

WHOLE SYSTEMS CHANGE

A Case Study in the Use of Large Group Interventions and OD Methodologies
to Effect Change in a Local School District

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Abstract

This case study explores the impact of multiple large group interventions that were combined with traditional OD methods to effect change in a complex system. The specific large group methods referred to are Future Search (Weisbord & Janoff, 1995), SimuReal (Klein, 1997), and the Conference Model (Axelrod, 1992), with an emphasis on using SimuReal to “test drive” a new organizational form. The author reviews the background and assessment of the case before introducing the intervention plan and its results. The author concludes that large group methods were critical to the success of the effort because they produced speed and a comprehensive approach; however, these methods could not have worked in isolation and depended on traditional OD methods to prepare and sustain the organization’s change effort.

Introduction

In the spring of 1995, I was contacted by a large metropolitan school district to work with their department of School Health Services. This department was on the verge of internal collapse due to labor management and communication problems, while under continual pressure to respond to the rising needs of 45,000 students in eighty-eight schools.

It seemed that the world had changed significantly for this district in the last ten years. Over sixty percent of its student population was now in poverty. Twelve percent had chronic illnesses. Almost five hundred children were medically fragile, requiring frequent monitoring and adjustment of life support systems while in school. School nurses and paraprofessionals were faced with four thousand visits per week for episodic care, in part because many children lacked health insurance and had no connection to primary care. Children were coming to school unhealthy and not ready to learn.

Like many other departments in the district, School Health Services (SHS) had also been plagued by continual budget cuts. It responded by cutting nursing hours and trying to stretch its services with the use of paraprofessionals. By 1995, only twenty-five members of its staff of one hundred eighty people were licensed school nurses; two thirds were part-time paraprofessionals.

Breakage occurred in 1994 when the union representing paraprofessionals appealed for a review of their job classification. Disagreements emerged between the administration and the union about the actual depth and breadth of their responsibilities and authorities. Although the result of the job study by the district’s Human Resources Department was little change to the job class, larger issues remained and communication had been strained.

What the department wanted to achieve was the following: (1) the role of the department defined, (2) a service delivery model developed, (3) common goals and strategies created to support that model, (4) job descriptions that clearly defined roles and responsibilities, and (5) improved communication and trust throughout the department.

Assessment

I conducted an assessment in September of 1995. It included focus groups with school nurses, paraprofessionals, and administration, as well as direct observation of staff and committee meetings and a review of pertinent documentation. What I found was:

1. Work overload: It was obvious that people were dedicated to the health of children and doing the best they could. However, morale was low, safety appeared to be compromised, and the potential for disaster seemed high.
2. Role confusion: Focus groups and documentation indicated that confusion existed between the role of the school nurse and the paraprofessional vis-à-vis provision of services. Nurses seemed to be delegating more and more procedures to paraprofessionals, who may or may not have been well trained or supervised to do the work.
3. Serious liability exposure: According to the National Council of State Boards of Nursing (1990), essential principles of appropriate nursing delegation were that (a) quality nursing care could not be provided in isolation by unlicensed persons functioning independently of the nurse ... and (b) a limited (or costly) supply of licensed nurses could not be used as an excuse for inappropriate delegation. Focus group discussions and job study documentation indicated that both of these principles were being compromised. The district as a whole was exposed for liability.
4. Lack of structure: There seemed to be a lack of supporting structure to assist people in getting their work done in a coordinated and cohesive manner. At all levels, people seemed to assign all of their time to work tasks. Communication and decision-making tasks received short shrift. Management tasks were not clearly defined and received a low priority. Paraprofessionals reported to two different functions, creating confusion and inconsistency.
5. Lack of personal communication and connection: People at all levels talked about isolation, lack of support, and lack of communication, although weekly newsletters were well read and daily hotlines well used. However, communication at this point was not personal. What people most often wanted was acknowledgment, connection, participation, and dialog.
6. Unclear departmental role: The bigger issue that needed to be addressed was the role of this department in providing health care services at all. Demographics and expectations had changed, and there were more players on the health care scene. The purpose of SHS needed to be clearly articulated and agreed with stakeholders in the school and community, so that expectations and staffing levels could be better matched.

