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ORGANIZATIONAL CULTURE IN A TERMINALLY ILL HOSPITAL

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Summary

This study analyzed an organizational culture in a community hospital in Texas to measure organizational culture change and its impact on Patient Satisfaction (PS). The study employed primary and secondary data, combining quantitative and qualitative methods for a case study. Participant observation was used and archival data were collected to provide a better understanding of the organizational culture and the context in which change was taking place. This study also applied a "Shared Vision" of the organization as the central process in bringing forth the knowledge shared by members of the community hospital who were both subjects and research participants. The results from the study suggest an increase in PS due to the shared vision of one subculture within the hospital. There were powerful subcultures in this organization based on occupation and specialization, and their interests and functional orientations were not conducive to a systems approach. Hospital management was conducted in "silos" and there was lack of feedback between organizational levels of the hospital, especially in financial management, with organizational dysfunctionality in reacting and adapting to the health care market.

INTRODUCTION

Hospitals as Organizations

The health care industry is broad, complicated, and fundamental to the United States economy. Its breadth encompasses numerous fields, including: medicine, general management, operations, finances, legal services, and information technology. The industry is complicated by its composition, and financial interests and incentives of many players, including patients, providers like physicians and nurses, hospitals and clinics, insurance, government, and endless technology supporters, such as the pharmaceutical, technological or equipment companies.

Public and non-profit service firms, hospitals, schools, churches, police departments, local, state and federal government agencies all share common characteristics of organizations. They are conceived as consciously coordinated units, composed of two or more people that function on a relatively continuous basis to achieve a common goal or set of goals (Robbins, 2001).

However, hospitals have been and continue to be one of the most complex organizations in existence (Rakich and Darr, 1983). The complexity of modern hospitals results from a number of attributes: (1) Wide diversity of objectives and goals for different personnel, professional groups and subsystems. Various segments of the hospital are responsible for, or involved in patient care, education, research, hotel service accommodation, and the carrying out of intricate medical and surgical procedures. (2) Diversity of personnel ranges from highly skilled and educated to unskilled and uneducated employees. (3) The hospital is in continuous operation, which requires high standby cost and causes substantial personnel and scheduling problems. (4) In many areas of the hospital there are dual lines of authority. Managers are responsible for

solving a wide variety of management problems, and physicians are independent contractors, over whom the hospital has no line of authority in the usual management sense. (5) The hospital often deals with problems of life and death, which adds a special psychological and physical stress level; and finally (6) there is a problem in measuring the major product. Patient care quality rendered in hospitals has eluded precise measurement (Rakich and Darr, 1983). Furthermore, in particular patient satisfaction empirical research has demonstrated a number of problems, including lack of an accepted conceptual or theoretical model, methodological dilemmas, lack of standardized approaches to assess patient satisfaction, and need of consensus with the medical profession on what role patient satisfaction should play (Arahony and Strasser, 1993).

Organizational Culture

Basically, organizational culture is the shared personality of the organization. Organizational culture is comprised of the assumptions, values, norms and tangible signs (artifacts) of organizational members, and their behaviors. Members of an organization soon come to sense the particular culture of an organization and management may direct or otherwise support it. Culture is difficult to express distinctly, but everyone knows it when he or she senses it. For example, the culture of a large, for-profit business corporation is quite different from a hospital, which is relatively different from that of a university. The culture of an organization can be indicated by looking at the arrangement of furniture, what members brag about, what members wear, similar to what can be used to get a feeling about someone's personality (McNamara 1999). It generally refers to a shared system of beliefs, values and norms about the way the organization functions, or "the way we do things around here" (Deal and Kennedy,

1983); or norms of behavior and shared values among a group of people (Kotter, 1996). Shared

values are important concerns and goals shared by most of the people in a group that tend to

shape behavior, and often persist over time when membership changes. Regardless of the level

or location, culture is important because it can powerfully influence human behavior, but it can

be difficult to change and it is nearly invisible, making it hard to address directly. Generally,

shared values, which are less apparent but more ingrained in the culture, are more difficult to

change than norms of conduct (Kotter, 1996).

Core values of organization culture

There has been much discussion about organizational values—bringing them to work,

running a company based on them, passing them onto employees. However the important thing

about values is really putting them into practice or "walking the talk" or "leading by example"

(Kotter, 1996, p. 95). In health care, the visual clues about the hospital's institutional core values

and the quality of care are particularly difficult to separate from actual service, because patients

spend significant time in the facility, and some can stay for days or weeks. At the Mayo Clinic,

long recognized for quality of care, management understands that the way employees present

themselves sends a strong message to patients. They have clearly identified a set of core values,

which gives a consistent message, and then manage the evidence, the facility, the approach to

care, even the shoelaces of workers to support that message, day in and day out. Mayo Clinic

encourages this type of culture, and by having all physicians salaried, it avoids the competition

of referrals, downplaying individual accomplishment in favor of organizational achievements. In

the words of one cardiovascular surgeon "By not having our economics tied to our cases, we are

free to do what comes naturally, which is to help each other." Another physician adds "The kind

of people that are attracted to work at the Mayo clinic have a value system that places the care of those in need over personal issues such as salaries, prestige and power" (Berry and Bendapudi, 2003, p. 104).

Organizational Change

Powerful macroeconomic forces are at work, and these forces may grow even stronger over the next decades. More and more organizations today face a dynamic and changing environment. This in turn is requiring these organizations to adapt to reducing cost, improving the quality of products and services, locating new opportunities for growth and increased productivity (Kotter, 1996). "Change or die" is the rallying cry among managers worldwide (Robbins, 2001).

