A Team-Based Roadmap for Healthcare Change in a Turbulent Environment: a Longitudinal Study of a Not-for-Profit Hospital Transitioning into a for-Profit Organization

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Abstract

This longitudinal research describes how a 50-person management staff, led by a committed chief executive officer (CEO), was able to successfully implement a team-based structure and strategy to achieve a radical change from a non-profit hospital to a for-profit organization over a 12-year period. Many of the issues addressed and practical steps taken to establish a team-based leadership model for the new organizational template are described. Organization development models, diagnosis, intervention, and specific practices to bring about a successful transition are discussed. Seven principles are presented that contain “The Lessons Learned” from the longitudinal organizational systemic change intervention.

Keywords Healthcare change · Turbulent environment · Organization development · Diagnosis · Intervention

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The Business of Healthcare: Class Five Turbulence Remains

Significant changes are continuing in the healthcare industry. Hospitals are clustering into multi-institutional groupings, the population is aging, and Americans are spending more on healthcare (Korman & Mujtaba, 2020; Berman et al., 2006). Hospitals are experiencing dramatically increasing debt and expense at the same time that inpatient admissions and government and private insurance reimbursements are declining. Healthcare leaders face major internal and external demands for change complicated by the structure of the healthcare industry itself (Fairfield & Wagner, 2004). Leadership in healthcare demands a response to these rapidly changing conditions. Society expects hospital executives to develop new strategies for growing admissions, achieving higher patient care standards, and reducing expenditures in the midst of financial and insurance coverage declines (Berman et al., 2006).

Altman and Gurvis (2006) remark, “One does not have to be a medical expert to know that the healthcare system in the United States is unequivocally broken and broke” (p. 19). Issues of access and affordability place the industry directly in the midst of the current political debate. The healthcare system is likely to remain broken without leaders who are courageous, visionary, charismatic, and skilled in dealing with complex organizational change (Altman & Gurvis, 2006). Altman and Gurvis (2006, p. 20) suggest the following:

The system will not be healed without excellent individual and collective leadership. Strong, capable individual leaders who are courageous, visionary, charismatic, and skilled will be needed. However, it will take a lot more than heroic individual efforts to make significant headway with this vexing and complex challenge. Our belief is that the development of leadership talent and of processes that support collective leadership is part of the solution.

Healthcare organizations are experiencing a demand to transform to meet the expectations of society, consumers, and governmental agencies, and to incorporate the latest advances in technology (Berman et al., 2006). Intense competition, reductions in reimbursements, mergers, and requirements to restructure and re-engineer for cost efficiency have exerted enormous pressure on healthcare organizations (Cunningham, 2002). As the magnitude and rate of change are predicted to accelerate, organizations must be able to successfully anticipate and manage their approach and process to change (Griener et al., 2003). Attempting radical change is a complex endeavor as it involves the “transformation of the organization” (Greenwood & Hinings, 1996, p. 1023), much like the one undertaken in this study.

In the case of the hospital, that is the subject of this longitudinal action research study, the CEO and his team were attempting a radical planned change by moving from being a non-profit hospital to a for profit organization. These changes were brought about by both internal forces and by external market conditions. In general, we know that:

...radical change in an organization occurs when there is a shift from one template to another (in the case of privatization there is an anticipated shift from

a public sector, bureaucratic template to a private sector template (Voges et al., 2009, p. 10).

After 50 years of leadership research in more than 1000 studies, what has merged is the need to fully understand and develop oneself to “discover where to use one’s leadership gifts to serve others” (George et al., 2007, p. 130). Hospitals are trying to prove their merit based on compliance with national, state, and local regulations as well as to have positive trend lines in surveys, management dashboards and balanced score cards. These accomplishments are important yet not sufficient evidence of the type of leadership needed by hospitals and the communities they serve (Hoffman, 2009). For this study, leadership is viewed as a “process of influence in which one person is able to enlist the support of others in the accomplishment of a common task” (Chemers, 2000, p. 27). Hospital executives with a clear understanding of how they function, perceive, interpret, and make decisions on perceptions may provide more targeted and intentional leadership for periods of organizational change. Provost (1993) suggests those with an awareness of their style are more effective at their profession. By helping increase self-understanding about style, type, typical responses, and needs during change, leaders may proactively prepare for and lead organizational change (Barger & Kirby, 2004).

