

Culture Transformation in a Health Care Organization *A Process for Building Adaptive Capabilities Through Leadership Development*

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Although its importance is often recognized, specific details on the process for transforming the culture of an organization are lacking. Culture is composed of behavioral norms that members of an organization follow as they perform their work. These norms are influenced by the behaviors organizational leaders model and reinforce. Consequently, bringing about a cultural transformation requires that leaders are capable of exhibiting and reinforcing behaviors that are essential to the desired culture. A systemic cultural transformation process was conducted at a New York area hospital. The process involved designing, implementing, and evaluating a leadership development intervention targeted at behaviors essential to an innovative and adaptive culture. The development program included a multisource feedback component and was conducted for all managers.

The importance of aligning the internal structure and processes of an organization to match the characteristics and demands of the external environment is well documented in the organizational literature (Howard, 1994; Kotter, 1999; Lawrence & Lorsch, 1967; Miller, 1987; Mintzberg, 1979; Schein, 1993). These authors highlighted the vulnerabilities that can arise in an organization when internal mechanisms are not aligned or compatible with the external environment.

Over the past 10 years, the health care industry has experienced tremendous turbulence as a result of competition spawned by deregulation, cost-cutting pressures associated with the expanding role of managed

care, and increases in aging patient populations demanding more complex services. These environmental factors have forced health care organizations to seek new ways to dramatically reduce operating costs and to respond to the competitive challenges introduced by mergers and acquisitions (Kleinke, 1997). Whereas other industries have transitioned to more adaptive organizational processes to accommodate increasing environmental changes and complexities, the health care industry has been particularly late in responding. In part, this lateness is due to mechanistic structures and large bureaucracies that have endured over time. Although extremely efficient in stable environments, many of these mechanistic structures and processes are counterproductive in the more complex and dynamic environment that defines the health care industry today.

Two accountabilities that make the transition to more adaptive processes particularly challenging in health care organizations include complying with regulatory requirements and maintaining failure-free performance in all patient care activities. Such accountabilities mandate the existence of mechanistic structures, including formalized work processes and the use of standardized

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patient care protocols. Consequently, the challenge for health care organizations is to build adaptive cultures that can ensure innovation and responsiveness to change while still being mindful of the needs and concerns associated with achieving a failure-free environment.

Building an adaptive culture is not an easy undertaking. Although its importance is often recognized, few details of the process for bringing it about are represented in the literature. Because culture is composed of behavioral norms and expectations that are reinforced over time (Cooke & Rousseau, 1988), one way to effect change is through the development of norms and expectations that are aligned with the culture that the organization is striving toward (e.g., to be more innovative and adaptive and less hierarchical and bureaucratic). Such norms are shaped by the behaviors leaders exhibit (which get modeled by staff members) as well as the behaviors they reinforce (which get repeated over time). Consequently, competencies that enable leaders to demonstrate and reinforce the behaviors critical to the mission and core strategy of the organization can become the focus for bringing about a cultural transformation (Kotter, 1999).

Kotter (1996, 1999) described adaptive organizations as those that rely on leaders at various levels to inspire workers to attain strategic goals. The result is more leadership from second- and third-tier managers and supervisors in deeper levels of the organization, who can define a clearer sense of direction to their subordinates (e.g., in the context and language their subordinates are most familiar with) and help create the bottom-up development of innovative solutions to complex business problems. Relying on mid-level managers to take on the role of change agents and leaders requires that they are capable of aligning individual and department activities with the core goals and objectives of the organization. Managers provide the context within which the creativity of organizational members can be channeled to enhance inno-

vation within their functional areas, and they often take on the role of coach and assist employees in areas where they need development (Lombardo & Eichinger, 1996; McCall, 1993). Managers in health care organizations must also be able to foster teamwork and align members from diverse backgrounds and departmental affiliations. This is needed to provide unique perspectives on resolving complex patient care issues and to identify new ways to be cost-effective in an increasingly competitive environment. Kleinke (1997) pointed to the increasing importance of leadership for the medical community, particularly as we move toward a more industrialized health care system.

The Project

This case study presents an overview of how one health care organization successfully made the transition from a primarily bureaucratic institution, operating efficiently in a stable environment, to a highly adaptive, world-class cardiac center. The hospital is a 300-bed tertiary-care institution in the New York metropolitan area that is nationally recognized as delivering the highest quality specialized cardiac care services. The hospital handles the highest cardiac caseload in the Northeast and the second highest in the nation, typically operating well above 100% capacity, with approximately 1,800 employees.

Despite a track record of success in delivering high-quality patient care services, the hospital's chief executive officer (CEO) and vice president (VP) of human resources recognized in the latter part of 1995 that in order to maintain its position as a leader in this increasingly competitive environment, the hospital would have to push innovation and strategy development down into the lower levels of the organization. Looking for innovation from down-up posed a dramatic shift in the culture of the organization. Traditionally all plans and strategy were devised by the most senior managers at the hospital,

who then instructed departmental managers to implement those plans within their functional areas. Although this approach was efficient during stable times, it became increasingly difficult for senior managers to use this method when demands for more expedient and diverse solutions were needed.