Today, health care organizations face constant change. Their success or failure depends upon how well health service managers understand the change process, diagnose organizational problems and present appropriate solutions. Healthcare executives are involved in various types of changes and innovation, ranging from introduction of new pieces of equipment or programs, to redefinition of goals of the organization. Powerful forces for change are at work in healthcare, due in part to the implementation of the managed care system, DRG system, the Balanced Budget Act of 1997 and many more. As a result, hospitals have been pushed to reduce cost, improve the quality of services and products, improve customer service, and locate new opportunities to growth and increase productivity.

The purpose of this study was to analyze an intended change of customer driven service culture, articulated by strategic management, occurring as a result of developing and

implementing social activities and training that staff considered beneficial in a community

hospital in Texas. This article is focused mostly on Patient Satisfaction (PS); the concept of

shared vision is fundamental to analysis of the implementation of the intervention, and is applied

in discussing the results, and linked to the general conclusion.

METHODOLOGY

This study was done in a stand alone, non-profit, 46 year old, teaching hospital in Texas.

The facility was a 150-299-bed hospital, and was the primary teaching hospital for a local school

of medicine. The study employed primary and secondary data, combining quantitative and

qualitative methods for an embedded longitudinal single case study. The field experiment was an

organizational intervention, from January 1, 2003 to December 31, 2003; this intervention was

conducted with the approval, participation and financial support of the hospital for necessary

activities, interviews, provision of materials, supplies and clerical support. The intervention was

entitled "Route 99", an organizational endeavor to achieve 99% excellence in four selected core

organizational values, defined as "Pillars of Excellence" (Studer, 2002). These values were: best

service based on PS, best quality, best people and low cost. In addition a shared vision between

the Directors and VPs was developed "To be the first choice for health care" and was agreed to

start and focus with PS first.

By choosing to conduct a case study to develop grounded theory, this research attempts

to reveal multiple aspects of organizational culture and change processes in a community

hospital.

Qualitative research was performed using participant observation, interviews,

observational notes on team behavior and senior leader behavior. The researcher conducted

active participatory research with all levels of the organizational structure--from CEO to grassroots employees--and in particular with the management team of Route 99.

In order to cover the research questions from several angles, the researcher conducted two sets of open-ended semi-structured interviews in the organization. The time length of interviews ranged from 35 minutes to 45 minutes. Most questions were asked directly, although some were covered in the respondents' elaboration on earlier questions and not asked directly.

The first set of interviews was conducted on month 6 of the intervention, to assess the penetration of the concept of Route 99 and change of culture in the organizational staff members. A total of 162 participants were interviewed with the first set of interviews, which included all levels of hospital staff, from physicians to janitors and labeled "Interview from employees" in the result section.

The second set of interviews was conducted to assess organizational culture. The inclusion criteria were: any person who was a member of the Executive Team (CEO, CFO, Medical Director, Chief Nurse, and VP for Community Health), the Chairman of the Board, and other members of the Board of this teaching hospital, senior administration of the university affiliated with the hospital and volunteers of both institutions who had an extensive knowledge of the hospital's culture or who had known the hospital founders and their vision. A total of 29 participants were interviewed and labeled "Culture Interview" in the result section.

Quantitative analysis was performed using an external agency's PS scores and percentiles from the Inpatient and Outpatient care areas, from the period of January 1998 to December 2003, to measure intended organizational change and its impact on PS articulated with Route 99, and to compare with prior interventions. The benchmark chosen for this study in PS was the overall database of hospitals using the same metrics reported by the hospital's Quality Management

office. The scores were reported as mean scores based on a Likert scale, along with correlations between each question of the survey instrument and overall satisfaction score.

In addition, two types of analysis of a survey instrument of 12 questions were conducted. The survey, conducted at the Kick Off event and at month 7 of the intervention was provided by the hospital, and administered to 600 employees, to assess the needs of the staff during the intervention. The analysis included overall frequency for each of the 12 questions and comparisons between categories in the chain of command. The survey was anonymous and no demographic data were collected. Because lapsed time was long enough (seven months), it was assumed that both samples were independent. The five variables or choices for each question were Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D) and Strongly Disagree (SD), and were aggregated into two main sub categories, SA-A and N-D-SD, following participant research with the suggestion and criteria of the Steering Committee of Route 99. Chi-square was used to assess difference of opinion between the layers of hierarchy of the organization at each event and also to measure change in time within each category, but using the non-parametric Kruskal-Wallis test.

Three research questions were examined:

Question 1: Was organizational cultural change affected by leadership change, cost cutting change or structural change?

Question 2: Did the hospital develop a shared vision and common core values and become a learning organization through Route 99?

Question 3: Did the **"**Route 99" intervention enable cultural change towards customer friendliness?

Quantitative data were collected and analyzed using SPSS. Triangulation of the quantitative and qualitative information through convergence or divergence of data sources and methodologies was employed described by Denzin and Lincoln, 1994, and Yin (2003), (Figure 1).

[Insert here Figure 1, triangulation]

As shown in Figure 1, adapted from Yin (2003), triangulation of evidence in a single case study results from convergence of information gather from multiple sources and methodologies. There may be an overall convergence of the "weight of the evidence" even when sub-component of the study experience non convergence.

RESULTS

Quantitative results

The scores and percentiles of PS were adopted as the main measurements to improve PS throughout all the hospital units and quarterly reports presented in the management team of Route 99. This was addressed at some of the Director Leadership meetings of the hospital and incorporated in the agenda of the Board in June 2003.

Patient Satisfaction scores and percentiles reported quarterly by the QM office are shown in Figures 2 and 3 trend lines for Inpatient and Outpatient departments from January 1998 to December 2003, respectively.