Research from the Center for Creative Leadership sample of 34,899 leadership effectiveness evaluations completed between 2000 and 2009 from people working in the healthcare sector identified the “most important priority for leadership development in the healthcare sector is to improve the ability to lead employees and work in teams” (“Addressing the leadership gap in healthcare,” 2011, p. 5). The pressure remains on hospital leaders to be more transparent, to protect and empower both patients and staff, and physician, to improve clinical outcomes, and to demonstrate proper stewardship of limited resources (Hoffman, 2009).

Bisbey et al. (2019) report that team training contributes to improved performance, reduced errors, and even saving lives. Their research highlights the salient role of multidisciplinary collaboration in response to real-world problems.

Purpose

The purpose of this action research study is to present longitudinal data that charts patient satisfaction, employee engagement, and physician satisfaction during a 12 year time period. “Longitudinal studies of culture change and change in performance on such measures as patient satisfaction would be a valuable contribution to the literature” (Meterko et al., 2004, p. 497). This research study will add to the body of knowledge about how effective leadership and teamwork strategies can be effectively employed during radical template change. Studies of this type are needed to help develop models for organizational culture change that “supports better patient care” (Meterko, Mohr & Young, p. 498). The results serve as the structure to examine leader-follower relationships during organizational change, to analyze similarities and differences, and reach informative conclusions about leadership styles that result in better outcomes during organizational change (Musselwhite & Ingram, 2003).

This study strives to document one hospital’s successful 12 year change effort that resulted in increased patient satisfaction and employee engagement. In addition, this

study provides healthcare leaders with an additional model for change during highly turbulent times (Barger & Kirby, 2004; Meterko et al., 2004; Musselwhite & Ingram, 2003).

Team training refers to a systematic set of learning initiatives that target and build teamwork KSAs (Salas et al., 2008). Today, team training is one of the more robust areas of teams' research, boasting extensive practical implications such as playing a role in reducing patient mortality in health care (Hughes et al., 2016). Its success has likely resulted from science being shaped over the years by the unique perspectives of psychologists across an array of disciplines and key players in industry who championed their research, used their tools, and demonstrated their impact. The objective of this article is to describe the multidisciplinary research effort that built a science around team training by responding to problems in the medical industry workplace and beyond.

This study contributes to the base of knowledge on leading organizational change in the hospital setting. By helping increase understanding about typical responses, and needs during change, leaders may proactively prepare for and lead organizational change (Barger & Kirby, 2004; Musselwhite & Ingram, 2003). Each individual leader possesses unique motivators and satisfiers that influence their approach to working with others during organizational change. Using multiple organizational development methods and approaches to accommodate the differing communication and information requirements benefits the organization during periods of change.

Methodology

Since the problems in healthcare are many and the solutions are complex, action research has been used in healthcare to take a more holistic view of the problems in context (Meyer, 2000; Bate, 2000). Action research is research in which "the researchers work explicitly with and for people rather than undertaking research on them" (Meyer, 2000, p. 178). This type of research combines theory and practice in a way that is participatory, consists of democratic processes and pursues practical solutions to problems (Meyer, 2000; Brydon-Miller et al., 2003; Rapoport, 1970).

Action research was introduced in the U.S. in the 1940's by Kurt Lewin, and has recently reemerged (Cummings & Worley, 2019). It attempts to test theory by applying it in the field, thus allowing the researcher to have a more nuanced view of the theory's application. The researcher works collaboratively with the subjects who have superior knowledge of the specific problem solving context to share with the researcher. Through effective dialogic organizational development process, this often results in a solution appropriate for the context (Marshak, 2013; Bushe & Marshak, 2008/2009). It also ensures that when the researcher is no longer there, the knowledge base remains in the employees who participated in the process. This embeds the knowledge in the organization facilitating the change process during challenging times such as the Covid-19 pandemic (Sarwar et al., 2021; Korman & Mujtaba, 2020).

Our action research project was conducted and extended across many years of a turbulent time period, both in which to participate and to facilitate change, while

the hospital was transitioning from a non-for-profit status to a for-profit organization. Participation allowed the results to be observed, altered in process, and linked to theory.

