

# **Cultural Transformation in Health Care**

*A white paper that describes the complex nature of organizational culture and its role in health care organizations.*

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## Contents

Introduction. . . . .	1
A Context for Organizational Culture . . . . .	3
Cultures of Distinction . . . . .	5
Into the Wilderness. . . . .	7
Learning from Pioneers. . . . .	9
The Journey of Cultural Transformation. . . . .	11
The Call to Adventure. . . . .	12
<i>Leadership's Role</i> . . . . .	13
Crossing the Threshold, Choosing a Path . . . . .	14
The Road of Trials and Obstacles. . . . .	19
Receiving the Boon. . . . .	21
Sustaining Momentum and Passion . . . . .	24
Offering the Gift to the Community. . . . .	26
Recommendations . . . . .	26
Appendix A. . . . .	29
<i>Participant Organizations</i> . . . . .	29
<i>Other Contributors</i> . . . . .	30
Appendix B. . . . .	31
<i>Interview Guide</i> . . . . .	31
References. . . . .	33

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## Introduction

The Robert Wood Johnson Foundation (RWJF) is committed to improving the health and health care of all Americans. Central to that mission is ensuring that a stable, experienced cadre of nurses is in place to provide high-quality patient care.

Following on its prior work centered on the profession of nursing (Donaho, 1996; Rundall, et al, 1998; Kimball/O’Neill, 2002) and current work environment initiatives with the Institute for Healthcare Improvement, RWJF began to focus its lens on hospitals’ **organizational culture** as a basis for improving quality of care and recruiting and retaining a strong nursing workforce, probing questions such as:

- How does organizational culture affect satisfaction and outcomes for people that are served by the organization?
- How does organizational culture affect people who work within the organization?
- What are the primary elements and processes necessary to transform and sustain a healthy organizational culture?
- How can philanthropy influence cultural transformation in health care organizations?

American hospitals are currently faced with a number of scenarios catalyzing the call for organizational culture change: unexpected, deaths related to errors during hospital stays; patient dissatisfaction with the hospital experience; workforce problems including significant nursing shortages and dissatisfaction with working conditions; and declining financial performance. RWJF seeks to lead, shape, and disseminate innovative work related to cultural transformation that will challenge the status quo contributing to these adverse conditions in health care organizations. The purpose of this paper is to:

1. Establish the need for culture change in American health care organizations to achieve a distinctly different set of results—to engage and satisfy patients, eliminate error, improve clinical outcomes and secure workforce loyalty and vitality.
2. Identify preliminary models of successful cultural transformation to stimulate innovative approaches and improve the overall performance of the American health care system.
3. Reframe change as an opportunity for growth, engagement and meaning.

This paper describes the complex nature of organizational culture and its role in health care organizations. To set the stage for culture change, the literature is reviewed for perspective on the role and function of culture in organizations. Organizational theorists as well as business consultants report that a strong organizational culture is essential for success because the shared assumptions, values and beliefs—or culture—

of an organization influence the behavior of its individual members. Although the literature reflects the challenges involved in assessing and changing culture, the operative question about organizational culture is its correlation to and impact on organizational performance and/or workforce vitality. What emerges is a growing realization that any significant organizational change must align not only systems and processes, but also the underlying organizational culture as well. Because organizational change is driven by its people, successful efforts in this area connect people to the meaning of their work.

After examining other industry examples of distinctive, high-performing cultures and providing a brief context for the significant external changes that health care organizations have recently faced, the paper focuses on the process of cultural transformation in health care organizations across the country. Interviews were conducted with 40 health care executives self-reporting deliberate cultural transformation efforts to become more patient-centered and ensure the long-term success of their organizations. These interviews, conducted with representatives of a cross-section of public and private health care organizations, provide a body of information on how organizational culture is developed, reinforced, and changed to effectively meet the needs of patients and families, as well as the mission and goals of the organization.

The interpretive framework of Joseph Campbell's mythical "hero's journey" is used to outline the archetypal stages which capture the essence of why, how and what elements are required for initiating and sustaining transformation. They include the call to adventure, choosing a path, the road of trials and obstacles, receiving the boon and offering the gift to the community. Regardless of whether the motivation for change was desperation or passion, or whether the desired future culture is based on a path of quality and safety, patient and family involvement, superior service, or a unique set of organizational values, the stages of the transformation process are identical. Organizations interviewed instinctively recognized the process as a journey, acknowledging the complexity of the transformation and the obstacles they encountered along the way.

Because transformation involves change, the process is fluid, often unpredictable. It requires commitment, time and flexibility. No two journeys are identical. And while there are lessons to be shared and learned from those who have gone before, each organization must seek and discover its own path to meaning. The exemplars can serve to stimulate additional work on cultural transformation in the nation's health care organizations.

Finally, the paper recommends strategies that RWJF might pursue to support improvements to the organizational culture of hospitals, an area in which they have not yet done much work. This white paper informs the ongoing formation of that strategy—a first step on the journey.

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## A Context for Organizational Culture

The word *culture* is derived from the Latin root *colere*: to inhabit, to cultivate, or to honor; it generally refers to human activity. Anthropologists define culture as the universal human capacity to classify experiences, to encode and communicate them symbolically through artifacts and behavior.

An *organization* is a formal group, or community of people, with one or more shared goals. It is comprised of individuals, who are simultaneously part of some other, larger collective whole or entity (Wilbur, 2000). Many organizations, including governments and government agencies, corporations, partnerships, charities, not-for-profit corporations, cooperatives and universities, are legal entities. Unlike organizational structure, which is easy to draw and describe, organizational culture is less tangible and more difficult to analyze or define.

The concept of *organizational culture* might best be described as the collective personality of an organization. It is a complex tapestry woven from the assumptions, attitudes, values, beliefs, collective memories and customs of an organization. It is upon these learned, shared assumptions that individuals base the daily behaviors that become habitual, patterned and integrated. Often unconscious shared assumptions and behaviors also reflect the organization's efforts to survive pressures exerted by the external environment, thereby defining reality and influencing culture (Schein, 1999). Reinforced over time, the collective unconscious manifests itself as "the way we do things around here," and organizational identity is both created and reinforced. A more contemporary definition of organizational culture would include values, leadership style, language and symbols, procedures and norms, and the organization's unique definition of success.

The concept of *managed cultural transformation* attracted significant attention among organizational consulting and planned change scholars and practitioners during the 1980s. The onset of this wave was marked by the widespread popularity of books, such as *In Search of Excellence* (Peters & Waterman, 1982). Cameron's "competing values framework," based on four dominant culture types (i.e., clan, market, hierarchy, adhocracy), posited that culture can and does change. An assessment tool sought to determine if organizations had a predominant internal or external focus and if they valued flexibility and individuality or stability and control (Cameron & Quinn, 1999).