Three primary steps were determined to be necessary for bringing about a successful culture transformation: (a) determine the most important organizational priorities that needed to be addressed in the changing health care environment; (b) assess the current organizational culture; and (c) design, implement, evaluate, and modify interventions targeted at the highest organizational priorities necessary for establishing and maintaining an innovative and adaptive culture.

The following sections outline the process that the hospital went through in conducting these steps over a 4-year period and describes the contributions of consultants who provided essential expertise, particularly in the areas of organization culture and leadership development. Although several broad organizational initiatives were developed over that period, the focal point for all of them was captured by an extensive effort to develop leadership skills that embodied an adaptive culture while still adhering to the fundamental goals of patient safety and compliance to protocol. There were two leadership programs developed and implemented over the 4-year period. The first, Leadership I, was designed in early 1996 and focused on individual skill development primarily in the area of coaching subordinates and inspiring them to take more initiative. The second, Leadership II, was designed in 1998 and focused primarily on cross-departmental teamwork. Built into both programs were multisource feedback processes primarily consisting of self- and subordinate ratings, with the exception of the most senior managers, who also gave and received peer feedback.

There were several significant challenges in conducting the initial organizational as-

essment and implementing subsequent leadership programs. The history of success for the hospital reinforced a focus on technical competencies with little attention being paid to the importance of interpersonal competencies (e.g., leadership behaviors associated with coaching, providing constructive feedback, and inspiring initiative). Thus leadership competencies were foreign to managers at all levels of the organization. Furthermore, the absence of any perceived threats resulting from the changing health care environment generated reluctance among many to take on any new initiatives. To overcome such resistance, external consultants initially spent much of their time aiding the CEO and VP of human resources in building trust with and convincing managers (a) that what was happening in the health care environment (e.g., reality of mergers and managed care organizations) was in fact threatening to the continued success of the hospital, (b) that consequently the hospital had to change the way it conducted business (i.e., become more adaptive and innovative), and (c) that the path to success was an intervention focused on the skill development and widescale adoption of leadership practices. This initial process was consistent with the steps recommended by Kotter (1996) for implementing a successful culture transformation.

Although the development of manager leadership skills was viewed as the cornerstone of the intervention plans, it was considered to be incomplete in creating a more adaptive and innovative culture. Critical to this transformation was the further development and implementation of several supporting human resource initiatives targeted at aligning and reinforcing the leadership practices with a more formal performance assessment process (i.e., as a means to support the adoption of leadership practices at levels below that of a supervisor); revised selection procedures, particularly for management positions; and compensation tied to interpersonal performance as well as technical per-

formance. In addition, there also needed to be opportunities for employees to implement the practices in their day-to-day interactions and activities as well as by participation in various task force initiatives, such as process improvement teams. Making sure there were sufficient training opportunities available (beyond the Leadership I and II programs) to further help managers develop necessary leadership skills was also critical. Interventions related to all these areas were designed and implemented over the 4-year period. It is beyond the scope of the present article to describe in detail all the supporting interventions; the following summary focuses on how the diagnostic process led to the development of the leadership programs and the subsequent impact those programs had on the organization.

Culture Transformation Process

To determine the organizational priorities that were most in need of attention, several focus groups were held with the members of the senior executive staff (e.g., VP level and above). The external consultants facilitated these sessions by providing the necessary expertise in organizational change initiatives plus an objective and unbiased view of the potential issues that the senior team would have to confront. One significant issue that the consultants along with the CEO and VP of human resources addressed immediately was enlightening the other senior team members that there was indeed a need for change despite the prior success of the hospital. Through the focus group process, the senior executives came to the conclusion that acting alone, they lacked the capacity to drive innovation and competitive strategies given the complexity of the challenges that needed to be addressed. They realized that they would have to rely more heavily on mid-level managers to develop innovative solutions within their respective functional areas and to involve members at lower levels of the organization (i.e., those closer to the patient

interface) in creating new work strategies. This realization led to the identification of one of the highest priorities of the hospital: to ensure that managers possessed the necessary leadership skills required to create and maintain an adaptive culture and to understand how far the organization had to go to embody such a culture.

Once this priority was defined, the next step was to assess the current culture in terms of its strengths and weaknesses in relation to the strategic objectives of the organization. To accomplish this assessment, an organizational survey was administered. Specifically, we used both the Litwin Stringer Climate Inventory (Litwin & Stringer, 1968), which asked employees to describe the kind of working environment present in the organization, and an open-ended form that gave employees a forum to express their opinions on what the hospital would need in order to be successful over the next 5 years. In addition, we conducted interviews with employees representing all levels and functional areas of the organization in order to gain a qualitative assessment of the current culture (e.g., to supplement the quantitative survey) and more specific details on possible improvement areas.

