especially true as the work plan unfolds, and the work becomes more intense. As a coach it is important to let the person being coached do the heavy lifting associated with formulating a course of action. They will uncover the answers they are looking for and be much more likely to follow through on the solution if they uncover it themselves. Providing ongoing coaching requires that the coach be available and approachable. Staff should be reminded regularly that you are available if they need help following through on a commitment, or need help coaching someone else with the same. As we have described, coaching is most effective when powerful questions are used to uncover solutions. The following questions are examples of common questions asked by coaches.

Are you asking for coaching from me?

Sometimes people just want to vent and not receive input. Other times they would like to be coached. Knowing the answer to this question will set the interaction off in the right direction.

What specifically is it that you would like to see happen?

This question seems obvious and therefore is sometimes not asked because a coach assumes they know the answer based on their history with the person or based on what they conclude from the information exchanged. Whether you think you know the answer or not this is a question worth asking because it helps to focus the discussion and provides modeling for how to effectively problem solve.

Is the action they are taking producing the desired result?

This question has been made famous by the television therapist “Dr. Phil” who often asks guests the rhetorical question, “How is that working for you?” It highlights two important points. First, your actions are your sole responsibility. You can either blame the person who is not doing what you want or take responsibility for changing your own behavior in order to get the task completed. This can be very difficult for someone to accept especially if they believe “the other” person should be doing this or that. Secondly, doing the same thing over and over and expecting different results is self-defeating. Albert Einstein went so far as to describe such behavior as insane.⁸ Abandoning the current course of action may be what is called for.

Is your commitment to the vision sufficient to outweigh your commitment to personal comfort?

Sometimes the choice to be effective at advancing a personal commitment is a choice to venture outside one's comfort zone. People need to know feeling vulnerable can be a healthy way to expose new options and ways of thinking. Traveling outside of the comfort zone can ultimately lead to new skills and areas of competence.

Have you secured promises from people to produce the desired result? Are you holding people to account for their promises (i.e. managing)?

There are times when we assume someone is going to do something and then they don't do it. If the commitment is not clearly spelled out then assumptions are made, not commitments. If the commitments were clearly articulated using SMART principles, then it may be time to focus on managing the person's commitment. Some managers are reluctant to manage commitments, and may just let the staff person continue to linger. Coaching can help the person see this is not fair to the organization, the customer, or to the person who is lingering.

What new promises can you make given the coaching you received and by when?

Coaching provides the forum where new commitments can be made or old commitments confirmed. Allowing a person to develop their own plan of action can be empowering. As a coach, don't get caught thinking that because the person is struggling you should develop a solution for them. There is dignity in growth. Sometimes good coaching involves remaining silent and present with the

person as they struggle to formulate a plan of action to which they can commit.

When can we meet again to review what we have decided here?

Follow-through is an essential component of coaching. Ongoing monitoring of commitments is also essential so that the person has the resources they need when they need them. Too often people struggle silently and alone right up until a due date. As soon as the difficulty is realized, coaching should occur so the person can successfully complete the task in the allotted time. Regular reviews of the individual and team work plan are an essential part of coaching. Consistency is an essential virtue. Senior managers often struggle with checking-in on the progress of a staff person or team. Typically there are two reasons. They are too busy with other things, or they don't want to "micromanage." There is a difference between micromanaging and checking-in. Reinertsen, Pugh and Nolan have written about the importance of paying attention to staff and teams (See Appendix C for a copy of their article).