More recently, the model of high-reliability organizations has emerged from research based on evidence that some complex, interdependent organizations (e.g., nuclear submarine, air control) have fewer than normal accidents. Technology is acknowledged to influence outcomes, but not in isolation, nor absent a change in culture (Weick and Roberts 1993). High-reliability organizations consist of a combination of organizational, managerial and adaptive characteristics. But during the 1990s, the view that organizations possess a single integrated culture, which management can transform, was

being debated by both research and practice. The literature also demonstrated how difficult it is to assess and change culture (Harrison and Shirom, 1999).

For organizational culture to change, there must first exist an awareness of the need for change. This need is often reflected by current normative behaviors and social structures. Whether the need for change is driven by survival or passion, a deeper knowledge of individuals' intentions and beliefs is essential. Sharing creates understanding and trust and identifies the common values that can serve as keystones for change. The destination or path an organization chooses is dependent on the reality of their current state.

In organizations where there is minimal alignment of shared values, control is frequently exercised through extensive procedures and bureaucracy—reflecting a “weak” culture. However, when individuals respond to stimuli because of their personal alignment with organizational values or consciousness, regardless of the extent of external regulation, a “strong” culture is reported to exist. Actions are intuitively guided by the existence of a shared “cultural workspace” (Wilbur, 2000).

Indeed, the operative question about organizational culture is its correlation to and impact on organizational performance and/or workforce vitality. Linkages between organizational culture and performance have been established, and in the business arena, evidence has confirmed that companies that emphasize key managerial components, such as customers, stakeholders, employees and leadership, outperform those that do not appreciate these interdependencies and their impact on culture (Kotter & Heskett, 1992; Wagner & Spencer, 1996).

Culture is complex. One of the major reasons that organizational change efforts reportedly fail is a lack of understanding about culture and the significant role it plays. What has emerged is a growing realization that, despite the best-laid strategic and tactical plans, any significant organizational change must include not only changing structures and processes, but also addressing the underlying organizational culture. Appreciating the complexity of culture is particularly important when attempting to manage organization-wide change, because culture is multifaceted, deep, broad and stable. It provides tacit rules that guide behavior, meaning and predictability (Schein, 1999). Culture, by definition, provides a framework to live in, to cultivate and to honor.

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## Cultures of Distinction

There are many organizations outside of health care that exemplify distinctive organizational culture. Consider Disney, Southwest Airlines or Ritz Carlton; each is known for creating, sustaining and constantly improving a service-oriented, innovative culture.

Disney doesn't just provide customer service; it creates experiences. The Disney approach combines common sense, strictly defined corporate values and nonstop attention to detail. Their formula? Hire for attitude, train for skill; design and reward a workforce culture aligned with a business model to bring customers into the parks; make guests happy and create memorable experiences that will bring them back time and again. During peak seasons, when hourly workers are stretched, executives are required to pitch in and do frontline jobs. This "cross-utilization program" gives leadership firsthand insight into the essence of Disney's business—creating magic for the customer. Organizations can create and build fabulous facilities for their customers, but it takes an entire "cast" (workforce) of dedicated people working together to make it come alive (Shuit, 2004).

Southwest Airlines is the most successful of all the United States airlines today, because it has created more value than its competitors, even though they serve the same customers, adhere to the same regulations, and use similar technologies and suppliers. In addition to hiring motivated people who fully support explicit organizational values, Southwest has empowered its employees to create an efficient organization that can get a plane off the ground (a key productivity and customer satisfaction measure) in much less time and with far fewer staff than its competitors (Gladwell, 2002). In addition to maintaining low fares, they have cultivated palpable customer and workforce loyalty.

The Ritz Carlton outperforms its competitors by hiring the right people. They examine their best performers, "the naturals," in every position to understand how they are different and screen candidates for employment according to that profile. By empowering frontline employees to manage the hiring process and select their teammates, they have the lowest turnover rate in the industry (Dow and Cook, 1997).

Other organizations outside of health care have aligned their values with missions that strive to improve safety and eliminate errors. These high-reliability organizations actively seek to know what they don't know; create systems to make all knowledge related to a problem available to every person in the organization; learn quickly and efficiently; avoid organizational hubris; train and empower staff to recognize, respond and act on system abnormalities; and design redundant systems to catch problems early (Roberts and Bea, 2001).

Organizations such as Toyota, Alcoa or the airline industry have demonstrated that it is possible to manage the contributions of hundreds or thousands of employees in a way that is competent and reliable in the short term and steadily improves in the long term, by marrying the processes of doing work with learning to do it better in real time

(Spear, 2005). One approach, first introduced as the Toyota Production System, is remarkably straightforward and interactive: design work as a series of real-time experiments to reveal problems; address problems immediately through experimentation; disseminate solutions rapidly; and invest in training and engaging the entire workforce to become experimenters pursuing perfection.

Toyota's culture is described as "destiny driven"—there are only two organizational values: 1) respect for people and 2) continuous improvement (Kaizen). For this tradition-bound culture, the "tradition" has evolved to become one that embraces change, even when change is painful or risky. The organization's willingness and ability to transform itself in the changing world is a result of "lean thinking"—a tireless pursuit of perfection, humility and lifetime commitment, evidenced by a series of loyalty oaths that are re-interpreted by each new generation. Every aspect of the corporation, including profitability, exists to reinforce a culture that strives to serve a higher purpose.

Lessons from these examples underscore culture's role in organizational performance and workforce vitality: the importance of hiring the right people, of investing and empowering people to improve performance standards, driven by a clear vision, mission and values. The role of the organization's leadership is to engage the workforce in creating seamless teamwork.



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## Into the Wilderness

Separation from the old way of doing things is typically followed by a period of chaos. Things fall apart; confusion and disagreement prevail until, eventually, a vision of what needs to come emerges and points to the future. The paradox is that, to find one's self, one must first become lost.

During the 1980s, a new prospective payment reimbursement mechanism was introduced to health care organizations in America, disrupting the established status quo of fee for service. In response, acute care hospitals, located at the epicenter of the transition, began to adopt more businesslike practices and behaviors. These included unprecedented cost cutting measures, organizational restructuring, re-engineering of care delivery, growth through mergers or acquisitions, and diversification of investments. Managing costs to create a healthy bottom line emerged as a primary focus for most organizations.

During the 1990s, the health care system continued to struggle with the increasing demand to be more accountable for outcomes, while having fewer resources. The anticipation and effects of the 1997 Balanced Budget Act, coupled with a steady pipeline of costly new technologies and pharmaceuticals, created a tension that produced stress and dislocation, translating to work environments that were more demanding and making employment less attractive than before. Chief executive officer and chief nursing officer turnover rates reached new heights and significant workforce shortages began to emerge (Kimball and O'Neill, 2002). A revolving door pattern of leadership provided a barrier to successful and sustainable change.

The 1999 Institute of Medicine (IOM) report *To Err is Human: Building a Safer Health System* focused the nation's attention on the issue of medical errors and patient safety. The report indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. In 2001, the IOM released another report, *Crossing the Quality Chasm*, that describes a fragmented, inefficient system of care resulting in medical errors, unnecessary treatment, under-treatment or wasted resources. In August 2004, a *Newsweek* article reported that the estimated deaths from medical errors were understated by 50 percent (Underwood, 2004).