We begin with the history of the organization that created a need for solutions and the leaders across departments and functions who worked together to develop a structure to improve teamwork. We offer an authentic, and at times poignant view of the process that incited action and breakthroughs through team partnerships. Next, we detail the theoretical drivers behind the process using OD tools and interventions and the hands-on approach of investigating how we turn a team of experts into an expert team. We discuss the spectrum of team training over time.

The Organization and its Environment

Colorado is a state where the pressures and conflicts between doctors, hospitals, managed care companies, and insurance companies regularly make the evening news. Hospitals are being challenged to deliver quality care in a fiscally responsible manner as dramatically altered reimbursement structural changes occur (Connors, 1990). Within this setting of complex social, medical, and financial changes this hospital has developed and applied a model that successfully connects leadership, teamwork, organizational culture, and performance. After the first two years of the hospital's organizational change effort, they received recognition as a finalist from the *RIT/USA TODAY Quality Cup Award for Teamwork*.

Hospital History

The Medical Center was founded in 1945 by a group of local Jewish community leaders who wanted to create a hospital that was free of discrimination and open to doctors and patients of all creeds, races, and origins. The Hospital opened for patients in March 1949. In 1996, the Medical Center became a part of a 50/50 joint venture owned by [HCA](#) (Hospital Corporation of America) and a local Health Foundation, a non-profit organization.

The hospital is a general medical and surgical hospital with 271 beds. Well known as hospital institution and landmark for 60 years, the Medical Center, known for obstetrics, has earned a reputation as a "Baby Hospital" while becoming a leader in comprehensive women's services, internal medicine, endoscopy, heart and vascular care, orthopedics and total joint replacement, bariatric surgery, sports medicine, and aesthetic surgery. With origins in Jewish teachings, traditions and community, the founders built the hospital to "serve the need of every creed." By offering a high level of expertise and service across all disciplines, this facility has truly become a destination hospital, attracting patients from throughout state and around the world.

The mission of this healthcare organization is as follows: "*Foremost in our hearts and minds is the commitment to our patients. Therefore, we assume responsibility for everything that affects their care.*"

The Competitive Healthcare Environment

Like many freestanding not-for-profit hospitals, this healthcare facility could no longer compete in the new marketplace of managed care. The board realized they would eventually have to close their doors and thus chose to sell to a for profit healthcare chain. This change in ownership and the resulting change in the environment, particularly from non-profit to profit based, had a major effect on the staff of the hospital.

Many of the staff had been employed at the hospital for ten, twenty, and even thirty years. They remained due to the unique identity of the hospital even though only a small percentage of the staff and patients were Jewish. At the time of the transition, the staff felt they had lost their identity, core values, and the psychological contract between employer and employee had been violated. A change to the delicate balance of the employment relationship had been unilaterally imposed, with more being demanded of the employees for a dramatically altered set of outcomes. Morale among these employees was at a new low.

Hospital managers struggled with meeting the conflicting challenges of quality, efficiency, cost effective delivery, and customer satisfaction. Hospitals traditionally have passed on costs to either the payers or the patients. They, like a regulated telephone company, knew little of the world of cost savings and competition. The managers were now spending more time looking at budgets and staffing patterns than patient care issues. They, like the doctors, were forced to spend more time thinking about the economics of patient care than patient care.

The CEO's goal was to make the hospital a first class hospital again and his strategy was organizational transformation and culture change through TEAMS. Acting as a change agent, the CEO had determined the "readiness for change" within the organization (Armenakis et al., 1993, p. 681). A culture of teamwork in hospital settings has been correlated to patient satisfaction and ultimately to the performance of the organization per Meterko et al. (2004). The CEO recognized this as the only way to leverage the talent of the organization and once again achieve excellence. Organizationally speaking the rules had changed and the situation demanded a redesign into new forms to replace the classical hierarchical work cultures fettered by rigid bureaucracies.

At this time, team-based structures were surfacing across all industries. It was a hot management topic. Sometimes, teams were successful and sometimes not. Too frequently people complained that teams were a good idea but usually did not achieve the desired results. Yet, team structure and leadership might have been just the fit for achieving effective performance in this unique and complex environment, as public pressure, and stakeholder expectations to provide accessible high quality, cost conscious service continued (Connors, 1990). Teamwork is a framework used for culture change in healthcare for the improvement of patient care (Rose et al., 2006). It did not take a rocket scientist to make teams work. It required perseverance, integrity, a plan, a willingness to learn while doing, and unwavering optimism (Kotter, 1996).