Administration of the Organizational Survey

In early 1996, the Litwin Stringer Climate Inventory was administered to a random sample of 350 hospital employees, representing approximately 20% of the total number of 1,800 employees from the various organizational levels and departments. The analysis of survey results was conducted according to the following organizational levels, with an approximate 20% sample obtained for each tier:

- Tier 1—senior management level (12 members at the VP level and above who report directly to the president and CEO),
- Tier 2—senior management direct re-

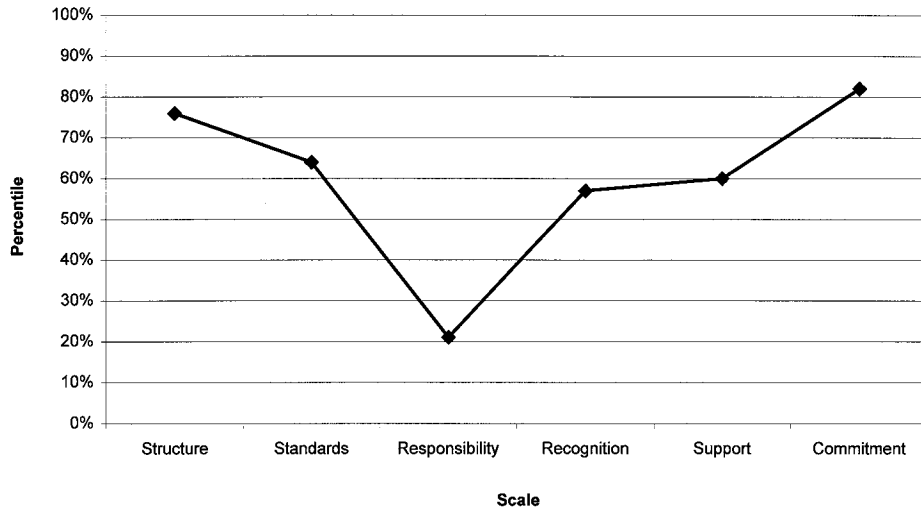


Figure 1. 1996 Litwin Stringer Climate Inventory results for overall organization.

port level (approximately 60 assistant VPs, directors, and division heads reporting to a Tier 1 senior manager),

- Tier 3—all other managerial staff (approximately 140 managers, supervisors, and foremen who report to a Tier 2 manager and who are primarily involved in oversight of the day-to-day activities performed by the hospital), and
- Tier 4—all nonmanagerial staff (consisting of approximately 1,600 line and support staff workers with no supervisory responsibilities).

The Litwin Stringer Climate Inventory (Litwin & Stringer, 1968) asked members to describe the kind of working environment that had been created in the organization. It consisted of questions categorized into six organizational dimensions:

- Structure—employees' sense of being well-organized, with clear roles and responsibilities;
- Standards—emphasis on improving job performance and personal pride for doing a good job;
- Responsibility—"being your own boss" versus having to double check decisions with others;

- Recognition—feelings of being rewarded for a job well done;
- Support—feelings of trust and mutual support that prevail within a work group; and
- Commitment—sense of pride in organizational membership and commitment to its goals.

Figure 1 provides the Climate Inventory results in percentile rank scores for the overall organization. The mean ratings for the overall organization were translated into a percentile rank score (noted below in parentheses) based on the norm database on which the Climate Inventory was validated (Litwin & Stringer, 1968). Overall, employees reported the highest ratings on commitment to the organization and its goals (82%). High scores were also reported for both structure (76%), indicating that employees generally understood their job responsibilities and the decision-making authority of the organization, and standards (64%), indicating that performance standards were high and that there was a feeling management expected people to strive toward performance improvement. With respect to recognition (57%) and support (60%), there was a moderate balance between rewards and criticism as well as a

moderate level of trust and teamwork in the organization. Low scores were reported on responsibility (21%), indicating that employees felt they had limited autonomy (e.g., their decisions were double-checked, and management discouraged independent action).

Figure 2 breaks out the inventory results by tier levels. Whereas the ratings on structure and commitment were high for all tiers, there were large differences in ratings between tiers on the other Climate Inventory dimensions. Particularly low scores on recognition were reported by the Tier 4 level (41%), and scores on responsibility reported by Tiers 2, 3, and 4 were consistently low (all between 17%–23%). These findings illuminated two issues that senior management felt were organizational priorities: First, that lower-level employees were not being properly recognized and encouraged for their accomplishments; and second, that groups below the senior staff level were not being encouraged to assume much responsibility. Another key finding turned up on the standards scale, as managers at the Tier 3 level (43%) did not share in the perceptions of high

standards exhibited by their supervisors in Tiers 1 (91%) and 2 (82%; e.g., they did not report the same pressure to continuously improve performance). Results from the support scale showed inconsistencies in the perceptions of support across the organization. Specifically, whereas Tier 1 and Tier 3 managers felt support, Tier 2 and Tier 4 managers did not sense the same level of support.