A 2004 survey of more than 2000 adults, conducted by Harvard University, the federal Agency for Healthcare Research and Quality and the Kaiser Family Foundation, found that 55 percent of those surveyed were dissatisfied with the quality of their health care, up from 44 percent in 2000. Forty percent said the "quality of care" had become even worse in the last five years. But their definition of quality was not just about numbers or outcomes; it was reflective of their own individual human experience—a combination of cost, difficulty and the increasingly impersonal nature of care (Kaiser Family Foundation et al, 2004). This criticism is of the same U.S. health care system that steadily consumes an increasing portion of the nation's annual income (Wilson, 2005).

The effect of two decades of externally driven change has been dramatic. Relationships were fractured at all levels. Patient care suffered from depersonalization. For many health care organizations, what became “lost” in the midst of the chaos and disruption was a focus on the organization’s reason for being; the traditional mission of healing people’s bodies, minds and hearts; the link between collective core values and high-quality care; the passion and humility of leadership; the engagement of the workforce and ultimately public trust. Organizations that neglected the cultivation of an interior consciousness to guide them through the chaos found themselves adrift.

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## Learning from Pioneers

In June 2005, RWJF convened a meeting of leaders with culture change experience to share their efforts, challenges and results. Following the session, an invitation was circulated to identify other health care organizations willing to participate in a focused project on cultural transformation. Referrals from across the U.S. totaled 67. Interviews were conducted with senior management representatives of 40 organizations reporting experience with cultural transformation and representing a cross-section of academic health centers, community not-for-profit hospitals, public safety net hospitals and clinics, health systems (ranging from three to 67 acute hospitals and including other vertically integrated entities), a physician organization, and a regional initiative involving 42 hospitals and a foundation (Appendix A). They included Malcolm Baldrige Award winners, Magnet hospitals and organizations listed on *Fortune's* 100 Best Places to Work. Telephone interviews were conducted using a standard questionnaire (Appendix B). Participants reported that they had initiated the process of culture change as recently as two years and as long as 19 years ago, the majority having begun within the last five to six years. A summary of their responses follows.

When asked to describe the organizational culture that they were *evolving from*, the responses were surprisingly consistent and can be grouped into seven broad areas that significantly affected performance and workforce vitality: purpose, structure, decision-making, responsiveness, quality, workforce and merging cultures.

1. **Purpose:** Lost, unfocused, lack of patient focus, lack of moral purpose, impersonal, patient not central to mission, purpose without vision, inwardly focused, task focused, overwhelmed with tasks, lost connection to the patient
2. **Structure:** Paternalistic, fragmented, independent silos, top-down, top heavy, bureaucratic, multiple layers, hierarchical, like a state bureaucracy, lack of two-way communication, physician centric, clinical model driven by business model
3. **Decision Making:** scarcity model, physician dominated, professional discipline centric, decision making from provider perspective, for the convenience of staff (not patients), seniority driven, entitlement mentality
4. **Responsiveness:** Crisis oriented, slow to change, slow to respond, timid, traditional, passive, risk averse, pure avoidance, losing patients, physicians and staff
5. **Quality:** Good—not great, no realization that health care was broken, average, great variation in quality and practice, no intention to improve quality, ignored broken systems, “bad things happen and that is okay,” focus on what “we do well,” arrogant, focused on people (not on competency); poor community image

6. **Workforce:** ineffective teamwork, poor morale, lack of trust, lost, not engaged, fearful, lack of understanding by management, lack of professional nursing community, disenfranchised, helpless, not heard or appreciated, high turnover, high use of agency staff, passive, apathetic, low internal pride
7. **Merging Cultures:** separate, different, variation, lack of common vision, lack of trust, each entity doing its own thing, silos, independent, competitive.

At the outset, what these different health care organizations held in common was a conscious desire to move their “community of people” to a different and better place, a process each has described as an intense, rewarding, long-term journey.

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## The Journey of Cultural Transformation

“People say that what we’re all seeking is a meaning for life. I don’t think that’s what we’re really seeking. I think that what we’re seeking is an experience of being alive, so that our life experiences on the purely physical plane will have resonance within our own innermost being and reality . . .”

Joseph Campbell, *The Power of Myth*

Myths reveal what people through the ages have in common, often through stories of a search for truth and meaning. Whether the experience of meaning is the result of actions or a discovery, myths are the narrative patterns that give significance to our existence. Myths have been compared to the beams of a house—a structure that holds it together so that people can live inside (May, 1991). In Joseph Campbell’s *The Hero with A Thousand Faces*, the hero’s journey is simultaneously external and internal, filled with the experience and meaning of being alive (Campbell, 1972).

Many people who choose to work in health care professions do so for altruistic reasons, driven by a desire to support and heal members of society during some of life’s most vulnerable moments. However, they increasingly describe their current work environment as mechanistic, task oriented and void of meaning. While they empathize with their patients, they as individuals feel powerless to create change. Organizations that have deliberately set out to change their cultures are responding to this call. The vision is to create a culture that recreates vitality, purpose and meaning by actively honoring the people they serve.

The journey of cultural transformation is not linear. It is fluid, unpredictable, filled with obstacles and surprises. It requires commitment, time and flexibility. As with any real transformative process, no two journeys are identical. And while there are lessons to be shared and learned from those who have gone before, each organization must seek and discover its own path to meaning. The “hero’s journey” offers an interpretive framework from which to capture the essence of why, what and how.

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## The Call to Adventure

The first stage of the mythological journey—the “call to adventure”—is the point when one is given notice that everything is going to change, whether they know it or not. The “call to adventure” can be the result of desperation, accident or passion. Participants revealed a variety of conditions that motivated the need and laid the groundwork for change. Many reported a confluence of two to three factors that served as a catalyst for changing the culture of their organizations. They can be grouped in five broad categories: burning platform/significant threat, external restructuring, new facilities/technology, passion to be better/the best and visionary leadership.

1. **Burning Platform/ Significant Threat:** Factors include financial crisis, economic viability, bankruptcy, massive debt, negative media, strength of competition, loss of market share, high turnover, staffing shortages, poor community perception, mediocre patient satisfaction, and union organizing.
2. **External Restructuring:** Factors include mergers, acquisitions, system creation or expansion, and divestiture from state government or civil service structures.
3. **New Facilities or Technology:** Factors include construction of new buildings that reflect patient needs and wants, movement of services to new location and implementing new information technologies that contribute to safety.
4. **Passion to be Better/the Best:** Factors include opportunity for increased productivity and staff morale, improvement in safety standards or outcome measurements, recognition through competitive awards or credentials, demonstrable “lived” values or community integration, and developing exemplary models of patient- and family-centered care, professional nursing culture, or holistic or other new models of care.
5. **Visionary Leadership:** Factors include often new (recruited, promoted, interim), visionary, action-oriented risk takers and team builders skilled and experienced at creating and managing change.