Remember the best way to learn how to provide coaching is to get it yourself. If you are currently without a person you can turn to and openly discuss your struggles and successes, it is important that you find someone. Good coaches regularly seek out coaching. This helps protect against internalizing perspectives about themselves or others that have gone unchecked by objective observers who are available to provide valuable information – when asked.⁹

Case Study Example:

Several weeks after the two teams first met, the CHC clinical director, John, stopped by Susan's office and asked, "Can I get your input on something?" Susan replied, "Sure" and the two sat down. "Well," the director started, "I am concerned that the CMHC staff are not on the same page with us on the behavioral specialist's role here at the clinic." "Okay, tell me how you see things", Susan said. John continued, "I understand that the CMHC clinical director agreed that the behavioral specialist would provide therapy for patients referred to him by the physicians. However patients have complained to the nurses that he is not providing therapy. When I talked with him about this, he said he only provides three sessions, and if the patient needs more help than that he refers them for therapy outside of the clinic. So I contacted the CMHC clinical director about this and she said their behavioral health staff cannot provide 'long-term therapy."

Susan responded by asking, "What was the commitment the CMHC clinical director made regarding providing therapy?" John explained that the agreement between the clinics was that the CMHC staff would provide therapy. "Well," Susan said, "it sounds like a few things need clarification. What do you think needs to happen next?" John replied, "I don't think we're getting what we need from the behavioral health staff if they can only see patients a few times. Perhaps we need to look into hiring more behavioral health staff?" Susan let John think for a moment before saying, "What did the CMHC staff commit to providing our patients?" "Screening, therapy and referral services", John said. Susan asked, "Is it clear to you how

each of these words was defined and what the related commitment was during the planning you did with the CMHC folks?” “Well it was clear to me how I define these terms and what I committed to, but I’m not sure how they define these terms or to what they committed to do,” John replied. “That is where I could start,” Susan said. “Thanks Susan,” John replied, as he turned to walk out of the office. “Hey is this what you and Jim were calling, coaching?” Susan replied, “Yes, that’s what we were talking about.”

Step Five

Follow-up & Supportive Accountability

“Accountability breeds response-ability.”

Stephen Covey

The follow-up step is simple, but not easy for most people. It is simply the act of ensuring that the person who made the SMART promise in Step 3 does what they promised. It is about holding people accountable. Most people think of accountability as a negative consequence that is imposed when someone fails. This is one aspect of accountability, but not that which we want to emphasize. Negative accountability entails taking an accounting of what actual results or actions have occurred, as compared to what actions or results were promised, and it is this latter element that we are addressing as of more primary importance.

An effective manager follows up with people to ensure that they succeed at achieving their promises. By being proactive; checking in to see if people are on track with their promises, and letting them know that you expect them to keep their word, a manager helps the person to perform at their best. Managers, who wait to catch someone failing, are acting as “promise police” and fail at their job of producing results. There are two primary methods to effectively managing people’s promises:

1. Reminding people of promised actions before the due date. The simple act of saying, “Remember you promised to ____ by tomorrow at noon” can help people perform.

2. Following up with people on the due date and simply saying, “You promised ____ by today, did you do it?”

Follow-up can be done by phone, in person, or by e-mail. When people know that that they will consistently be held accountable for their promises they tend to make good on their promises. Acting as a support rather than the “promise police” will create trusting relationships that will allow for an innovation-driven climate in which change becomes a strategic enabler for personal and organizational growth.

In Conclusion

Alan Deutschman's book *Change or Die: The Three Keys to Change at Work and Life*¹⁰ investigates the reasons why people with chronic life-threatening illnesses refuse to change behaviors that are clearly accelerating them toward death. Whether it is a person with diabetes who refuses to regulate their intake of sugary foods, or the smoker who continues to smoke despite having emphysema, people struggle to change their behaviors even in the face of death.

Deutschman found that there are six common approaches to facilitating behavioral change. The first three approaches are the most commonly used approaches: Fear, Facts and Force. A typical description of the use of these three tactics can be found in a stereotypical patient-physician interaction. The physician attempts to convince a patient to change their behavior by explaining how dangerous it is if they do not stop smoking (Fear). She then provides statistics on how dangerous smoking is, and how the solution is to enroll in a stop-smoking program (Facts). Finally the doctor shares a look of concern and says, "If you don't enroll in the stop-smoking program there is nothing more I can do to help you, so I am strongly urging you to follow-up on my recommendation and begin a smoking cessation program immediately (Force)." These same tactics are also used in the business world. Staff are scared by the facts that profits are eroding, and that if something doesn't change some staff may be out of a job. In practice,

Fear, Facts and Force only work some of the time. ***A more effective set of tools can be found in the change leadership model described in this guide.*** Deutschman's terms for these three tools are Relating, Reframing, and Repeating.