Intervention Plan

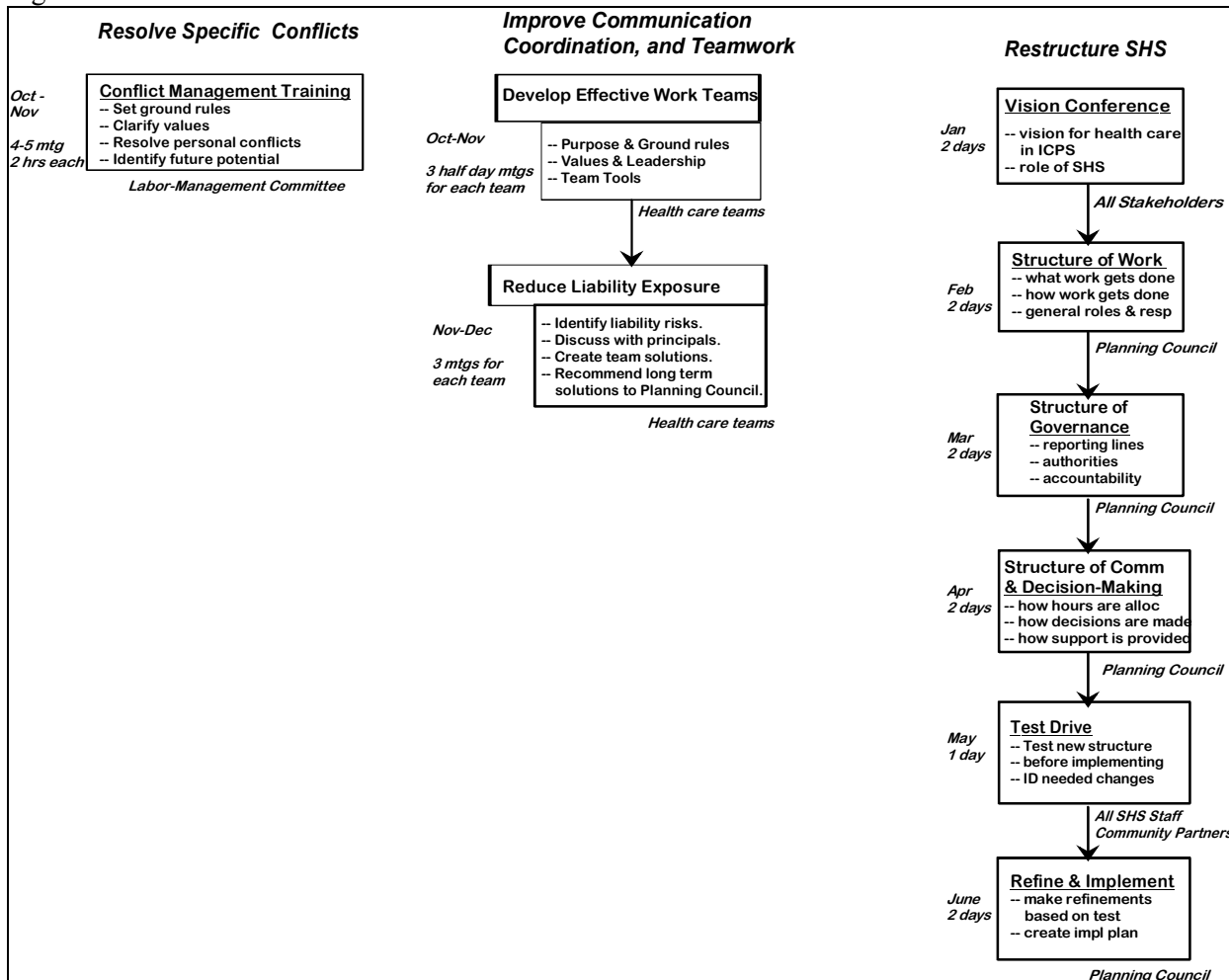
The consulting team was composed of John Reardon from Phoenix Process Consultants in Minneapolis, who specialized in conflict resolution and team formation; Joyce Essien,

Director of the Center for Public Health Practice at the Rollins School of Public Health in Atlanta; Lee Bell of Excel, Inc. who provided administrative support in Minneapolis; and myself, who acted as project manager and lead consultant.

Our recommended approach focused initially on improving communication and teamwork within the current structure in order to reduce isolation and liability exposure. It then moved into examining the role of School Health Services within the community and developing a new structure to provide clarity, support and accountability for services in the long term. (See figure 1.) The intervention was planned for the length of the school year. Key elements were:

1. Providing conflict management training: Because of communication breakdowns in the past year, we needed to start by resolving interpersonal conflicts on this Labor Management Committee and teaching members how to communicate more effectively. We believed that if this group improved its functioning, it would have a ripple effect on the rest of the organization.