Transformative change arising from desperation is by nature reactive, but can lead to a new and strong culture, if—once the short-term crisis is under control—positive lessons are internalized and sustained by articulating a long-term vision and meaningful shared values. Change arising from accidental opportunity is generally intuitive, aligned with goals and advantaged by flexibility. Change fueled by passion is described as proactive, insightful, deliberate and fully engaging at every level. Ample evidence to support and benchmark the need for change was readily available for all those who sought to find it, in the form of, for example, clinical and safety outcome measures, national benchmarks, staff and community surveys, patient/staff/physician satisfaction scores, human resource and productivity metrics, labor union relations, financial and economic metrics, and organizational assessment and readiness tools. Timing was situational: in some cases it was reported as essential; in others, the process evolved intentionally, but incrementally. Refusing “the call” is all too common; maintaining the status quo is comfortable. Answering “the call” is an act of courage whether the mo-

tivation is driven by passion or desperation, because once the “call to adventure” is answered by leadership, the journey is about to begin.

## Leadership’s Role

The “call to adventure” that precedes cultural transformation is always a leadership opportunity. Every day, leaders are given opportunities to raise questions, seek out and resolve conflict, speak to a higher purpose and make a difference in the lives of the people who surround them. In a world characterized by uncertainty and vulnerability, leadership can be risky. In *Leadership on the Line*, we are warned, “To lead is to live dangerously because when leadership counts, when you lead people through difficult change, you challenge what people hold dear . . . habits, tools, loyalties, ways of thinking—with nothing more to offer perhaps than a possibility.” (Heifetz and Linsky, 2002).

In 100 percent of the interviews conducted, the organization’s top leadership initiated the change effort. In addition to being described as visionary, they are also described as demonstrating a willingness to “step out in front,” take risks or “take the bold step forward.” Embarking on a journey into the unknown requires a deep level of personal commitment. When leadership moves beyond personal achievement or advancement and seeks to improve peoples’ lives, it enters the realm of creating purpose and meaning. At the most intrinsic level, it means putting yourself and your ideas on the line (Heifetz and Linsky, 2002). Many leaders interviewed reported that the process of working from within the organization to create a *new* culture was also personally transformative—a renewed awareness of their unique gifts of communication, understanding, curiosity, presence, heart or wisdom. One of the leader’s most significant roles is to create an environment in which others can take risks—to “hold the space,” invite people in and make transformation possible.

It is also clear that successful leadership is a team effort. Effective leaders make sure that the “right people” are on board. In *Good to Great*, Jim Collins found that in the initial stage of the journey, the first priority is getting “the right people on the bus, the wrong people off the bus, and the right people in the right seats.” (Collins, 2001) Leaders were regularly credited with creating broad understanding and alignment, and securing buy-in from the entire management team and key stakeholders. In a few cases, members of the management team who were unwilling or unable to sign on were encouraged or allowed to leave. The expanded leadership “team” often included board members, physician leaders and champions recruited by the leader from throughout the organization. Visionary leaders ensure that patient and family advisors are part of the process—participating in planning, site visits, and other phases of this work. In today’s changing world, effective leaders use emotional intelligence to facilitate the team’s ability to work synergistically and productively (Goleman, 1998). With a cohesive team in place, the stage is set for the next step of the journey.

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## Crossing the Threshold, Choosing a Path

“The adventure is always and everywhere a passage beyond the veil of the known into the unknown; the powers that watch at the boundary are dangerous; to deal with them is risky; yet for anyone with competence and courage the danger fades.” (Campbell, 1972)

Organizations that made the decision to embark on cultural transformation journeys all stood on the threshold and chose a path into the unknown. Those with burning platforms/significant threats smartly seized the opportunity to pursue a path of change by building on the confidence that accompanied successful results, laying the groundwork for culture change. Those with external restructuring activity, new facilities construction or new information technology wisely used the opportunity to leverage a cultural transition by including all stakeholders in the design and implementation process. However, those whose primary motivation for change was driven by a passion for being better/the best have skillfully managed to translate that passion into a collective set of organizational values that consistently guide decision-making and behavior over the course of time.

For the organizations that have taken a long-term perspective on cultivating culture, choosing a path to the future (becoming better/the best) was generally based on a clearly-defined set of organizational values or a theoretical framework, such as an integrated patient- and family-centered model of partnership, a culture of safety (no preventable errors), Lean Thinking, holistic healing, the American Nurses Credentialing Center’s principles of magnetism, or a theory of caring. The framework serves not only as pillars on which to build, but also as a touchstone or point of reference for implementing change and fostering innovation.

When asked to *describe the process used or created* to move forward on the path, a number of steps emerged: assessing current reality, defining a desired state, guiding change and engaging the workforce.

**Assessing Current Reality.** Most organizations employed some type of activity to identify or assess their current reality and create an opening for new possibilities. The approaches ranged from informal to formal, inventory to comprehensive assessment, internal to external. Examples along the continuum included: leadership rounds, staff focus groups, learning maps, organizational surveys, internal readiness assessment tools, organizational culture inventories, gap analysis models, focus groups that included patients, families, staff and physicians, external organizational assessment processes and site visits to other organizations. Done well, identifying the current reality is the organizational version of looking in the mirror.

**Defining a Desired State.** In response to information gathered regarding current reality, the next step for many was the development of a clear definition of the desired state: shared values, a collective vision, goals, a strategic plan, new service or quality standards, and in a few instances, a comprehensive framework or a “roadmap” for navigation. In one hospital system, the roadmap outlined the structure, process,



outcomes, deadlines and accountability for moving forward. Across the organizations interviewed, the approaches ranged from top-down to interactive, including leadership planning retreats, management retreats, mandatory staff meetings, employee forums, leadership development workshops, mandatory staff trainings retreats for all staff. Several organizations involved patient and family advisors in visioning retreats. In one hospital, a process was designed to involve every employee and physician in describing the place that he or she would want to come to receive health care, from the moment they arrived in the parking lot: their interactions with staff and doctors; type and quality of information received; the colors, lighting, sounds, smells and tastes; their need for family and friends, safety and security. The experiential process engaged the staff as real consumers of health care and the “desired state” they envisioned, and eventually created, was collectively owned.

**Guiding Change.** Organizations often identified or created a specific group to monitor and guide the change process. Guiding is an act of integration, of “showing the way” (Fields and Zwisler, 2001). In addition to the essential leadership team described earlier, organizations created steering committees, councils, transition teams, transforming teams, dream teams, new roles (facilitators, black belts, consulting pairs, coaches) or positions, which could be time-limited or permanent. In the most successful cases, the group of people charged with guiding change included champions from management, frontline staff, patients, families and physicians. Because of the interdependent relationship of physicians and health care organizations, their participation in design and implementation enhances commitment and reduces the risk of obstructive behavior later in the process (Silversin and Kornacki, 2000). The formal space created by the network of relationships serves as a “holding environment” where members of the guiding group address conflict, resistance or other difficult issues. When involved in adaptive work, it is necessary to create a safe place, or a cohesive vessel, to offset tensions that naturally arise (Heifetz and Linsky, 2002).