Part II of the survey consisted of additional open-ended items that gave employees the opportunity to provide comments and opinions on what it would take for the organization to be successful over the next 5 years. The majority of respondents consistently expressed that information sharing, collaboration, and teamwork all needed improvement, particularly at lower levels of the organization (i.e., Tiers 3 and 4).

Overall, the results from the Litwin Stringer Climate Inventory characterized the hospital as an organization with a high level of staff commitment and structure but lacking in the areas of innovation, individual initiative, communication, and teamwork.

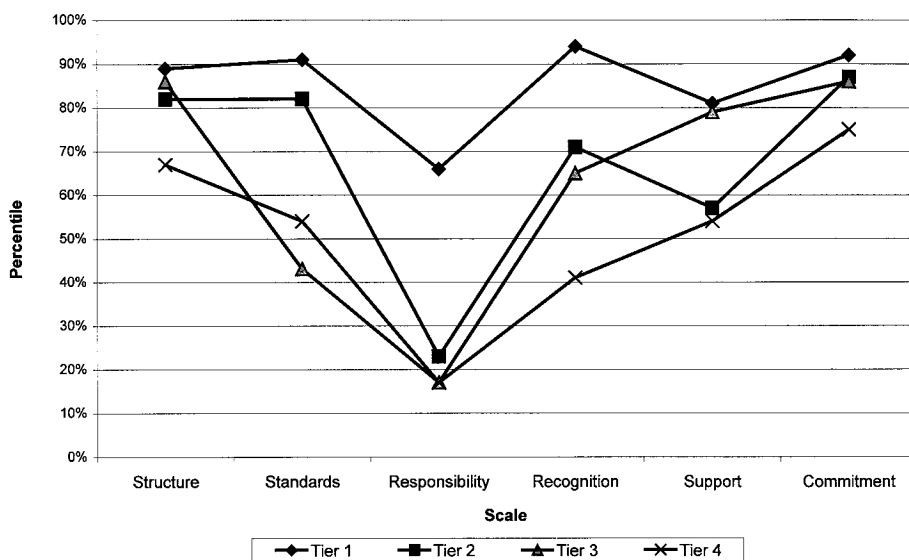


Figure 2. 1996 Litwin Stringer Climate Inventory results compared across tiers. Tier 1 = senior management level; Tier 2 = senior management direct report level; Tier 3 = all other managerial staff; Tier 4 = all nonmanagerial staff.

Table 1
Leadership Practices Placemat

I: Communicating the hospital's values	II: Encouraging individual initiative	III: Providing constructive feedback and coaching	IV: Creating a climate of openness and trust	V: Demonstrating personal leadership	VI: Leveraging the entire hospital team
1. Effectively balancing the hospital's business and patient care priorities	7. Clarifying who is responsible for what within the group	12. Giving people candid feedback on how they are doing on their jobs	18. Conducting meetings in a way that builds trust and mutual respect	23. Selecting and promoting the best people for the organization	28. Putting hospital objectives ahead of personal, unit, or departmental agendas
2. Communicating high personal standards of compassionate care in one's behavior, conversations, and daily contacts with others	8. Encouraging people to initiate tasks or projects they think are important	13. Providing feedback that is even-handed and fair (especially during formal appraisals)	19. Behaving in a way that leads others to trust you	24. Managing change in a thoughtful and well-planned rather than a reactive manner	29. Collaborating effectively with people in other departments or units
3. Setting challenging performance goals and standards for people	9. Expecting people to find and correct their own mistakes rather than doing this for them	14. Recognizing people for good performance more often than criticizing them	20. Encouraging an open exchange of ideas and different points of view	25. Focusing your time and energy on the most important priorities	30. Encouraging people to share ideas and information with other hospital departments and units
4. Treating employees fairly	10. Encouraging and rewarding innovation and people who are willing to experiment and try new approaches	15. Being supportive and helpful in daily contacts with others	21. Listening carefully to what others have to say	26. Being a person who delivers what is promised	31. Understanding which decisions can be made alone and which decisions need to involve others
5. Demonstrating personal concern for the well-being and success of hospital employees	11. Empowering people to "do whatever it takes" to deliver high-quality patient care	16. Going to bat for people with your manager when you feel they are right	22. Responding in a nondefensive manner when others disagree with you	27. Acknowledging one's own mistakes and limitations	32. Recognizing the value of bringing people together with different perspectives and opinions
6. Pushing people to constantly look for new ways of saving money, increasing productivity, and improving the quality of care	17. Spending the time necessary to coach people effectively	17. Spending the time necessary to coach people effectively			33. "Reaching out" to help people in other departments

Interview Process

To supplement the organizational survey, two of us conducted approximately 50 interviews with employees from various levels and departments of the hospital. Interviews further clarified deficiencies identified by the survey and also identified leadership behaviors that would be necessary for the future success of the hospital. Three questions related to leadership were addressed in the interview process: First, what aspects of leadership need to be improved the most? Second, what do the best leaders at the hospital do now? Third, what practices will the successful "leader of the future" have to demonstrate?