Figure 1. The Intervention Plan and Timeline



2. Asking school nurses to take a leadership role in developing health care teams: Everyone wanted connection and teamwork. The most logical person to lead a team effort was the school nurse, who had liability responsibility. Since most school nurses supported multiple sites, it was natural to develop teams around that configuration. To support team formation we provided team development and quality training with all teams, focused on helping them reduce the liability risk.

3. Engaging all stakeholders to create a new vision and role for School Health Service: We recommended using Future Search (Weisbord and Janoff, 1994) to involve health staff, school staff, district administrators, government agencies, health care providers, unions, parents, and community representatives in creating a new vision. The focus was the future of health care for school-age children and the roles of the school and community in helping to provide it.

4. Creating a smaller, cross-functional planning council to restructure the department: A group of twenty to twenty-five people was charged with fleshing out the details of a new structural plan, once the vision was established. Members were drawn from the Future Search conference, and included representation from all unions and stakeholders involved. We used a variation of Axelrod's Conference Model (1992) to create feedback loops between the planning council and staff as the redesign occurred.

5. Holding a large group meeting near the end of the process: Originally dubbed a "dry run," we thought it would be important to provide one last, major review and feedback session before finalizing the new design. Our thinking in this area changed from considering Real Time Strategic Change (Dannemiller & Jacobs, 1994) to something a bit more experiential. (See Critical Issues.)

6. Evaluating the process every six to eight weeks: A steering committee was established to provide feedback, oversight, and coordination during the intervention process. It was composed of the director of School Health Services, the district's executive sponsor, the president of the paraprofessionals' union, a representative of the school nurses' union, and a representative from one of the special programs in the department. The Steering Committee was also charged with leading the communication effort both within the department and between the department and its stakeholders.

Critical Issues

As pieces of the intervention plan unfolded, we began to recognize and confront some increasingly difficult dynamics. First, we began to understand the depth of the concern about potential outsourcing expressed by the paraprofessional union as we began to plan the Future Search with the steering committee and design team. There was a great deal of resistance to inviting private sector health care providers to the conference, although these parties were key elements of the whole system and needed to be in the room. Eventually, the Future Search principles won out and these parties were invited with a great deal of mistrust on the part of union members.

There was an enormous outpouring of community support that resulted from the Future Search. The vision produced was very supportive of a continued health care presence in the schools, albeit in a different form than today. Partnerships were created and funding followed statements of support. The mood of the department seemed to shift as people realized they were no longer alone in their efforts for children's health.

Unfortunately, the strong community support did nothing to mollify the president of the paraprofessional union, who was a member of the steering committee and the planning council. As the intervention progressed and there were noticeable improvements in communication, participation and team work, this person fought even harder to sustain a power base. The union leader became more and more strident during the course of time, using highly manipulative tactics to attempt to sabotage the restructuring effort. Our approach was to stay focused and stay the course, although it took more effort to do so as time elapsed.

Another challenge that presented itself was the typology of the organization. We learned through team training that almost ninety-five percent of the staff were Sensing-Feelers in the Myers-Briggs typology. This was challenging because as an organization they (1) relied on past experience and extrapolations to think about the future, and (2) were driven by strong, individual values. (Bridges, 1992) The effects of these preferences showed up in feedback meetings throughout the restructuring process. Participants had difficulty conceptualizing the new model and assessing its impact on their work. Feedback was viewed as a personal attack. The anecdote was the preferred mode of informational communication.

We knew we had to do something different to make the final event a better match with their organizational style. We wondered if we could find a way to help people try the new organization on for size. Our goals were to let people experience the new organization, to get better feedback, and to find gaps in the organizational design.

We chose to use SimuReal, a large group method pioneered by Don Klein in the 1970's to help the staff "test drive" the new structure before it was finalized. Although this application was not the original intent of SimuReal, Alan Klein (Don's son and partner) agreed to help us design the one-day event. The planning council acted as the design team.

Together we decided to simulate three different processes that would be important in the new structure, making each the focus of one action period. The layout of the new organization was simulated within the confines of the room used for the event, and the participants were placed in new configurations envisioned by the model.

SimuReal Results

As the day approached for the "test drive," we as consultants held our collective breath. The event was being held on the last day of the school year. Not only did we wonder if people would come and what kind of feedback they would provide, we braced ourselves for a confrontation with the paraprofessional union. We realized that the future of the organization truly lay in the hands of the people during this event, and we secretly prayed that our trust and processes were well founded.