**Engaging the Workforce.** Although the processes used to assess the current reality, define a desired state and guide the change process are necessary, the critical step in engaging the workforce is in creating an environment where new ideas and behaviors are welcomed and change experimentation and change are safe. Organizations either chose to reinforce the desired state through broad dissemination efforts (multifaceted communications and trainings) or created intentional opportunities for participation and further development by stakeholders (retreats, interactive work groups). Of the latter, a subset systematically introduced adaptive change methodology to lay the foundation for a learning organization. Whether the degree of inclusion and participation at this formative stage affects long-term results, ownership and sustainability is a hypothesis worthy of future study.

When asked to rank the *three most important elements* of a successful culture transition process, the critical triumvirate cited by the majority of participants was:

1. Leadership commitment and support
2. Shared vision and values
3. Involvement and ownership at all levels

Communications, retreats and trainings were important vehicles for engaging people at all levels, while systems improvements, recognition and rewards, and measurement were effectively used to build new organizational infrastructure to reinforce and sustain the emerging culture. In a number of instances, external partners supplied experience, tools, process and support.

**Leadership Commitment and Support.** As illustrated earlier, leadership must articulate the vision, open the window of possibility, and actively invite all the people in the organization to engage in the “call to adventure.” This invitation to join signals the leader’s commitment and is a step towards building trust. However, as the journey continues, many other facets of leadership come into play. Unfaltering confidence in the vision is a key leadership attribute manifested through focus, authenticity and consistency. Maintaining a resolute focus on shared values is a demonstration of leadership discipline. When leaders visibly model value-driven behaviors, others naturally follow, and what begins to emerge is a culture of discipline evidenced by value-driven behavior. Communities of disciplined people require less hierarchy, bureaucracy and controls (Collins, 2001).

Leaders who have guided their organizations through transformative change were described as role models who were authentic and consistently honest, trustworthy, approachable, present, respectful, supportive, caring, and good listeners who “walked the talk.” By offering guidance, coaching, facilitating interactions, and collaborating at every level, they took an active role in developing and inspiring people to continue the journey. Contrary to popular belief, charisma is not a necessary quality; professional will and personal humility are the two primary character traits deemed essential to leading and creating outstanding organizations (Collins, 2001).

**Shared Vision and Values.** Another essential element is a shared vision and values that are clear and simple enough for everyone to remember and communicate. The meaning of their work is understood. In the most successful examples from this project, the vision and underlying organizational values are centered on valuing and involving the patient and respecting his or her priorities, preferences, goals, and beliefs. A common flaw in the current culture of most hospitals is that they promote social isolation through narrow visiting policies, staff practices and attitudes, and lack of supportive accommodations for families. The many organizations that have placed the patient relationship the heart of their culture, understand—at both collective and individual levels—what the experience of being a patient in the organization feels, looks, sounds and smells like. Every task in the delivery of care is an opportunity for human interaction that can improve healing, whether that is measured by uncomplicated recovery, satisfaction or quality outcomes (Frampton, Gilpin, and Charmel, 2003). The patient is the reason health care organizations exist.

**Involvement and Ownership at All Levels.** Organizations that enjoy involvement and ownership at all levels understand that culture is a highly valued community asset. Many embraced this concept by including not only management and employees, but also patients and families, physicians, board members and labor unions in both the

planning and implementation process. Inclusion of a diversity of stakeholders changes the conversation. It recognizes competence, which helps build trust. It also has the potential to introduce a healthy tension that disrupts the usual patterns of communication and decision-making. Organizations that took a broad based inclusive approach reported that the new dynamic helped to hold individuals accountable. Everyone was present at the table. Once empowered, the frontline staff—not management—led the revolution.

From the onset, communication served as a vehicle for illuminating the road ahead. Whether describing the big picture or what desired behaviors might look like, messages that were honest, clear, concise and consistent moved the process forward. Disclosure of the truth helped to build trust. Many organizations actually named the journey or developed an acronym to represent and reinforce the shared values or goals. Feedback loops were created to ensure that communication was a two-way exchange. Often organizations reported that as people became engaged and energized by what they were experiencing, a new internal language or terminology emerged to name a process, a tool or a positive result. A shared language linked to success and accountability was an indication of a new collective identity.

But language is important to transformation on a much more basic level because it helps to build trust. Change is abstract; many people may have difficulty with abstractions and need a lens that is more tangible or concrete to understand what it means to them. Telling the truth, without spin, is essential. Inviting discussion, admitting to not having all the answers and sharing what is known are keystones in building transactional trust. Language and communication become tools, a lens for helping people understand what is working (Reina and Reina, 1999).

Formal trainings, retreats and interactive forums with leadership often provided safe places for staff interaction and direct input into the process. Internal facilitators, black belts and coaches were trained to enable the organization to reach people in their own work environments. Building and sustaining momentum was accomplished by celebrating early wins, recognizing early adopters and using appreciative inquiry to reinforce positive adaptive behaviors. Appreciative inquiry suggests that by asking what is working in an organization, and capturing the high energy and reality of accomplishment, people will know how to repeat success (Hammond, 1996).

Integration and continued engagement were frequently supported through real-time systems improvements and the development of new human resource practices (hiring, orientation, training, performance evaluations), recognition programs and rewards. Measurement was used by 100 percent of participants to benchmark, reinforce, direct and sustain the emerging culture. Further descriptions of these efforts will be provided in a later discussion on sustainability.

External partners with proven experience were used in a number of instances to guide or support the processes of assessment and implementation. In addition to expertise, they supplied principles, tools, tested methodology and ongoing support. A common

theme among those who use external partners was the value added by being a part of a network of organizations that act as a learning laboratory, collaboratives that willingly share experiences and ideas and offer consultation (peer or expert). External resources recommended by more than one organization included the ANCC Magnet Recognition Program, Baldrige National Quality Program, Baptist Healthcare Leadership Institute, Birchtree Center for Healthcare Transformation, Disney Institute, Institute for Family-Centered Care, Institute for Healthcare Improvement, Lean Enterprise Institute, the Pebble Project of the Center for Health Design, and Planetree/The Planetree Alliance. An important note of caution from one leader who has worked on both sides: external resources may serve as guides, but their expertise and tools are futile without internal organizational values and commitment.

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## The Road of Trials and Obstacles

As the journey unfolds, the road is filled with trials and obstacles. These can be viewed as a series of tests, tasks, or ordeals that the organization must undergo in order to carry on. Failure of a task is not uncommon and may be considered a test of resolve or a learning experience. For each stage of the journey, there is a corresponding pitfall. The pitfalls generally represent an attempt to accelerate the process by skipping or shortcutting required steps, or a failure to appreciate the length of time required for transformation (Kotter, 1995).