The 1998-2003-trend line for Inpatient scores and percentiles showed a minor decline of Patient Satisfaction from the fourth quarter, 2002 from the 12th percentile to the 10th percentile reached in second quarter, 2003. The percentiles of the third quarter of 2003 reached the 24th and 30th percentile in the fourth quarter, which were the highest measurements since the second quarter of 2001, with the same percentile, and the score for the fourth quarter of 2003 reached

82.3, which was the highest point since the third quarter of 2000 with 83.4, prior to a Full Time Employees (FTE) reduction (Figure 2).

[Insert Figure 2 here, Inpatient percentiles]

The Outpatient percentiles showed a more reactive line, with first a decrease from the 17th to 12th percentile in the first quarter of 2003, to an increase to the 57th percentile in the second quarter, 2003. This was the second highest percentile and the highest score in six years (Figure 3). There was no change in the third and fourth quarters of 2003, with both at the 29th percentile; however, the scores reported 88.7 and 88.8 respectively, representing the second highest scores achieved in six years, only below the second quarter, 2003. The scores for the second, third and fourth quarters showed 89.9, 88.7 and 88.8 that were the highest scores collected ever (Figure 3).

[Insert Figure 3 here, Outpatients percentiles]

Pre- and Post-test of the Needs Assessment

The pre-test of the needs assessment survey was administered at the "Kick Off" event of Route 99 in February 2003 and the post-test was performed seven months later in September 2003. Overall, 600 surveys were collected, two thirds for the baseline and one-third at follow-up. The survey recorded only an employee's level within the organization with a distribution of 56.7% Employees, 9.2% Supervisors and 4.5% Directors or above. There were 178 cases or 29.7% who did not identify their category and were labeled as unknown, 169 of which were from the baseline survey. This category was excluded when the analysis was performed comparing pre-and post-test analysis between the three employee categories, to assess difference of opinion between levels within the organization, and to assess pre/post change in each of the categories and between categories (Table 1).

[Insert here Table 1]

Specific results from the employee and supervisor level will be reported elsewhere.

At the "Director or above" level there was a statistically significant difference in three questions in the pre-and post-test. These questions were: (1) "Do you have material and equipment at work"; (2) "At work do you have the opportunity to do your best" and (3) "Are your coworkers committed to do quality work" (Table 2).

[Insert here Table 2]

Qualitative Results and Triangulation

The results were triangulated for each hypothesis in order to reject it or not, with a multi factorial analysis or convergence of evidence, as described by Yin (2003) and shown in Figure 1. The conclusions at the end of question are based on the strongest evidence available at the time of the analysis, in the context of this hospital and in corroboration, which provided brackets of findings, simulating confidence intervals.

Question 1: Was organizational cultural change affected by leadership change, cost cutting change or structural change?

Supportive Evidence

Leadership:

1. From participant observation, public observation and institutional literature. There was a change of leadership in May 2003, with the resignation of the CEO, at the fifth month of the intervention and in February 2004, two months after the intervention in the financial leadership, specifically the CFO, who was fired.

2. From public observation. The interim CEO presented a series of Town Hall meetings in June 2003 to inform the staff of the financial situation, in particularly the long-term debt of the

health system, which was unknown to most employees. He presented the names of the owners of the debt, the future steps of the strategy and the options to follow: continue to be a stand alone hospital, to merge with a chain of hospitals with the best offer or to find a middle-range solution with a capital investor in a joint venture. This was a change of communication of public knowledge, and feedback on the financial health of the hospital, from the interim CEO to the grassroots, in the organizational culture.

3. From participant observation and public observation: The interim CEO, frequently attended the Steering Committee meetings and at the social events of Route 99. The attendance by a CEO in this type of events was a change of leadership style in the culture of this hospital.

   Structure

1. From participant observation, public observation and institutional literature. There was a separation from the position of CEO and Chairman of the Board to two separate positions and the CEO reporting to the Board; therefore there was change in the leadership structure for first time in 12 years in this hospital. Until the end of the organizational research, December 2003, there was a new Interim CEO and a Chairman of the Board, who was the former CEO.

2. From participant observation, public observation and institutional literature. There was a change in the health system structure, with the closure of non-profit outpatient units such as the outpatient pharmacy and the Fitness Center in 2002, the Home Medical Equipment in November 2003 and selling of all land properties, reserved for future health development facilities, close to the hospital in December 2003.

Cost cutting

1. From the pre-and post-test of the Needs Assessment. Statistical difference was found in the Director level in three questions on the pre and post-test after six months of the Needs Assessment. Directors or above had a statistically significant result in the question "Do you have material at work," a change from 93.3% of SA-A category, to 58.3% and an increase of the N-D-SD category, from 6. 7% to 41.7% (P=0.033). Also, this group had a statistically significant change in "Do you have the opportunity to do your best", with a decrease from 93.3% SA-A category, to 50% and an increase of the N-D-SD category, from 6.7% to 50% (P=0.03). Finally, it was found as well a statistically significant change, in the question "Are your coworkers committed to do quality work", with a change from 93.3% of SA-A category, to 58.3% and an increase of the N-D-SD category, from 6.7% to 41.7% (P=0.033) (Table 2).

2. From the pre-and post-test of the Needs Assessment. When analysis was performed between Directors vs. Employees in September, there was a statistically significant difference of opinion in the question "Do you have the opportunity to do your best", surprisingly with the directors more negative in their answers, N-D-SD, 50 % compared to 16.1 % of employees (P= 0.01). In addition, when the same analysis was performed in February set of surveys, between the same categories in this question, there was a statistically significant difference but in the opposite direction, therefore there was radical change in the opinions between Directors within the seven-month period (and who knew the cost cutting changes that were happening).