"The US Healthcare system requires radical, not incremental change" (Waldman et al., 2003, p. 5). Systems thinking was required. The organizational change model that was followed consisted of a system wide focus on diagnostics and assessments and targeted interventions implemented in phases through teams to positively impact the culture of the hospital (see Fig. 1 for the transition phases).

Note. (Adapted from McLagan, P. & Nel, C., 1995)

Fig. 1 Organizational Change Model Transition Phases

OD Intervention Model, Phases, and Intervention

OD Model

In an OD program, the emphasis is placed on a combination of individual, team, and organizational relationships (Brown, 2011). Through a five stage process centered on an action research model, the focus is to drive continuous improvement throughout the entire organization impacting all functions and elements for increased effectiveness.

1. The first stage is to obtain perspective from external environment in order to detect the need for change. The need for change could be from growth or decline as well as technological, social, or competitive changes.
2. Once the need for change is established the second stage is to develop the practitioner-client relationship. During this stage, the importance is in establishing a relationship of trust within the organization that will undertake the change initiative. This will enable the practitioner to have open communication with key stakeholders to best evaluate the situation to later implement the necessary change program (Brown, 2011).
3. The third stage is the diagnostic process where the practitioner and the client analyze the information gathered that was essentially designed to identify the problem that is currently causing the issue. "A weak, inaccurate, or faulty diagnosis can lead to a costly and ineffective change program" (Brown, 2011, p. 14).
4. The action plans or interventions come in the fourth stage to implement the necessary changes through effective planning, organizing, leading, and controlling management functions. Of course, the purpose of the final stage is to measure the results.

5. Stage five centers on ensuring that the change program delivered the results that the organization and the practitioner set as the desired outcomes. In this final stage, modifications can be made if the change program is not delivering as promised or in sharp contrast stay the course if the results are being produced by the organization (Brown, 2011).

OD Approach to Change

Action research involves collecting information about the organization, feeding this information back to the client system, and developing and implementing action programs to improve system performance (Ali, 2011). Using Brown's (2011) five stage model of change the process involved establishing a need for change and then applying fundamental knowledge of OD.

As presented in Fig. 2, the integrated approach to change is structural, technological, and behavioral (Brown, 2011). The structural approach focuses upon changing the organizational design through adjustments to the lines of authority-moving from a hierarchical to team based problem-solving, communication, and decision making arrangement. The technological approach involves new computer systems and equipment. The behavioral approach emphasizes the people and human assets.

YEAR	Behavioral Strategy		Structural Strategy		Technical Strategy	
2009-2011						
2006-2008	Change Attitudes & Values	New Behaviors			Change Service & Methods	New Processes and Procedures
2003-2005	Change Attitudes & Values	New Behaviors	Change Structure & Design	New Relationships	Change Service & Methods	New Processes and Procedures
2000-2002	Change Attitudes & Values	New Behaviors	Change Structure & Design	New Relationships	Change Service & Methods	New Processes and Procedures
1998-1999	Change Attitudes & Values	New Behaviors	Change Structure & Design	New Relationships	Change Service & Methods	New Processes and Procedures
			Improved Performance: Patient Satisfaction Physician Satisfaction Employee Satisfaction Fiscal Performance			

Fig. 2 OD Strategy: An Integrated Approach to Change. Note: Organizational Change Strategy. Adapted from Donald Brown (2011) in *Organizational Development*. (8th ed.). Saddle River, NJ: Pearson

OD Interventions

A series of OD interventions based upon the stream analysis took place from 1998 to 2011 supporting an integrated approach to change. The OD practitioners and the leaders of the organization jointly diagnosed and planned these interventions over a 12 year period (see Table 1).

The OD processes and tools from Table 1 facilitated team development not as an additive function of individuals becoming more effective team players but an entirely different capability (Wageman et al., 2008). The OD interventions emphasized collaborative leadership and effective teamwork to successfully fulfill the vision of the organization. These interventions helped teams focus on improving patients, physicians, employees, and community experiences to transform current services and practices to better serve all stakeholder groups (Hawkins, 2011, 2017). Specifically, the OD tools and methods were organized into three clusters designed to provide structure and create a common language:

1. *Inquiry and diagnostic instruments* – psychometric instruments used to explore personal and interpersonal relationships on the team and among the teams; team appraisal questionnaires, and instruments including a team 360 = degree feedback tool.