Several common themes emerged for organizational members in leadership positions. They needed to

- possess strong, effective communication skills;
- have the ability to motivate and provide constructive feedback;
- encourage staff participation in setting goals and developing plans;
- challenge people; and
- strengthen teamwork.

Design of an Intervention

The information obtained by both the organizational survey and the interview process led to the development of 33 critical leadership practices on which managers needed to focus. These practices were organized into six broad clusters and were formatted on a leadership "placemat" (see Table 1). The placemat became an icon for the organization in clarifying its mission and providing immediate recognition of what leadership behaviors were necessary for the future success of the hospital. The clusters were

- Communicating the hospital's values,
- Encouraging individual initiative,
- Providing constructive feedback and coaching,

- Creating a climate of openness and trust,
- Demonstrating personal leadership, and
- Leveraging the entire hospital team.

The leadership practices depicted in Table 1 relate to interpersonal competencies spanning peer relations (e.g., teamwork) and subordinate interactions (e.g., coaching) as well as communicating, listening, and prioritizing work activities. In light of the outstanding technical knowledge and skills already exhibited by the hospital employees, being competent in these interpersonal aspects was believed to be of high importance given the recent and impending changes in the health care industry.

Leadership I Program

To initiate the transformation to a culture that would embody the 33 practices, an initial leadership development program was designed for managers to help them identify those leadership practices they needed to improve most and to provide them with an opportunity to develop skills in areas where they were deficient. To support the identification and prioritization of the leadership practices that needed improvement, the 33 practices were translated into a Leadership Feedback Survey. The objective of the feedback survey was to support each manager's awareness of his or her leadership strengths and areas for improvement. For each manager, a representative sample of subordinates completed the feedback survey (typically 10 subordinates for each manager) along with a self-assessment by the manager. An individual leadership feedback report was developed to show each manager a comparison of his or her own assessment on the 33 practices with that of his or her direct reports.

Two important attributes of the leadership feedback process were (a) the feedback needed to be accurate and solicited from a credible source, and (b) managers needed to be supported to facilitate their acceptance of

the feedback, to help them overcome any resistance to changes suggested by that feedback, and to design their development activities in accordance with organizational objectives.

Merely giving managers feedback on how their self-assessment compared with the assessments of their subordinates was not considered to be enough to stimulate meaningful individual development and certainly not enough to initiate a change in the culture. Consequently, the provision of feedback results was incorporated into a 2-day workshop as well as several follow-up activities (i.e., one-on-one coaching and superior-staff interactions to discuss feedback implications). The objectives of the workshop were twofold: (a) to explain to managers how to interpret their feedback survey results and identify individual development needs and action plans and (b) to provide training in those critical leadership skills that were determined in both the initial climate survey and the interview process to require the most broad-based attention. Training during the workshop focused on teaching managers techniques on how to provide effective coaching, inspire individuals to take more initiative, and create processes for facilitating teamwork. Workshop activities included case study discussions, videotaped role-play exercises, and individual coaching. All case study and role-play materials were developed and piloted through a process of in-depth interviews and focus groups with hospital employees to ensure their organizational relevance.

We provided further assistance through one-on-one coaching sessions designed to facilitate the creation of action plans targeted at addressing the most significant individual development needs. The role of the coach was to discuss individual feedback from an objective, confidential, and neutral position, thereby providing psychological safety (Dalton, 1996). It was also important that the external coach be intimately knowledgeable of the organization's overall goals in order

to be able to help managers design development plans aligned with those goals.

Because the program was implemented in a top-down manner starting with senior managers, each new level of participants was encouraged to work with their superiors to understand the feedback results and to plan the best way to work toward improvement. Managers were also encouraged to present a summary of their feedback results to subordinates and to seek further insights from them on what could be done to address the areas that needed improvement. In many instances, managers committed to a change strategy developed with input from both their subordinates and superiors and established specific measures to monitor progress toward their individual development goals.

The initial leadership development program described above was first introduced into the organization in April 1996, starting with the senior executive team and continuing over a 2-year period spanning all management levels (i.e., Tiers 1, 2, & 3). For the initial program, individual feedback results were confidential and used purely for self-development purposes. The 2-day workshop component of the program was held off-site, away from institutional distractions, with two external facilitators who had expertise in leadership development and who could provide unbiased and objective support to managers in interpreting their feedback survey results.

Results of the Leadership I program. A total of 182 managers participated in the Leadership I program during 1996 and 1997. Whereas evaluations of the program workshops were conducted throughout the 2-year period, a more formal assessment of the program was conducted at the beginning of 1998. This assessment included an analysis of the initial leadership practice ratings for the organization based on aggregating the results for the 182 managers. These ratings were aggregated from subordinate feedback survey results that were obtained approximately 2 weeks prior to the time when each

manager participated in the Leadership I program. Thus, they were collected over the entire 2-year period.