Non-supportive evidence

1. From participant observation, institutional literature and "Culture Interview". There was addition of structure with the official creation of the Steering Committee of Route 99. The Patient Satisfaction scores and percentiles were reported to the Board from June 2003, through the VP of QM and the Senior VP of Patient Care. However, when the Board was when asked, "What is Route 99", only three of eight (37, 5%) members interviewed knew Route 99 was a "PS endeavor or program". When they were asked, "Do you think Route 99 will change the current culture of the organization, 62.5% answered "No".

2. From institutional literature, artifacts, and participatory research. From the beginning of Route 99, finances were one of the fourth Pillar of Excellence, and were labeled as "low cost and fiscal responsibility", which was presented in the retreat of January of 2003. In addition, in this one-day meeting, "efficiency for the lowest possible price, quickness in adjusting to market and high productivity" was reinforced in the same presentation. However, since August 2002, the hospital management had begun a change of strategy, implementing proposed cost cutting changes from an external consulting company. This company assessed the first financial outcomes in October 2002 and did it again in February of 2003, declaring them as insufficient. In September of 2003, the interim CEO created the Office of Business Improvement and a professional was hired, who had the role of continuing the assessment of the consulting company in 40 metrics, most of them financial indicators.

3. When asked in the Culture Interview, "How is the organizational success measured?" financial success was the most frequent answer 82.8% by far, compared to Patient

Satisfaction. In the Vice-Presidents categories, which were the real managers of this hospital, financial success was answered in six of seven (85.7%) of the participants.

4. From the pre-and post-test of the Needs Assessment. In overall categories, there were no statistically significant change in any of the questions of the survey, pre and post-test after six months of the intervention and especially in questions which could have shown dissatisfaction due to lack of resources.

 Conclusion, *Based on these three categories, there was a change of leadership and structure, which affected the organizational culture, but not in cost cutting, which was considered more a process than a change, so the question "The Organizational change of culture is affected by major change" can be accepted under these premises.*

Question 2: Did the hospital develop a shared vision and common core values and become a learning organization through Route 99?

Supportive Evidence

Leadership

1. From institutional artifacts and literature (minutes of Directors meeting). Route 99 achievements were incorporated into the monthly agenda and reported by members of the Steering committee. The scripting tool kit (for the core values), developed by this team, was presented in September, October and November meetings. In November, the VP of Patient Care addressed it directly to all the Directors and said "Representatives of the Steering Committee will meet with each Director to assist in tailoring scripts for individual departments" and the "culture change has to occur."

2. From participatory research, since June 2003, the VP of QM began reporting to members of the Board, the PS scores and percentiles. This achievement was also reported to the Steering Committee team.

Employees

1. From public observation and institutional literature. The hospital staff first began to add signs of Route 99 in many key areas of the hospital's walls, first, then the core values (for increasing PS) appeared in signs like traffic signs, attached to the walls close to the elevators in the six floors of the hospital. The dashboard with laminated sheets containing the same values for Patient Satisfaction was used. Employees, supervisors and VPs escorting people in all areas of the hospital were frequently observed. The elevator etiquette and telephone etiquette was changed as well, with a more customer friendly staff in many areas. Staff members, inside and outside of the hospital, used the Route 99 T- Shirt regularly on Fridays. The main hallway of the general public to the cafeteria was changed and materials from Route 99 activities were displayed with many pictures of the employees from all levels of the hierarchy, along with some of the social activities of Route 99. Traditional pictures of the employee and Director of the month were added into a frame with the sign of Route 99.

2. From the Interview from the employees, excluding physicians and weekend staff, 78.1% of overall participants, answered that it was a customer service program when they were asked, "What is Route 99". When they were asked, "Why is Route 99 important" 56.4% responded that it was to improve patient satisfaction, as such or in combination with another reason. When they were asked about their expectations about Route 99, 14.5%

had no expectation and 46.3% were related to improve Patient Satisfaction as such or in combination with another reason, and 39% answered another reason.

Non-supportive evidence

1. From the Culture Interview. When this group was asked "What is your vision of this hospital", 31% of overall answers were that the hospital lacked a vision or strategic plan, 24.1% responded that it was to provide a hospital based on osteopathic medicine and or philosophy and 10.3% expressed as "same as the founders". At the Vice-President level this was more evident with 28.6% (two of seven) thinking that the hospital lacked a vision, the same percentage answering that it was to provide a hospital based on osteopathic medicine and philosophy, with only one (14.3%) that expressed as "To be the first choice for health care" and the remaining (2) gave a different answer.

2. From participant observation and institutional literature. When the researcher asked what was the purpose of the retreat done in January the answer was "It was done to find how to get employees to become involved and have ownership of the hospital in PS and how to get more cooperation from the public and coworkers. It was not meant to be a financial strategy but a better PS would "translate financially", or as one VP mentioned, "I went only because I had to do it". The interim CEO never considered Route 99 a strategic plan neither did some members of the Board as mentioned before.

3. From the culture interview, participant observation and public observation, there was a lack of communication and fragmentation between upper management. Many units

not reporting to the VP of Patient Care Services were not interested in Route 99 nor in the shared vision.

4. From the Culture Interview. When the VPs were asked "Is customer service valued in this hospital", three of seven or 42.9% answered "Yes" and the same number of VPs responded "No" and one VP did not know.