Table 1 OD Interventions: Stream Analysis across the Years of the Study

YEAR	Behavioral	Structural	Technical
Final Years	Critical Incident Stress Debrief, Appreciative Inquiry, Team Building	Team Structure for Self-Managed Leadership Teams	Facility University Board Certified Leader
	Team Building Friday Night at the ER Executive Team Development Survey, Groupthink, Trip to Abilene, Open Space Technology	Team Structure for Self-Managed Leadership Teams	
Middle Years	Team Building Coaching for Teams and Leaders Goal Getter Activity	Team Structure for Self-Managed Leadership Teams	Facilitation of Groups & Teams
	Coaching for Teams and Leaders Team Building MBTI for Teams	Team Structure for Self-Managed Leadership Teams	Six Sigma Tools and Techniques
Early years	Team Building Orienteering	Team Structure	Roles in Teams
	Conflict Lens Change Style Indicator		
Beginning	Team Building		
	Self-Awareness		
	MBTI		
	Values Surveys of Stakeholders		

Note. Organizational Change Strategy Stream Analysis Chart. Adapted from Donald Brown (2011) in *Organizational Development*. (8th ed.). Saddle River, NJ: Pearson

2. *Exploration and action techniques* were used during leadership meetings and off site advances (versus retreats) for exploring team dynamics and functioning to enable better collaboration and learning.
3. *Alternative approaches* to foster team innovation and creativity were applied using appreciative inquiry and solution focused practices.

The overall goal of the OD based approach was to develop collective transformation leadership that was built on the structure of teams. The teams' learning and wisdom was applied by working together across disciplines, roles, borders, and self-interests in a way that had not been attained previously (Thorton, 2016). The core teams delivered value as measured by the patient, physician, employee, and community surveys conducted during the period on the interventions. In addition, the team member surveys provided a qualitative measure of the impact of the team organizational structure.

Analysis and Discussion: The "Lessons Learned"

The teams at the hospital have been in existence for 12 years. The leadership teams have survived many challenges and changes in personnel. The hospital leaders and staff have accomplished an organizational transformation that has led them to excellence. The team methodology offered an approach to increase quality and profit and to restore the positive and purposeful spirit across the organization. A team approach is appropriate where interdependencies exist, where there is an organization-wide application of teams as a strategy, and where the systems support teams (Katzenbach & Smith, 1993). "Collaboration among individuals or groups in a culture means working together at a significantly higher level than cooperation (Rose et al., 2006, p. 438).

Table 2 provides the engagement data from 1998 to 2011 for our study in this hospital, which shows a significant 17% increase in employee involvement in the spirit and purpose of this healthcare organization. As such, it can be concluded that any successful change and transition from a non-profit to a for-profit hospital must include a large percentage of the organization's employees at all levels.

Strategic Organizational Health Outcome

The core teams have been in place in various iterations for 12 years. What have they attained? What is the value added for all of the training, consultants, and employees' time?

Selecting the appropriate outcome measures of organizational change efforts remains challenging, particularly when corporate culture is studied (Waldman et al.,

Table 2 Employee Engagement Survey Overall Satisfaction Summary

Year	Overall Satisfaction
1	67%
5	72%
10	84%

**Note: Gallup conducted surveys during the study period*

2003). In this research study, the formation and development of team-based leadership structure, the focus and work of these teams led to measureable achievements in patient satisfaction, physician satisfaction, and employee engagement. Financial data, while studied, is subject to many “outside” variables that impact the financial outcomes.

Tables 3 and 4 present the results of the relevant metrics and key performance indicators of the team-based results-oriented strategy regarding satisfaction of physicians, nurses, and patients. For example, Table 3 shows that physician satisfaction survey results from which shows a positive and sustained trend in this longitudinal study.

The Hospital Consumer Assessment of Healthcare Providers and Systems’ (HCAHPS) patient satisfaction survey results demonstrated an overall rating of the facility 73%, which increased year over year. In 2007, HCAHPS’ first national, standardized, and publicly reported survey of patients’ perspectives of care was implemented. They participated for the following reasons:

- It’s the right thing to do.
- Hospitals that do not participate will not receive the 2% annual payment update from CMS.
- In the future the annual payment update will likely be tied to how well a hospital performs on HCAHPS.
- When we excel, we can prove it and attract more patients (Table 5).