Summary of leadership practice ratings. The aggregated results for the initial leadership feedback survey during 1996 and 1997 identified strengths in the following areas:

- effectively balancing the hospital's business and patient care priorities (Practice #1 in Table 1);
- communicating high personal standards of compassionate care behavior, conversation, and daily contacts with others at the Hospital (#2);
- setting challenging performance goals and standards for people (#3);
- expecting people to find and correct their own mistakes, rather than doing this for them (#9); and
- empowering people to "do whatever it takes" to deliver high-quality patient care (#11).

These strengths demonstrated that coming into the program, managers were at their best in communicating the values of the hospital and encouraging individual initiative.

The aggregated leadership survey results also identified the following weaknesses:

- being supportive and helpful in daily contacts with others (Practice #15 in Table 1);
- putting hospital objectives ahead of personal, unit, or departmental agendas (#28);
- acknowledging one's mistakes and limitations (#27);
- focusing time and energy on the most important priorities (#25); and
- spending the time necessary to coach people effectively (#17).

Several general themes emerged from the weaknesses reported, including providing constructive feedback and coaching, demonstrating personal leadership, and leveraging the efforts of the entire hospital team. These themes were consistent with what the leadership development program was initially designed to address and provided con-

firmation that the program objectives were in line with the development needs of the managers.

In the later part of 1997, several off-site meeting sessions were held with the senior management team to identify the next steps in the culture transformation process. On the basis of the available Leadership I program results plus feedback from managers on the leadership development process, the senior team reached consensus on two major priorities: first, further developing constructive feedback and coaching skills; and second, improving the manner in which managers worked together to leverage the entire hospital team. A recent merger of the hospital and another local facility also shaped these priorities. Although teamwork within individual departments and process improvement teams had improved over the 2-year period, the merger required increased cross-departmental teamwork on a day-to-day basis. The senior management team also concluded that the Leadership Feedback Survey should be re-administered to all managers in order to provide an updated comparison of their self- and subordinate ratings regarding how their performance on the 33 leadership practices had changed and to help managers isolate particular areas for continued development. With these priorities in mind, the Leadership II program was developed.

Design of Leadership II Program

To develop the second leadership program, a series of interviews and focus groups was conducted with managers representing each managerial level of the hospital (Tiers 1, 2, & 3). This information helped prioritize development needs and provided input on learning exercises and activities. On the basis of this input, a 1-day leadership workshop was designed that consisted primarily of an intensive staff allocation role-play exercise focused on cross-departmental teamwork and incorporated a negotiation process for satisfying both unit and overall organiza-

tional goals. The activities also centered on helping each manager interpret his or her individual feedback (resurvey) results and then design an updated development action plan.

We provided coaching for the second leadership program during the 1-day workshop and spent time helping managers understand how the practices translated into actionable leadership competencies that could be improved. As part of the second program, managers were provided with a copy of the leadership development handbook *For Your Improvement* (Lombardo & Eichinger, 1996) and taught how to devise a customized action plan based on the competency improvement recommendations provided in the book. Under our guidance, each manager devised an action plan tailored to meet his or her individual development needs as well as the demands of their particular work situation.

Although individual feedback results for the Leadership II program remained confidential, managers were required to share their developmental action plan with their superior at the conclusion of this program and were held accountable for the development areas and corresponding measures they selected. The Leadership II program was administered during 1998 and 1999 to the same population of managers who had participated in the first program in a similar top-down fashion.

Comparison Between the First and Second Leadership Programs

Similar to Leadership I, the data from Leadership II was aggregated across participants to indicate the feedback results from managers just prior to their participation in the Leadership II program. This also allowed for a comparison to be made with regard to progress since the first leadership program. Figure 3 highlights the comparison of the Leadership I and Leadership II aggregated feedback results. The data are presented in terms of percentile rank, obtained by translating mean raw scores into percentile scores

based on a database consisting of only hospital managers. Thus, the normative database was composed of only managers from the specific hospital, where raw mean scores on the five-point Feedback Survey scale were rank ordered by percentile ratings ranging from 1% to 100%.

Between the beginning of the first and the beginning of the second leadership program (approximately a 2-year period for each manager), an increase was demonstrated on all leadership practices, including a 10% or greater increase in percentile rank for 22 of the 33 practices. Moreover, all of the practices identified as weaknesses from the Leadership I results increased by 10% or more. Results also demonstrated that the hospital was clearly improving in collaboration and teamwork as seen by increases on Practices #15 and #33. These results attested to the success of the Leadership I program.

As shown in Figure 3, for Cluster 1, communicating the hospital values, managers showed noteworthy increases in demonstrating personal concern for the well-being and success of hospital employees (Practice #5) and pushing people to constantly look for new ways of saving money, increasing productivity, and improving the quality of patient care (#6). In encouraging individual initiative (Cluster 2), the largest increases were in encouraging people to initiate tasks or projects they thought were important (#8) and empowering people to "do whatever it takes" to deliver high-quality patient care (#11).