To our delight, over 125 people attended the "test drive." They seemed upbeat, demonstrating curiosity about the new model and excitement about trying it out. In fact, participants were so engaged in the process that when the union president tried to stage a walk-out, no one joined. The impact on the union leader was nearly immediate -- she actually reversed course and began to engage in the process. By the time the last restructuring workshop was held two days later, the leader was not only supportive of new directions, she was urging others to follow suit.

Another surprise was that the feedback from the workshop matched that received from the district's executive team. The executive feedback had been dismissed a month earlier by many members of the planning council as off-base. However, when the view from the "scull

boats” matched the view from “the bridge,” the council could no longer ignore the gaps in their design.

The final result was that the design changed by 50% and the meaning of work changed by 99% in the days following the “test drive.” The school board and district leadership approved the new design with a strong statement of support. Our consulting engagement ended that summer after a final evaluation by the steering committee.

Follow Up

At the opening of the following school year (1996-97) an implementation council was formed to oversee and coordinate the change process. Half of the original planning council served on this, taking leadership positions in various work groups. They were joined by many additional staff and community partners who could provide a fresh look and support for the implementation effort. The department continued to use the participative processes it had learned, and was able to accomplish the following that school year:

1. Clarified goals and developed indicators of successful outcomes.
2. Redefined all job descriptions and required competencies.
3. Established a partnership with the city health department to develop a data system. It started to collect baseline data from which to measure progress against goals.
4. Produced its first report about student demographics and data assessment.
5. Survived high-level leadership changes in the district and the union. In May of 1997, the superintendent resigned and a new one was hired. That same month, the union elected a new president. It is noteworthy that the new superintendent patterned a restructuring of the entire district after the same geographic model by used by this department and several others in the district. The new union president brought a more moderate, win-win perspective to the paraprofessional union.

During the 1997-98 school year, the department started to “move in” to its new organization while adapting to budget constraints, and community partners have provided additional funds where possible. The department has proposed adoption of a new standard regarding school immunizations, which invites the community to address the high rate of unimmunized children as a whole community problem. The district is now in the process of establishing a joint high-level board chaired by the superintendent and a major health system executive to implement this new standard. At the same time, the department is piloting a new process that helps schools structure themselves internally to support student health, readiness, and success more adequately.

What happens from now on will be based in large part on the community’s response to the immunization initiative and its ability to continue collaboration and support. As of this writing a key partner, the city health department, is being merged with the city’s jobs and training department in an effort to provide a continuum of family support. This has a potential impact on the data collection system and funding support for key positions. Only time will tell if it will be a major impact, and whether or not other partners will rally to fill any gaps.

Conclusion

There is no doubt in my mind that the large group methods employed in this intervention were critical to its success. These events helped all stakeholders see the big picture and embrace the complexity of the situation very quickly, and built a solid foundation for future work. The partnerships and the community support generated by the Future Search are still a cornerstone of today's efforts. The shared experience of the staff in the "test drive" continues to provide a touch stone for the unfolding organization.

I am equally convinced that these large group interventions would have failed without the benefit of traditional organization development to prepare the way and support the implementation. The lure of large group events is that they can be truly transformational. Yet, participants must be willing to be transformed! In this case, we needed to warm the environment, alleviate the symptoms, and give participants a sense of hope before launching large scale events.

In retrospect, would I change anything about our approach? No, I do not believe so. The leadership, commitment, and passion for children's health were the true leverage points in this intervention process. We just helped those levers reach as far as they could.

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Biography

Catherine M. Perme is the president and owner of C. M. Perme & Associates, Inc., an organizational consulting firm located in Minneapolis, MN. C. M. Perme & Associates, Inc. provides leadership consulting and planning facilitation to help clients focus clearly, organize effectively, and act with courage. The business was established in June 1990 and since then has served clients in the public sector, private sector, industry associations, and information technology organizations in all sectors.

Catherine Perme has had over 23 years of experience in line management and leadership positions with IBM, MN state government, and her now own business. She holds an Associate Degree in Computer Programming, a Bachelor Degree in Management and Leadership Development, and a Master's Degree in Human Development.

Cathy has been professionally facilitating and leading groups in the process of planning since 1978, and has concentrated her personal and professional development on large group methods since first learning about them in 1994. She has been applying large-scale facilitation methods since 1996, and has become adept at incorporating these new approaches to support change efforts that produce measurable results.