A failure to remove obstacles was a commonly observed pitfall that included policies and procedures or leadership behaviors that were incongruent with the vision and values. Inability to address simple systems issues in a timely manner created frustration and bred negativity. These are also trust-breaking behaviors. Lack of readiness was illustrated by not having made a convincing case for change or not developing or communicating a clear and concise vision. Sometimes a state of readiness is assumed, but there is an inherent lack of understanding at a deeper level, of the potential for betrayal and lack of trust (Reina and Reina, 1999). What surprised participants the most, and was perhaps the most common obstacle described, was peoples' resistance to moving forward.

Change is situational. A structure is changed, new policies are introduced, a workforce enlarged or reduced, a strategy shifted or discarded. Bridges' seminal work on managing transitions reminds us that imbedded in the American culture and its frontier heritage is the notion that you can always start over and leave the past behind. In contrast with older nations that evolved slowly over thousands of years, the U.S. is often viewed as the product of a series of intentional changes. On that historical note, it is not surprising that many leaders fail to understand the important process of managing human transition (Bridges, 1987).

Picasso said, "Every act of creation is first an act of destruction." Transition, according to Bridges, is a three-phase process of psychological reorientation that people must travel through as they come to terms with change. Transition always begins with an ending, which must be a very real ending for people to successfully begin again. After the ending, people leave the known limits of the old reality and move into the neutral zone—a state of dormancy—where old behaviors and attitudes fade and people internally prepare themselves before venturing into an unknown realm where the rules and limits are not fully known. Only after completing the first two phases can people embrace the third: beginning again with a new purpose, outlook and identity (Bridges, 1993). In one organization, all staff were invited to participate in a ceremony to honor and let go of the "old way." It was a time for memories and stories, honoring their work, wisdom and the completion of a chapter. It recognized the past as a necessary experience for moving forward, together, to a new and different place.

Resistance to change is generally based on loss of identity, fear of the unknown or lack of trust. Habits, attitudes, assumptions and beliefs are components of identity, which

are challenged when people are asked to change. Giving up the “way we always do things” is difficult for two reasons. First, because habitual behaviors and patterns are by nature predictable and offer stability and second, because imbedded in the process of giving them up is the notion that one is being disloyal to a deep attachment—an underpinning of identity. Because change triggers a re-definition of identity, it also can raise questions about competence (Heifetz and Linsky, 2002). Resistance is a symptom of the underlying combination of fear, loss, disloyalty or challenge to competence. The remedy is to proactively and systematically build trust.

The Reinas’ Transactional Trust model offers rich insight. Trust is a value that is often communicated in the abstract. It is emotionally provocative, highly complex and can mean different things to different people. When change is called for, the message that “what we are today is not good enough” is often internalized as a betrayal. This is particularly true in environments where patterns of communication, collaboration and involvement are ineffective. When people experience betrayal, their capacity for trust declines and they begin to lose a sense of self. Messages about change need to reach for the higher purpose of striving to be better. Resistance is often a reflection of lack of trust in the process or the fact that people don’t yet trust themselves to move to the new territory. One organization found that staff resistance was minimized when patient and family advisors spoke from their hearts and opened a discussion about the need for change. Capacity to trust can be increased through understanding, clear expectations and goals, and building competency and confidence. Transactional (reciprocal) trust is created incrementally by actions that enhance character, capability and ethical truth (Reina and Reina, 1999). At the heart of transformation lies the healing and building of relationships based on trust—a cumulative, long-term process.

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## Receiving the Boon

The boon is the realization of the goal of the journey. There is a recognition that all the previous steps served to prepare the organization for this benefit, and in many myths the boon is transcendent, like the elixir of life itself. Joseph Campbell believed that what is sought is the “experience of being alive, so that our life experiences on the purely physical plane will have resonance within our own innermost being and reality . . .” (Campbell and Moyers, 1988). Taken in that context, the boon of the transformative journey for health care organizations is in harnessing the healing power of the new culture to benefit patients and the excitement of what the future may hold for the organization.

As the journey culminated and momentum increased, leaders observed and were offered evidence that their organizations’ cultures were changing. There were tangible metrics showing improvements in patient and staff satisfaction, vacancy rates, agency use, turnover, recruitment, quality indicators, productivity, volume and market share. And then there were a flood of anecdotal examples of the human impact: people willing to speak up, people using the language, public testimony by staff, staff volunteering to participate, saying “we are ready,” telling stories about spending more time with patients, holding each other accountable, physicians engaging in problem solving and patients offering unsolicited testimonials of personalized care. In describing the climate of the organization during this transition point, the word “trust” was called out again and again, underscoring the importance of transactional trust in creating a vibrant culture. There were additional descriptors of decreased resistance, lack of blame, an absence of arguments or defensiveness, seamless calm teamwork, interconnectedness, responsiveness, engagement, visible pride and palpable excitement. People were continually affirming the importance of working together. A new threshold had come into view.

As new habits and identities began to take root, the new culture moved from legitimacy to authenticity. The change, according to those who lived it, was palpable. A culture of authenticity is first being true to one’s own self and being what you say you are to others (Gilmore and Pine). When a critical mass holds a shared identity, language and accountability, the result is nothing less than a social epidemic—it has reached a tipping point. Epidemics are strongly influenced by the circumstances and conditions of the environment in which they operate, and human behavior is no exception (Gladwell, 2000). Not only do behaviors become contagious, but the collective accountability factor kicks onto autopilot: a self-correcting mechanism to adapt to a changing world.

When asked to describe the *culture of their organization today*, participants were resplendent in their characterizations. What they observed, as new behaviors and habits gained momentum, was an endlessly evolving culture. Once again, the themes expressed by the participants in describing the evolving culture were highly consistent: a *patient centered environment of healing* built upon *collective shared values* evidenced

by *prideful teamwork* and *trusting engagement* that continuously advances *quality improvement* and *innovation*. These are their words:

**A Patient Centered Environment of Healing** promotes a culture of professionalism, and means that patient relationships are primary, the patient is the center of decision making; and staff always doing the right thing for the patient, no matter what.

**Collective shared values** drive the organization, are based on clear principles, support intentioned values based behavior, drive the mission, create alignment, focus on quality; provide a touchstone for decision making, mean that all staff focus on the patient and each individual contributes to the whole.

**Prideful Teamwork:** cohesive, collaborative, purposeful, mutually respectful, professional, sense of community, multidisciplinary, shared identity.

**Trusting Engagement:** truthful, honest, effective communications; genuine, authentic, constructive interactions; transparent, participative, less competitive environment of robust openness; empowerment; high expectations and performance; a vital, engaged culture of accountability

**Quality Improvement:** continuous, focused, constantly raising the bar, a culture of safety, outcomes driven; zero defects; data driven; continuous measurement; values the patient; health care that works, is safe and leaves no one behind

**Innovation:** flexible, creative, adaptable, resilient, a vessel for experimentation, progressive, improved planning, risk-seeking, a learning organization, entrepreneurial, action oriented, excitement, always looking to the future

Organizations have actively employed infrastructure to support integration and ongoing engagement. Some examples include the development of new or flattened structures to support decision-making (shared governance, patient and family advisory councils); new human resource practices (hiring, orientation, training, service standards and performance evaluations, recognition programs, rewards and gain-sharing programs for all employees); systems improvements (supplies, resources, real-time safety alert system, reduction of waste, elimination of outdated policies), use of new technology (electronic medical records, portable phones) and new operations practices (no layoff policy, management physically on patient care units 50% of time). In one medical center, staff are regularly assigned to the Kaizan promotion offices, which support the integration of quality improvements. In several other organizations, patients and family members serve as advisors on councils, hospital committees and task forces. A few organizations have elevated the Human Resource department to support and grow their human capital or created gain-sharing programs for all employees: tangible rewards for achieving collective goals. Infrastructure creates form, which serves to reinforce new behaviors and habits and increase sustainability.