5. From the Culture Interview: The most frequent values of the organization mentioned were quality of care 69%, education and teaching 31%, financial success 17.2% and commitment to the medical profession in 37.9% of the responders. When the Vice-Presidents were asked they answered in 85.7% or six out of seven interviewers, quality of care and financial success in 42.9% or three of seven VPs. On the contrary, when asked, "How is organizational success measured?" 82.8% of overall answered financial success with 85.7% of the VPs with the same answer. In contrast, when asked about organizational success with Patient Satisfaction, this category was mentioned in 31% of all the cases and in 28.6% by the VPs.

6. From the Culture Interview. "When asked, "How is organizational success measured" in this hospital, 24 of 29 (82.3%), interviewers mentioned financial success. At the Vice-President level six of seven (85.7%), mentioned financial success and at the member of the board level six of eight (75%) mentioned the same answer.

7. From the Culture Interview: When asked "Is Customer service valued in this hospital", 58.6% of the overall did say "Yes" compared to 31% that said "No" and 10.3% who said they did not know. This was very evident at the Vice-President level of this hospital in which 42.9% or three of seven responders equally thought "Yes",

42.9% thought "No" and one VP who did not know (14.3%). When asked of this same subpopulation, "What is Route 99", 100% recognized that it was a customer service or Patient Satisfaction program.

Conclusion: Based on convergence of facts and evidence presented at this point in time, there is enough evidence to say that the hospital overall failed to develop a shared vision and common core values and become a learning organization through implementing "Route 99".

Question 3: Did the "Route 99" intervention enable cultural change towards customer friendliness?

<u>Supportive Evidence</u>

Organizational Culture

1.   From public observation and participant observation. The Interim CEO in one of the Town Hall meetings in June 2003, to introduce himself and to explain the financial health of the hospital, mentioned the "terrible situation that is happening with patient satisfaction" and gave the example that "one bad experience is transmitted to 11 people and a good one is transmitted only to two".

2.   From institutional artifacts and archives (minutes of Directors meeting). Route 99 achievements were incorporated to the monthly agenda and reported at the Directors meetings. In November, the VP of Patient Care addressed it directly to all the Directors and said "Representatives of the Steering Committee will meet with each Director to assist in tailoring scripts for individual departments" and the "culture change has to occur ".

3.	From participatory planning. Since June 2003, the VP of QM began reporting the customer service scores and percentiles to members of the Board. This achievement was also reported to the Directors meetings.

Patient Satisfaction

1.	From quantitative data. The Inpatient PS scores, which compares the hospital scores as own benchmark and isolating environmental factors like improvements of PS in other hospitals, showed scores in the third and fourth quarters of 2003, which were the highest since the third quarter of 2001, and two values in the first and second quarter of 2003, which both were below the score of same quarters in 2002, previous to the intervention of Route 99 (Figure 2).

2.	From quantitative data. The Inpatient PS percentiles, showed the lowest percentile of the period 1998- 2003 in the third quarter of 2002 with a percentile of six, the lowest of the six year period tracked, which had a small increase initially after the intervention was started arriving to the 11th and 10th percentile the first two quarters of 2003 respectively. However in the third quarter of 2003 arrived to 24th and 30th percentile in the fourth quarter, which were the highest measurement since the second quarter of 2001, but way below from the period of the second quarter of 1999 to the third quarter 2000, when a similar endeavor took place in 1999 ("99 in 99") (Figure 2).

3.	From quantitative data. The Outpatient PS scores showed two values in the second and third quarter of 2003, which were the highest in the six year recorded period. The scores reported by QM for the second, third, fourth quarter 2003, showed the highest scores collected ever. Based only on scores there has been a constant improvement in

Patient Satisfaction for Outpatient since Route 99 began from the second quarter of 2003 (Figure 3).

Non-supportive evidence

1. From quantitative data. The Outpatient percentiles were shown to be more reactive than any other category, with an initial drop from 17th to 12th percentile in the first quarter of 2003, an increase to 59th percentile in the second quarter and drop to 29th percentile in the third and fourth quarter 2003. The increase to 59th percentile was the second highest in six years of retrospective follow up of the time period observed, only below to 61st percentile achieved in the fourth quarter 1999 (Figure 3).

2. From the Interview with all the employees, 51.9% of the total employees answered that Route 99 was not affecting their day-to-day operations; 80% and 70.3% of the physicians and the weekend participants answering the same respectively, when analyzed alone. However when these two categories were excluded, the overall group gave a positive answer in 56.4% of the cases, either that Route 99 was affecting their day to day operations as a reminder of the core values, being more positive or improving PS.

Conclusion: Based on convergence of facts presented, there is enough evidence to accept the hypothesis "Route 99 can affect the organizational culture change to a customer friendly culture".

DISCUSSION

A number of changes occurring in the health care market place, including the growth of managed care, are forcing the senior management of health care organizations to

reexamine, reevaluate and redefine their strategies and operational plans. In the case of this hospital, the market competition area was vast, competitors had financial strength and were making major investments in their organizations; moreover the county market share for the hospital was around 5.5 %. One of the greatest challenges to health care organizations operating under financial constraints imposed by changing market conditions is to determine how to allocate scarce resources, to address the demands of the current market, while instituting changes that will help position the organization for future challenges as they arise.

The findings support the conclusion that there was a change in the culture towards customer service, using creative ways that were developed from the employees, to provide feedback to the front line staff for being customer-friendly and increasing patient satisfaction; this was basically indicated by the increase of the scores and percentiles of the patient satisfaction surveys. This change was dependent on the situation that "In today's healthcare environment, communication needs to remain two ways, with feedback from employees and combined with direction from leadership" (Warner, 1998 p. 1). As they shed light on a broad range of processes, roles, department and group behaviors, patient satisfaction surveys can identify quality management needs throughout the hospital. Employees, patients, families and other outsiders know when they are in a facility that is customer-friendly and when they are not. That was the intention and objective of this Route 99 management endeavor and the subject of this research. Route 99 also resisted change of leadership, which is a major change in any organization.