These approaches do not exclude or replace the “3 Fs” of Fears, Facts and Force. As we discussed earlier, sometimes managing a commitment is necessary. A staff person may need a dose of Fear, Facts and Force to get them back on track. The “3 Rs” approach instead describes key components of the five-step change leadership method described in this guide. The process of developing a shared vision by combining each staff person's personal life vision is a strong example of the power of **Relating** one's person vision to the shared vision of others. The second “R” concept is described in the learning organization approach where the problems and barriers found in the current reality are **Reframed** from being barriers to becoming opportunity areas for improvement. Finally, being a coach involves regular **Repeated** reminders and checking-in with staff and teams to make sure the shared vision is kept in focus as the driver behind commitments acted on.

We hope this short guide has provided some insights into leading change in your organization. Good Luck!

Appendix A

Function	Minimal Collaboration	Basic Collaboration at Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility

Function	Minimal Collaboration	Basic Collaboration at Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Reynolds, K. revision of Doherty, W. J., McDaniel, S. H., Baird, M. A. (1996). Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*, October, 25-28.

Appendix B CMHC/FQHC WORK PLAN					
Goals/Objectives	Key Action Steps	Expected Outcome	Data, Evaluation & Measurement	Person/Area Responsible	Comments
A. Increase access to primary care and a full array of preventative services for mental health and substance abuse consumers.	A.1.(a) Identify CMHC consumers without a medical home who live near FQHC centers and refer them to those centers for primary care services	A.1.(a) 232 consumers without a medical home will have one	A.1.(a) Medical records will be established and maintained by FQHC	A.1.(a) CMHC Clinical Director	
	A. 1.(b) Identify CMHC consumers without a medical home who live near CMHC site; identify barriers to seeking primary care at FQHC Centers; work with FQHC to coordinate and schedule appointments at clinical site at CMHC one day per week	A.1.(b) 14-20 patients will be seen per day at the CMHC site by primary care providers	A.1.(b) Patients will sign a release of information form so that clinical information from both organizations may be shared	A.1.(b) Scheduling staff at FQHC	
	A.1.(c) Expand primary care capabilities by hiring .4 FTE PA and .4 FTE MA	A.1.(c) 750-1000 primary care visits will be scheduled at CMHC	A.1.(c) All labs that are obtained by CMHC will be copied and included in the primary care record	A.1.(c) FQHC Medical Director	
	A.1.(d) FQHC provider will use 340 B programs as well as others to provide consumers of CMHC a fuller array of primary care services	A.1.(d) FQHC primary care clinical staff increased by .8 FTE	A.1.(d) Any change in patient mental health or primary health care will be shared at the time the change is made	A.1.(d) Clinical/Program Coordinator	

Appendix C

Goal Area: 1				
Objective:	Action Steps:	Responsible Party:	Partners:	Target Date

Appendix D

Executive Review of Improvement Projects: A Primer for CEOs and other Senior Leaders

James Reinertsen, Michael Pugh & Tom Nolan

Background

It has been said that currency of leadership is *attention*. If that is true, then leaders who wish to transform their organizations should channel their attention to the key leverage points for the quality transformation, and use their chosen leverage points well.

Improvement projects are important processes in the overall transformation of institutions. Well-chosen projects, with high aims for improvement, capable project leadership and teamwork, and good organizational support, can raise the standard of care in the project area or department, promote spread throughout the organization, and demonstrate the values and behaviors that will drive the transformation. If a project produces real results—i.e. sustained improvement of a breadth and depth that makes both patients and caregivers notice—it sends a signal that will be heard throughout the organization that quality improvement is not just a sidebar activity. If, on the other hand, projects produce superficial results, or tepid results are over-praised, or those working in projects cannot connect them to overall organizational strategies, this also sends a signal—one that will hinder, rather than accelerate the transformation. For these reasons, projects are key leverage points—high visibility moments—in the long-term transformation process.