Measurement is a tool that 100 percent of participants use to benchmark and gauge progress. Because behaviors link to process, measures often serve as proxies for underlying changes. Common metrics include patient, employee, physician and community satisfaction and loyalty; continuity of care; clinical, safety and other quality



outcomes; patient and employee referrals; turnover, vacancy, injury; and agency use; training, education and development activity, financial measures of productivity, profitability, market share, length of stay and volume. Many of the organizations represented currently exceed comparative national benchmarks in satisfaction and quality, have waiting lists for employment, and enjoy minimal turnover and robust financial measures. What is absent is a comprehensive analytic process to tie the various measurements (satisfaction, clinical, safety, workforce vitality and financial) together to correlate interdependencies or make meaningful comparisons across organizations. In the long run, this type of research may lead to a better understanding of sustainability.

Measurement, rooted in a scientific approach, can be a useful tool. But it is also important that the means do not become the end. We live in a world that places tremendous emphasis on achieving results and adopting new technology, but must take care to distinguish form from substance (Heifetz and Linsky, 2002). When the leaders of these 40 organizations answered the “call to adventure” to create a healthier culture, it is doubtful that their motivation was driven purely by numbers. Instead, they reported that answering the call to adventure was the “absolute right thing to do.” Organizations that have “received the boon” know at a collective, unconscious level that what they have achieved is far more than what numbers prove; it is about creating meaning.

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## Sustaining Momentum and Passion

Almost without exception, participants described the *culture of today* as continuing to evolve, still in transition, “a 10-year work in progress” and “clearly a long-term investment.” Many admitted the journey would never end; “it becomes a way of life.” In the traditional cycle of renewal there is a natural repetitive sequence that includes germinating, emerging, thriving, harvesting, a return to germinating—and beginning anew. Change resolves old challenges and inherently creates new ones, which in turn create opportunities for growth.

When asked *what work still remains in the short and long term*, participants identified many areas for continued improvement that fall into the following groupings: people, integration, systems, sustaining momentum and uncharted territory.

**People** developing new champions, behavioral interviewing, ongoing training and development for all, leadership mentoring, succession planning, employee health and wellness, understanding the DNA of next generation leaders

**Integration** standardizing evidenced based practices, increasing physician engagement, establishing more effective incentives and rewards, hospital wide shared governance, increasing patient involvement

**Systems** to create alignment, restructuring systems for patients without “care partners,” detecting early warning signals, measuring the costs of failures and benefits of reliability, better comparative data, building infrastructure, use of information technology to support goals, developing networks and partnerships for information and experimentation

**Sustaining Momentum** fostering restlessness, “raising the bar,” constantly improving and innovating, “never accepting that we are good enough,” delivering on the promise to our patients, relentless rigor, sustaining credibility, building identity, advocating for public disclosure, never losing sight of values, seeing through the patient’s eyes

**Uncharted Territory** ever-changing patient expectations and needs, establishing new industry standards and benchmarks for safety/satisfaction/workforce vitality, focusing on the safety net, addressing the needs of the poor and mentally ill, recreating the entire U.S. health care system, remaining open to all possibilities

In the ongoing cycle of renewal, when new challenges arise, a values-based culture has a touchstone reflecting the communal destiny. Rituals of public celebration and storytelling help weave and embellish the tapestry of shared assumptions, attitudes, values, beliefs and collective memories that become the cherished customs of an organization. Imbedded in the concept of cultural sustainability is the pattern of succession: passing the passion and leadership from generation to generation. Patients and families who serve as volunteer advisors willingly share their stories and time. Their motivation

comes from wanting to give back to those who cared for them, and their insights, perceptions and suggestions provide reinforcement for sustaining and continuously improving the evolving culture. One hospital regularly creates internal videos of patients, families, staff and physicians sharing the moments of the human connections where healing occurs. Shown publicly, the storytelling touches an emotional nerve, reinforcing both their success and shared values.

Organizations whose journeys commenced recently (3 years or less) or that had a single dominant leader shared concerns about sustaining the transformation should the current leader depart. But several organizations whose original leader had retired or moved on reported a seamless transition. In general, the hiring authority (often the board) was well aware of the cultural values and recruited a replacement that shared the same values. In a number of situations, because of leadership development efforts, a successor was promoted from within, fulfilling the promise.

Health care organizations are unique. They exist to provide care and services to people during some of life's most vulnerable moments. Because culture is a community affair, investing in and caring for the organization's people is the core of sustainability. When seeking and welcoming new members and guiding and empowering the next generation become time-honored community norms, the cycle of renewal pulses its rhythm at the heart of the organization. Everyone's role holds meaning and promise. Unspoken truths are honored. Like the emotion that arises when hearing a beautiful song, culture is internal, yet palpable as it becomes as an instrument of healing.

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## Offering the Gift to the Community

The willingness of participants to share the accounts of their journeys—the trials, lessons and gifts—was an example of generosity. When participants were asked to look back, with full hindsight, and consider *what actually allowed the transformation to occur*, the story evolved, over and over, in the same way.

*“At a moment in time . . . there existed an intuitive awareness . . . that the time was right for change . . . and that providing every aspect of care from the patient’s perspective and . . . always doing what is best for the patient . . . is at the core of our values . . . our mission . . . our vision. The leadership lived it . . . demonstrated personal conviction . . . believing in our people . . . unleashing their creativity . . . and a desire to be better. We had a strong team . . . made up of the right champions . . . and beneath the surface . . . there were the values . . . alignment . . . and trust. But it was always about the patient.”*

When asked what advice they would offer to other leaders who might be considering embarking on a transformative journey, participants reinforced all of the concepts previously explored (leadership commitment and support, team alignment, assessing current reality, defining desired change, shared vision and values, engaging the workforce, involvement and ownership at all levels, guiding change, removing obstacles, letting go, learning from mistakes, building trust, honest and consistent communication, and time). In addition, they offered this advice based on their experience:

- Be passionate, personal, persistent, and patient. Don’t give up.
- A healthy, thriving culture drives performance.
- Be bold. Don’t worry about those who think you’re crazy.
- People will go where value is added.
- Maintain the safe vessel for your people; protect against centrifugal force.
- Hold up the mirror for others to see.
- Try different things; small steps, early wins, major hits. If you fall, get back up.
- To change the culture of your organization, you must be willing to change yourself.