Cluster 3 showed substantial improvement in the practices providing fair and even-handed feedback (Practice #13), being supportive and helpful in daily contacts with others (#15), and going to bat for people with your manager when you feel they are right (#16).

In both creating a climate of openness and trust (Cluster 4) and demonstrating personal leadership (Cluster 5), all practices increased, with the most notable improvements in conducting meetings in a way that builds trust and mutual respect (Practice #18) and ac-

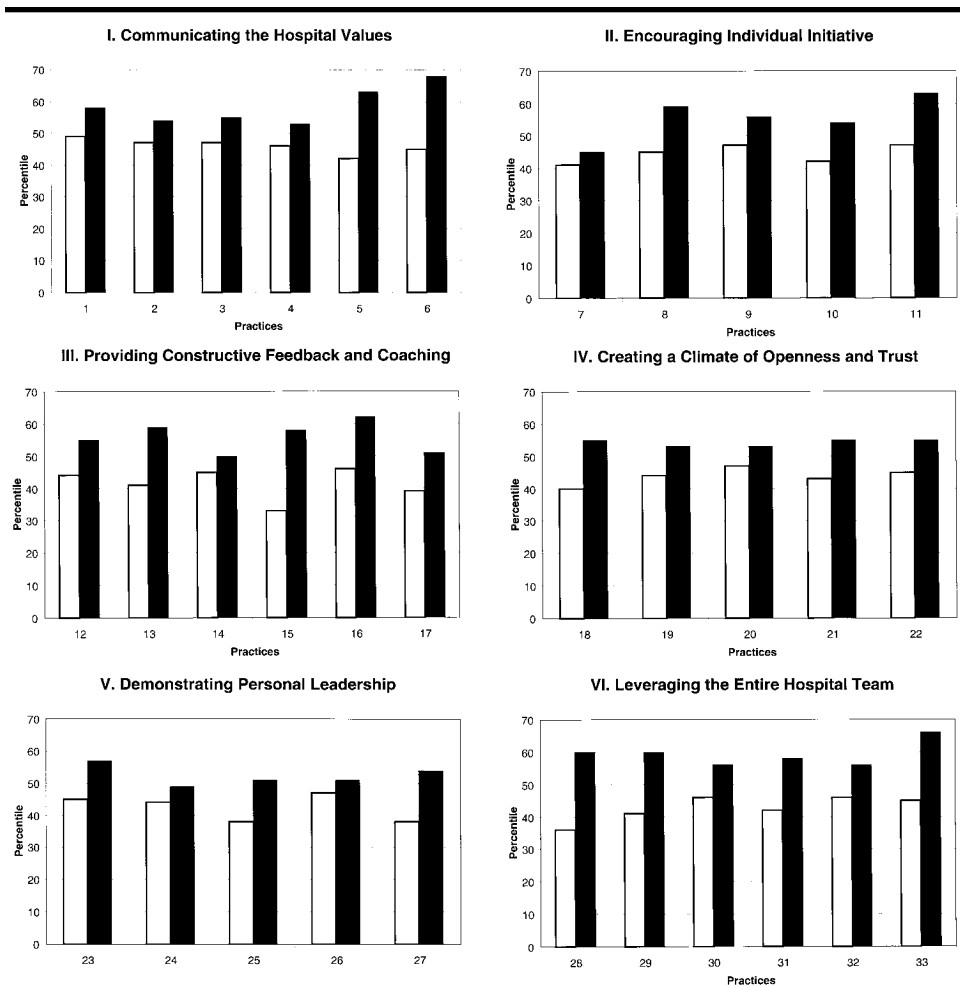


Figure 3. Comparison of leadership practice ratings between Leadership I program (open bars) and Leadership II program (solid bars).

knowledging one's own mistakes and limitations (#27).

The greatest improvement within any cluster was clearly shown in Cluster 6—leveraging the entire hospital team. For example, putting the hospital's objectives ahead of personal, unit, or departmental agendas (Practice #28) increased by 24%; collaborating effectively with people in other departments or units (#29) increased by 19%; and "reaching out" to help people in other departments or units (#33) increased by 21%.

In terms of overall progress against the objectives of the hospital, at the completion

of the Leadership II program, an increase was shown in all of the 33 leadership practices. Managers showed marked improvement in how they managed their direct reports and in their ability to facilitate teamwork within their departmental areas as well as in their peer-to-peer relationships.

Discussion

Over the period of 4 years (1996–2000) the leadership programs were being implemented, the yearly profit margin of the hospital rose from 4.2 to 12.7%. In addition, the

overall patient satisfaction rating during the same period of time was maintained above a 95% level, and in 1997 the hospital was awarded an accreditation with commendation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for the third consecutive time. Although a direct causal relationship cannot be made between the culture transformation efforts and these outcomes, they are particularly noteworthy given the increasing demands on the hospital, such as having to dramatically cut operating costs, reduce reimbursement rates, and respond to competitive challenges introduced by mergers and acquisitions.