Executive review of projects can be a critical factor in whether the projects will help, or hurt, the transformation. The first step is for executives to make the decision to channel attention to project reviews, and to budget the time in their own schedules for this activity. The next step is to learn how to do a good project review—the principal focus of this brief practical guide. It's not

enough to give projects your time. You must also know how to use that time well—so that your reviews help, rather than hurt.

Purpose of Senior Leader Project Review

The purpose of reviews of projects by CEOs and other executives should be clear:

1. To learn whether the project is on track, or is likely to fail
2. If the project is not achieving the intended results, to understand why:
 - a. Lack of organizational will?
 - b. Absence of strong enough ideas for improvement?
 - c. Failure to execute changes?
3. To provide guidance, support, and stimulus to the project team on will, ideas, and execution
4. To decide whether the project should be stopped.

Process of Review

Good process review doesn't happen by walking into the team meeting and asking, "how's it going?" Maximum impact for your time comes from some pre-meeting preparation, a well-executed meeting process, and a system for post-meeting communication. It might be helpful to think of these phases in the form of a checklist, to be completed for each project review that you conduct.

Pre-meeting preparation

- Know the context for the project, and be prepared to remind the team why the project is important, and how it fits into the overall goals and system-level measures of the organization. Example: An organization goal is to reduce hospital mortality rates (HSMR). The project is aimed at improving inpatient flow. As CEO, you should be prepared to answer the question, "Why are we doing this project, and how does it relate to our strategic goals?"
- Read the project report prior to the meeting. A good general rule for reports is: "If even the CEO can understand the aims, measures, and results, it's a good report."

- Communicate with the project leader to establish a meeting agenda and expectations: no big presentations, review of aims, measures, results, prognosis, ideas for next cycles of improvement

The Meeting itself

- Start the review by clarifying the aim: “What, exactly, are you trying to accomplish in this project?” Look for aims set at the level of best practice, or raising the bar, rather than more conservative goals.
- Then ask about the measurements: “Please summarize for me the measures you’re using to know whether you’re moving towards your aim.” Look for a few solid measures, well defined, with comparative data available.
- Within 3 to 5 minutes of the project review, you should move to reviewing the data. “So let’s look at your results so far.” Look for clear graphic displays (graphs should be clear, sample size identified, time series.) Spend considerable time on these results—enough to establish that you understand the numbers, but more important, that you really care about getting results.
- Share with the team two to three good elements of the project and provide encouragement. E.g. “Excellent use of stratification in breaking this project up into manageable chunks.”... Or... “You’ve already completed 16 improvement cycles? That’s almost one every 2 days. Wow!”
- Discuss trends and prognosis with the project team. “OK, given your progress to date, and the ideas you’re planning to try, make a prediction: Are you going to achieve this project’s aim?”
- If there is any uncertainty about the project’s prognosis, try to determine whether the failure mode is primarily related to Will, Ideas, or Execution. Indicators of each of these failure modes include:

- **Will:**
 - Resources necessary to the project's success are not made available
 - A few loud nay Sayers are blocking implementation and spread of good ideas
 - Absence of any obvious connection between this project and key strategic goals
 - Lack of executive and board attention to this project
 - Line managers appear to be on the sidelines, not responsible for project success
- **Ideas:**
 - The project team has not gone outside the organization, or outside healthcare, to find the best ideas
 - Few cycles of improvement have been attempted
 - “Big Ideas” appear to be absent—changes being tested are safe, incremental, not radical redesigns
 - The team can't tell you who has the best results in the world on this topic
- **Execution:**
 - Project setup, and project management appear to be weak
 - Preparation for spread is not part of the project from the inception
 - The project team can not articulate a coherent change leadership framework being used by the project
 - The project gets good results on pilots, but never seems to scale up