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## Recommendations

This paper describes the complex nature of organizational culture and its role in health care organizations. There is a respectful recognition that lasting change takes time. The participants in this project have demonstrated with conviction that culture is a determining factor in organizational performance and workforce vitality. Their collective journeys provide a story about the essence of health care organizations and their ability to transform themselves into thriving workplaces that exist to serve the needs of patients and their families.

Culture is the underpinning that makes some health care organizations exceptional. Clearly, much is known that can be shared immediately, and there is more that needs to be understood and discovered. As the Robert Wood Johnson Foundation once again imagines a new future for health care organizations and the people who depend on their care, the operative question is:

**What should the foundation do now to stimulate or support the process of cultural transformation in health care organizations?**

- What steps can be taken to stimulate patient-centered, quality-oriented transformation in other organizations?
- What leverage points offer the greatest opportunity for culture change?
- Are there resources or infrastructure that could facilitate culture change?

The following recommendations are offered for consideration:

1. *Sponsor a health care cultural transformation confab with existing patient and quality focused organizations involved in cultural transformation to leverage change, create a critical mass and consider joint ventures*

(e.g., ANCC Magnet Recognition Program, Baldrige National Quality Program, Baptist Healthcare Leadership Institute, Birchtree Center for Healthcare Transformation, Disney Institute, Institute for Family-Centered Care, Institute for Healthcare Improvement, Lean Enterprise Institute, the Pebble Project of the Center for Health Design, and The Planetree Alliance)

- Explore common ground, efforts and short-term goals
- Share information on size of networks and annual meetings
- Identify the gaps that need more attention or innovation
- Brainstorm common long-term goals and opportunities to collaborate

2. *Create a health care culture collaborative of “most promising practices” to better understand the different approaches to transformation*
  - Facilitate cross-talk and information sharing between promising practices
  - Fund continued development, efforts to sustain culture and next generation innovations in culture
  - Require these exemplars to share knowledge in #3 and #4 below
  
3. *Showcase lessons from health care culture promising practices (different models and approaches) to disseminate information to a wide audience and stimulate interest and adoption*
  - Sponsor presentations at national conferences
  - Co-sponsor regional forums with regional and local foundations
  - Leverage articles in national journals
  - Create roadmaps: transition processes, tools used, life cycle stages
  - Post lessons, resources on the Internet
  - Create a resource network for information and innovation sharing
  
4. *Provide matching competitive grants in partnership with local foundations to safety net providers to support them in achieving meaningful culture change for America’s underserved.*
  - Create pilot programs that can serve as replicable models for other safety net organizations.
  
5. *Develop partnership programs with existing health care leadership programs and fellowships across the country to provide curricula and projects that:*
  - Examine and explore different approaches to culture change
  - Evaluate the impact of patient and family involvement on clinical and business outcomes, staff development, facility design.
  
6. *Sponsor planning grants to explore various organizational assessment and outcome measurement tools and the value of comparative measures as they relate to culture’s impact:*
  - Compare and test various organizational assessment and readiness tools in a cross section of organizations
  - Examine the impact of degree of staff participation and engagement on measurable outcomes and sustainability
  - Analyze multiple outcome measurements (personal, clinical, safety, workforce vitality and financial) to correlate interdependencies and compare sustainable outcomes across organizations.

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## Appendix A

### Participant Organizations

Adventist HealthCare, Rockville, MD

American Association of Critical Care Nurses

Ascension Health, St. Louis, MO

Aurora Health Care, Milwaukee, WI

Bronson Healthcare Group, Inc., Kalamazoo, MI

Clinica Campesina Family Health Center, Denver, CO

Denver Health, Denver, CO

Georgetown University Hospital, Washington, DC

Griffin Hospital, Derby, CT

Hunterdon Medical Center, Flemington, NJ

Inova Health System, Falls Church, VA

Jersey Shore University Medical Center, Neptune, NJ

Jewish Healthcare Foundation/Pittsburgh Regional Healthcare Initiative,  
Pittsburgh, PA

Johns Hopkins University and Children's Center, Baltimore, MD

Massachusetts General Hospital, Boston, MA

Medical College of Georgia Health System, Augusta, GA

Methodist Hospital, Houston, TX

Mid-Columbia Medical Center, The Dalles, OR

Mountain States Health Alliance, Johnson City, TN

Nebraska Medical Center, Omaha, NE

North Shore-Long Island Jewish Health System, New Hyde Park, NY

North Valley Hospital Foundation, Whitefish, MT

Ohio State University Medical Center, Columbus, OH

Prairie Lakes Healthcare System, Watertown, SD

Robert Wood Johnson University Hospital, New Brunswick, NJ

Robert Wood Johnson University Hospital–Hamilton, Hamilton, NJ

Saint Alphonsus Regional Medical Center, Boise, ID  
Sentara Birthing Center, Virginia Beach, VA  
Southwestern Vermont Medical Center, Bennington, VT  
St. Joseph Health Care System, Orange, CA

University Hospital, Cincinnati, OH  
University of Colorado Hospital, Denver, CO  
University of Michigan Health System, Ann Arbor, MI  
University of Minnesota Hospital, Fairview, MN  
University of Pennsylvania Hospital & Health System, Philadelphia, PA  
University of Pittsburgh Medical Center & Health System, Pittsburgh, PA  
University of Rochester Medical Center, Strong Memorial Hospital, Rochester, NY  
University of Washington Medical Center, Seattle, WA

Valley Hospital of the Valley Health System, Ridgewood, NJ  
Virginia Mason Medical Center, Seattle, WA

WakeMed Health & Hospitals, Raleigh, NC  
Weill Cornell Physician Organization, New York, NY

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## Appendix B

### Culture Interview Guide

How would you describe the culture of your organization today?

Your organization consciously created this new culture . . . how would you describe the previous “culture” from which you are evolving?

What was the primary motivation for creating a new culture in your organization?

Who led the charge?

Did it have a name (internal or external)?

When did the cultural transformation process begin? How long did it take?

Describe the process that was undertaken to create the new culture.

What were the key elements in “transforming” the culture? In your opinion, what were the top three elements critical to transformation?

As you continued on this path, what evidence did you have that the culture was changing?

Was there a turning point for the organization? When did you and others know it had shifted from the old to the new?

Did anything occur that was unexpected?

Looking back, what do you believe allowed the organization to reach for/achieve this goal?

How important was timing?

What resources were necessary to support the process?

How would you describe your organization’s readiness to change today? Give me an example.

How does your organization foster innovation today? Give me an example.

What work still remains?

What is required to sustain this culture over time?

What are you measuring/monitoring? How is that information shared?

What would happen today if (leader who led change) left the organization?

What advice would you give to a colleague that wants to influence or change the culture of his/her organization?

What other organizations, books or articles inspired you or provided useful information?

Is there anything I should have asked you that I did not?

What could the Robert Wood Johnson Foundation do to stimulate or support cultural transformation in other health care organizations?

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