The findings rejected the development of a shared vision for the hospital. The vision of the CEO was "to be the best hospital", translated by the Steering Committee of Directors into a vision statement: "To be Your First Choice in Health Care", in September 2002. This statement

replaced the older version of the vision of the hospital on the ID badge of all employees of the hospital, including the physicians, actively supported by the CEO. On the other hand, the financial condition of the hospital was weak with a long-term debt between $80-90 million, and this fact was not presented as an issue in any of the many Steering Directors' strategic management meetings, even with the CFO and CEO present.

The owners of the long-term debt declared that the hospital was in technical financial default in April 2003, because it was not maintaining the required Adjusted Debt Service Coverage ratio of 1.15 for a long-term debt. The CEO and his team disputed this fact and decided to retire in May 2003, although he maintained the position of Chairman of the Board until the end of December 2003. A transition team in upper leadership was put into place, seeking an interim CEO. After finding him, the hospital began a process to be sold or merged with a capital investor or a public or private facility. It is not clear why this long-term debt was never communicated to the Director's level or to the physicians of this hospital, who did not know about it or understand the financial crisis. In fact after another "financial crisis" in FY 2000 (see figure 2), there was a general understanding, mostly among Directors, that the hospital was short of cash (but not why) and Town Hall meetings were held with the participation of the CEO in July and August of 2000, to communicate to the employees that the hospital was not going to close. In August 2002, financial goals were established to reduce cost, with a target of savings of $13 million.

The study had the support of the CEO to implement Route 99 and he contributed with ideas, financial support to the planning, implementation of the retreat of January 2003, and the Kick Off event in February. He attended both events and was active in the one-day retreat. However this strategic planning model was never officially presented to the members of the

Board as such, and was only presented to them as Route 99 by the Senior Vice President of Patient Services, along with another initiative for nursing recruitment.

There was lack of active support from the rest (3 of 4) of the Vice Presidents of the organization for Route 99, ranging from light or occasional participation to no participation at all and ignoring it, especially by the CFO. This strategic model Route 99 approach was always considered an "academic exercise" of the researcher. Nevertheless, it is not clear why the CFO and CEO did not communicate the weak financial position of the hospital to the staff.

There was a "paternalistic" shared vision of those in charge of the finances, or those who knew about it and could understand the financial health of the system in terms of "the overall picture", including the members of the Board. There was no feedback transmitted in the proper form to the middle management on "the overall picture". This could potentially have changed the vision, the culture and the general strategy in all layers of the organization, toward reaction and adaptation to the real financial condition and hostile environment of this health system. This is also consistent with the position of Bar-Yam (1997), who argues that feedback is essential in most systematic ideas about the actions of a system in its environment; learning, adaptation, evolution; all require feedback. The current view of organizations is based on adaptive learning, which is about coping. Senge notes that increasing adaptiveness is only the first stage; companies need to focus on Generative Learning (learning organization), which emphasizes continuous experimentation and feedback; or "double-loop learning" (Senge, 1990; Argyris, (1977); Argyris and Schon, 1978).

In summary, Route 99 had the support of the former CEO and the new interim CEO, in the context of a major organizational change and change of leadership, although most of the members of the Board did not know about it. This shows corroboration by the CEOs of the

project, but inconsistency of feedback between the highest layers of the organization. The project Route 99 started as a strategic planning endeavor, with a first step focusing on patient satisfaction, but never got the "buy in" of the rest of the members of the executive team. As soon as the former CEO left the administration of the hospital, the project lost the support from leadership to be a strategic planning endeavor and was put on hold as such, but the Patient Satisfaction endeavor was maintained.

There was a lack of buy-in to the innovation from the rest of the leadership and the board. This is in line with Senge's observation that even a leader with a clear vision may lack mechanisms for sharing the vision with the entire organization (Senge, 1990). In addition, there was fragmentation of the leadership team in terms of shared vision, and management by "silos," with the employees following the attitudes of each senior leader and their own sources of data. There were many subcultures, at the Board level, at the Executive Team and their employees, and even between the physicians from private practice and those from the medical school, with different visions regarding this organization.

However, the overall goal of the study was to analyze the strategic planning process, which in retrospect was an effective tool for evaluating how bad the strategic management in this hospital was. As discussed above, the lack of shared vision and commitment of the top leadership impacted all dimension of this hospital. The Service dimension, both Inpatient and Outpatient, were less than the bottom 33 % of hospitals included in the overall PS database used by the QM office; the financial dimension was very weak and the hospital was in technical default; and the hospital had negative growth in Inpatient, Outpatient and ER admission and visits respectively.

This endeavor to change the culture and align a shared vision could not change this hospital's fate due to organizational dysfunctionality in reacting and adapting to the health care market environment. To quote Beer, "change is happening all around us. It could yet leave us managerially unadapted, and at the end, extinct" (1981 p.5). Finally, the hospital closed in October 2004, laying off approximately 1000 persons, 300 doctors and 60 interns and residents. This elicited responses of surprise from many employees and the community in general, who thought that the hospital could survive or merge with a chain of local hospitals. As we mentioned before the rallying cry between managers was "change or die", and the latter was unfortunately the destiny of this terminal hospital.

The findings of this study could be used for future research in organizational behavior and culture of health care settings. Limitations included the following: the research is on one organization, so generalizability of results may be limited. Also, due to the limited time available for the study, the same units were investigated before and after the innovation was applied, but after only 12 months of implementation. Further analysis was not possible because the hospital closed in October 2004, with only two reports of PS that were not analyzed.