Other outcomes realized during the period from 1996–2000 included (a) the design of and transition to a new patient-centered care model, (b) the streamlining of patient admitting and medication administrative procedures by cross-functional process improvement teams, and (c) the revision of the selection protocol and performance assessment process at the hospital.

In a follow-up assessment, many hospital managers reported that these outcomes were facilitated by the skill development they experienced by participating in the leadership development programs. Such accomplishments gave supporting evidence of the overall impact of the leadership programs on important organizational outcomes, including profitability. In isolation, improving the leadership skills of individual managers was not enough to sustain meaningful culture change. The aforementioned outcomes resulted from providing management and their subordinates an opportunity to put the leadership practices to use. Thus, the leadership practices, and their extension to various organizational initiatives, became the underlying support mechanisms for the culture transformation process. For example, over the course of the 4-year transformation effort, the processes used by performance improvement teams vastly improved, and the dramatic outcomes they produced in areas such as medication and admitting practices were a result

of improved team functioning reflecting skills gained in the leadership development process.

Incorporating the 33 leadership practices into the more formal yearly performance assessment process for all hospital employees was also considered critical to the culture transformation. This procedure created expectations for nonsupervisors to engage in leadership behaviors similar to those their managers were being trained in and held accountable for. The revision to the performance assessment process also gave managers the means to evaluate employees in their job settings and to identify improvement opportunities on competencies consistent with the leadership practices. This was particularly challenging because the hospital had never before focused on competencies related to interpersonal (soft) skills, especially at levels below supervisor.

Through a process led by a task force with representatives from the various hospital divisions, a new performance assessment instrument was developed and a training program was conducted to educate managers on how to implement the newly designed assessment tool. The tool included behaviors reflecting particular leadership practices, that is, relevant for each employee job category, along with behavioral anchors to guide the assessment of the manager. For example, behavioral descriptions were developed for each leadership practice on a scale that ranged from “exceeds” performance expectations to “meets” performance expectations to “needs improvement” to meet performance expectations. The use of such an instrument provided managers with an opportunity to coach their subordinates on the same set of competencies now expected of them. Managers also worked with subordinates in designing development plans on how they would work toward making improvements. In many instances, development activities encompassed new assignments that provided opportunities for the competencies to be put to use as well as attendance

at relevant training programs offered by human resources.

Conclusion

The results outlined above bear light on the fact that culture can indeed change but, as noted by Schein (Quick & Gavin, 2000), slowly over time. Changing the hospital culture was also not without obstacles that needed to be overcome. Accordingly, there was a clear need for consultants, in this case from outside the organization, to facilitate the change process. The independent nature and experience with similar interventions that these individuals possessed complemented the knowledge of the hospital executives about the internal processes of their organization. In order to accomplish the culture transformation, several major hurdles needed to be addressed, such as a departmental mindset that encompassed protectionism and mistrust of "outsiders" as well as the slow acceptance of the human resource function by the line organization of the hospital (whose traditional view of human resources was more as a personnel department with little value to add to the core mission of the organization). The challenge for the CEO and VP of human resources was to ensure that

- all initiatives were tailored to the specific context of the organization,
- employees were involved in the process of defining strategic initiatives,
- a high level of senior staff commitment was maintained with the necessary financial resources being provided,
- a sense of urgency was created among all employees,
- ongoing evaluations of all improvement initiatives were conducted as well as repeated organizational surveys and interviews to modify or create new initiatives, and
- the external consultants were used on a selective basis to provide an unbiased viewpoint, to help build trust at

the senior management level and to add specific expertise in change management and leadership development.

Implications for Consultants

The approach taken by the hospital was consistent with the eight-step method for implementing a successful culture transformation proposed in the book *Leading Change* (Kotter, 1996). With our assistance, the CEO and VP of human resources established a sense of urgency in the organization and created a guiding coalition with the other members of the executive team. We helped the executive team develop a vision and strategy that incorporated the ideas of organizational members representing all levels and functional departments. The vision for change was clearly communicated to all members of the hospital staff through the leadership competency model (Table 1) and associated development programs. All employees were given opportunities to develop skills in the leadership practices and to apply those skills through various initiatives linked to the behavioral norms and attributes necessary for characterizing an adaptive culture.

The potential for failure without first obtaining backing from hospital leaders was recognized and addressed at the initial stages of the intervention. We concentrated on arming leaders with the skills necessary to motivate others in adopting the new culture and in creating champions throughout the organization for guiding the culture transformation. We also emphasized the need for the organization to look beyond subjective rating increases on leadership feedback surveys to more tangible evidence regarding the impact of these leadership interventions. Such evidence was observable in the ability of the hospital to make significant process improvements in the delivery of patient care services, in the commendations it received from the independent JCAHO, and in its ability to in-

crease profitability as well as compete with other larger institutions in the surrounding metropolitan community. It is noteworthy that throughout the transformation period, and with the added burden of a merger, patient satisfaction continued to be above the 95% level.

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