- If it appears that Will is the problem, this is often something that the CEO or other senior executive can make a major impact on. You can make resources available, deal with the few loud voices, channel attention to the importance of this project, make the connections to key strategies, and assign responsibility to line managers.
- If Ideas are the problem, ask questions that will stimulate the search for ideas.
 - “What ideas do you have for further improvement?”
 - “Where are you looking for new ideas?” (Encourage them to look far and wide, including outside of healthcare)
 - “Who’s the very best in the world at this? How could we find out?”
 - Give explicit permission, and broad encouragement, to try small-scale tests of big ideas. “It sounds as if you have a number of good ideas already. How could you test one of those ideas, and have an answer by the end of the week?” Senior executives doing a good review have to be comfortable pushing and supporting innovation and small tests.
- If Execution is the problem, it is a good opportunity for you to teach good project management and change leadership skills to the project team, and to learn about the larger organization’s barriers to execution in its culture, information systems, human resource policies, and other areas.
- Finish the meeting by asking: “Where do you need help from me?” Projects often encounter significant barriers within the organization, and it’s important for the executive doing the review to understand how she can help the team reach its goals.

Meeting follow-up

- Set a reminder to call or email the team leader in a week, and periodically thereafter, asking for the results of tests of change.

By doing so, your “attention” to the team will extend over a much longer time period, reinforce the importance of the team’s work, and encourage many more cycles of improvement.

- Communicate to the team what you have done in response to their requests for help. This communication could be at the next project review that you do, but it might be timelier if it were simply an email or other communication to team members.

Common fears and antidotes

CEOs and other executives sometimes avoid doing project reviews because of fears such as:

1. “I don’t know much about clinical medicine,”(or whatever the content of the project is). The good news about the above template for doing a review is that you can do it, and do it well, without being a content expert. You need not fear embarrassment on this matter.
2. “I don’t know how to interpret run charts and control charts. What if I ask a stupid question?” There are only two answers to this fear: knowledge (learn the basics of QI so that you can ask meaningful questions about the results) and humility (don’t be afraid to show your ignorance, and to be taught by your team members.)
3. “I’m concerned that by doing these reviews I’m stepping into the area of responsibility of one of my direct reports.” This is a legitimate concern, if you were to assign yourself to do every project review. Obviously, you shouldn’t be doing your direct reports’ jobs for them, and you shouldn’t do every review. But wouldn’t it be a good idea to show them a model for how to do the reviews? And demonstrate what it is you want them to emphasize and encourage?

Retrieved Sept 30, 2008 from:

<http://www.jhi.org/JHI/Topics/LeadingSystemImprovement/Leadership/Tools/ExecutiveReviewofProjectsIHI+Tool.htm>

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- ⁸ Quote attributed to Albert Einstein; see <http://www.quotationspage.com/quote/26032.html>

⁹ Arbinger Institute (2002). *Leadership and Self-Deception: Getting out of the Box*. San Francisco: Berrett-Koehler Publications, Inc.

¹⁰ Deutschman, A. (2005). *Change or Die: The Three Keys to Change at Work and Life*. New York, NY: Harper Collins Publishers.

Useful Web Links

Personal Mastery Programs

<http://pmpcoach.com/>

Discover your goals for personal development.

http://www.mapnp.org/library/prsn_dev/prsn_dev.htm

Share your personal life vision with your coworkers.

<http://atlanta.bcentral.com/atlanta/stories/1998/04/27/smallb1.html>

Create alignment and synergy on your team.

<http://www.teamtechnology.co.uk/tt/h-articl/tb-basic.htm>

Build supportive management to encourage achievement.

<http://www.ee.ed.ac.uk/~gerard/Management/art6.html>

Institute for Healthcare Improvement

<http://www.ihl.org>

The Recovery Center of Excellence

<http://www.recoverymi.org>

National Council for Behavioral Healthcare

<http://www.thenationalcouncil.org/cs/newattheresourcecenter>