Health issues are endless and personal. Online banking users, for example, conduct online processes, such as transferring funds or requesting loans, regardless of their background. In hospitals, health problems and diseases are as distinct as every patient is different. These days, doctors, drug suppliers, pharmacists, medical device suppliers, underwriters, managers and other industry professionals are, more often than not, completely separate entities that run different, incompatible systems to accumulate and track, for example patient records. As a result, initiatives in healthcare have lagged behind those of other industries; however with soaring Medicare and Medicaid costs, the federal government is also pressuring the industry to

modernize. In other industries like the automotive, large customers regularly exert pressure on their suppliers for continuous improvements in quality and costs. This is just beginning in health care as large group purchasers want the health care organizations to improve their performance, but has not become standard industry practice so far, and PS is a good example of it. Finally, as shown in this case study, there are powerful subcultures in health care organizations based on occupation and specialization, and their interests and functional orientations are not conducive to a systems approach.

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Figure 1: Triangulation of Data and Methods

CONVERGENCE OF EVIDENCE
(Single study)

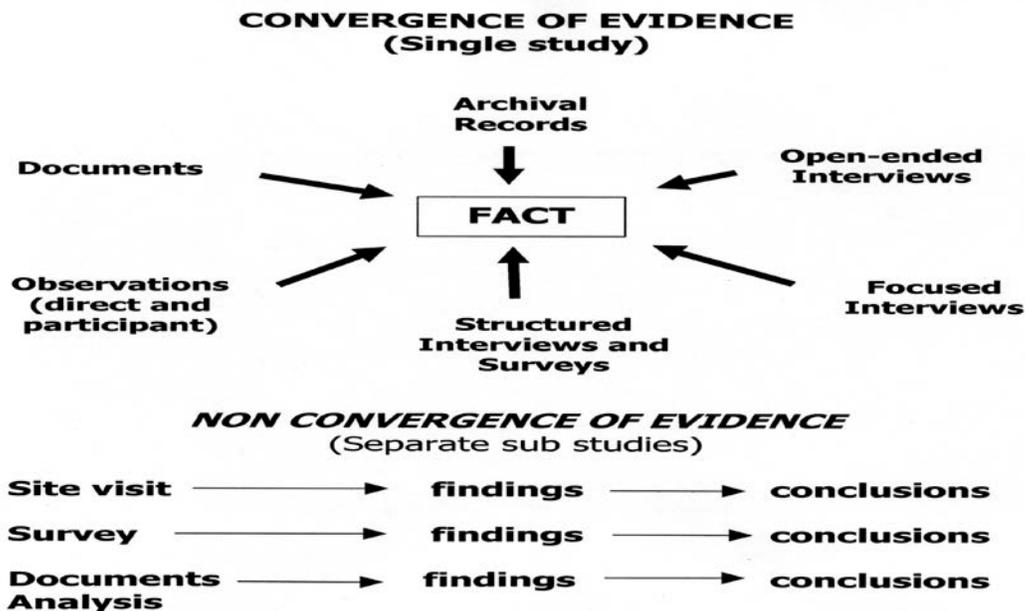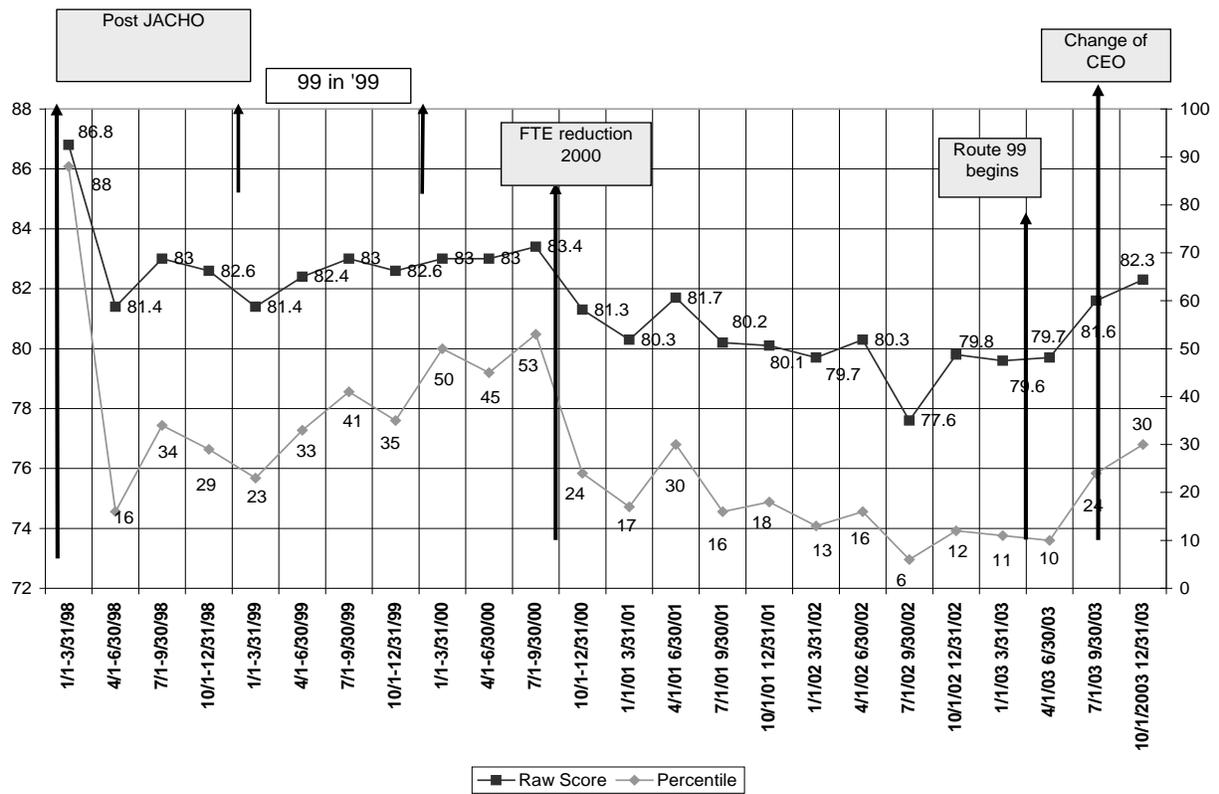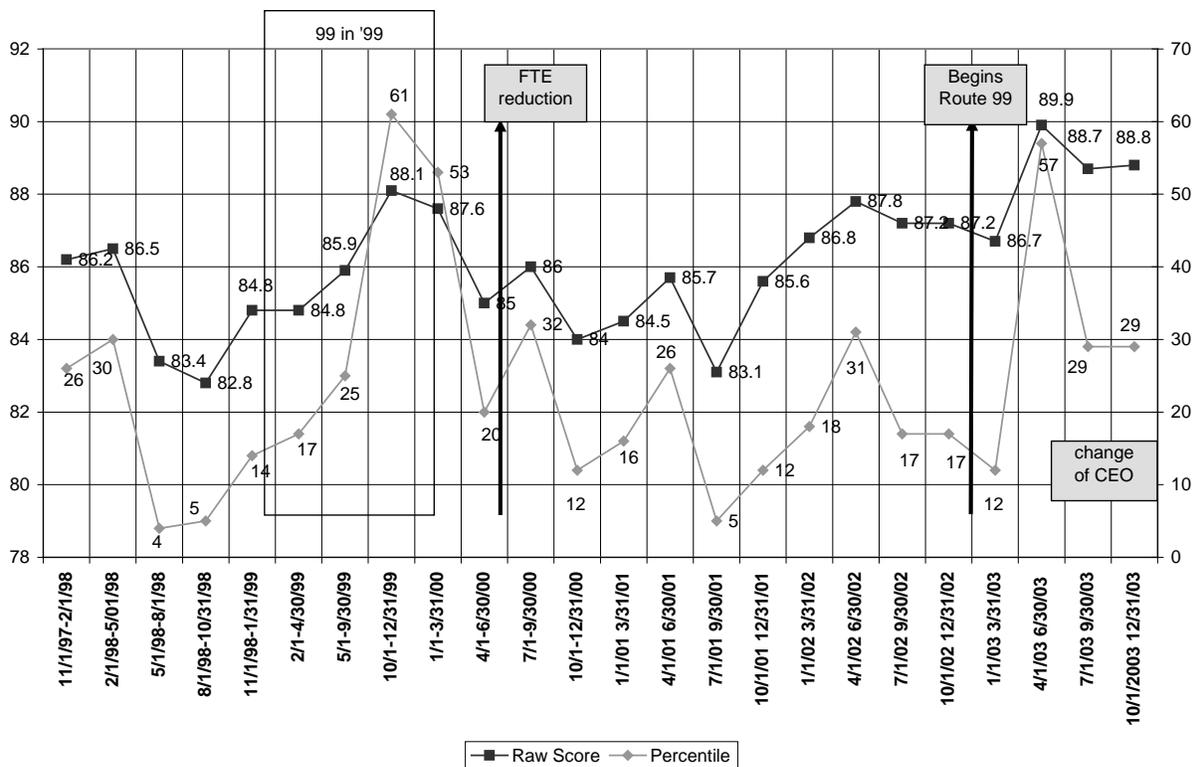NON CONVERGENCE OF EVIDENCE
(Separate sub studies)

Figure 2: Inpatient Patient Satisfaction Scores and Percentiles 1998-2003

Source: QM office, Texas hospital, January 1998-December 2003.

Figure 3: Outpatient Patient Satisfaction Scores and Percentiles 1998-2003

Source: QM office, Texas hospital, January 1998-December 2003.

Table 1

Pre and Post Test Need Assessment by Category

Category within the hospital	Total population		
Employee	986	985	
Supervisor	*N/A	*N/A	

Director Or Above	40	41	
February Survey	**Frequency**	**Percent**	**% To total pop**
Employee	185	80.8	18.8
Supervisor	29	12.7	*N/A
Director Or Above	15	6.6	37.5
Total	229	100	
September Survey	**Frequency**	**Percent**	**% To total pop**
Employee	155	80.3	15.7
Supervisor	26	13.5	*N/A
Director Or Above	12	6.2	29.3
Total	193	100	

* This information was not available to the researcher from Human Resources of this

hospital.

Table 2

_____

Director and Above Category Pre-and Post -Needs Assessment

Do you have the material and equipment at work?	SA-A (%)	N-D-SD (%)	TOTAL
February	93.3	6.7	100
September	58.3	41.7	100
Chi Square (Kruskal -Wallis Test)			0.033
At work do you have the opportunity to do your best?	**SA-A (%)**	**N-D-SD (%)**	**TOTAL**
February	93.3	6.7	100
September	50	50	100
Chi Square (Kruskal -Wallis Test)			0.03
Are your coworkers committed to do quality work?	**SA-A (%)**	**N-D-SD (%)**	**TOTAL**
February	93.3	6.7	100
September	58.3	41.7	100
Chi Square (Kruskal -Wallis Test)			0.033