In terms of overall performance regarding the hospital’s budget over the 12-year period, financial data were analyzed as either “Did not meet budget”, “Met budget”, or “Exceeded budget”. As can be seen from Table 6, this hospital met or exceeded budget for most of the years, with the exception of one year during 2006.

Our study demonstrates that while employee engagement is very important and essential for success, there are many other functions (such as employee and patient satisfaction, financial outcomes, etc.) that all managers, employees and consultant must assess and track in order to bring about positive and goal-oriented changes in the organization, while increasing the probability of retaining the diverse and talented employees (Delapenha et al., 2020; Udechukwu & Mujtaba, 2007). As a result of this longitudinal study for over 12 year period, we have compiled a list of various lessons that were learned. As such, the following principles and concepts are some of the lessons learned and provide insights into how the transformation was achieved.

Table 3 Physician Satisfaction Survey Results Summary

Year	Overall Satisfaction	Satisfaction with Nursing Care	Would Recommend the Facility
1	87	82	94
5	94	92	97
7	94	93	98

Note: Surveys conducted by Data Management and Research, Inc.

Tables 4 Patient Satisfaction Survey Results Sample During the Study Years

Nursing Area	Starting Year Mean	Middle Year Mean
Inpatient	3.55	3.91
Emergency	3.46	3.90
Outpatient	3.52	3.91
Outpatient Surgery	3.75	3.94

Note. Gallup Organization

Principle #1: For Teams to Be Successful, Begin with Training

Historically, in the spring of every year, the management staff held a retreat. The usual format was as a reward ceremony, a speaker or two, socializing and recreation—the typical off-site perk for management. In the spring of 1997 an experienced management consultant was brought in to do a three-day learning retreat instead (Hutton Consulting Services, 1997).

Instead of calling it a retreat, the CEO called it an *Advance*. The CEO believed in the power of words by creating the metaphors. They learned about Systems Thinking, Chaos Theory, team dynamics and how to better communicate with each other. They completed the Myers-Briggs Type Indicator and analyzed the results. They read Peter Senge's (1990) book—*The Fifth Discipline*. They committed to move the culture toward a systems oriented shared leadership learning organization.

To begin to institutionalize the cultural transformation every manager was placed on a team after their initial team training. Six teams were formed: The Patient Satisfaction Team, The Employee Satisfaction Team, The Physician Satisfaction Team, The Community Satisfaction Team, The Values and Tradition Team, and a Core Team made up of the leaders and facilitators of each team to whom all the teams would be accountable. Managers could join any team they wished as long as it was not related to their regular job duties. For example, a manager whose job involved working with the doctors could not join The Physician Satisfaction Team.

Each team was given the task of forming a charter, developing a vision and mission statement, as well as establishing norms for operating. Each team was encouraged to be creative and to challenge the existing system and underlying assumptions in pursuit of

Table 5 Comparison of Gallup and HCAHPS Survey Elements

HCAHPS	GALLUP
Always	Very Satisfied
Usually	Satisfied
Sometimes	Somewhat Dissatisfied
Never	Very Dissatisfied
Publicly reported	Not publicly reported
Only answer that counts is “always”	Answers are averaged to obtain a mean score
Patient surveyed 48 h. to 6 weeks post discharge	Patient surveyed within 72 h post discharge

Table 6 Hospital Financial Performance: Performance to Budget Summary

Year	Performance to Budget*
1	Exceeded budget
5	Met budget
6	Did not meet budget
8	Exceeded budget
9	Met budget
19	Met budget
11	Exceeded budget

***Note.** Actual fiscal results cannot be presented due to propriety nature of the data

achieving excellence in their particular area. Explicit permission was given to experiment with new ways of doing things and to take risks.

Principle #2: There Must Be an Underlying Value System and Vision for the Training

The CEO knew what very few CEOs know about teams – you have to have a philosophy and a vision that you believe in, teach, and continuously communicate. This CEO identified a vision of personal mastery and organizational excellence, a sense of value in teamwork, systems thinking, and a goal to become a learning organization. He desired to help people find the power within and help them to achieve their own goals in providing excellence to simultaneously achieve the same goal of excellence for the hospital.

It was a requirement that every manager be a team member in addition to his/her regular duties. One either accepted these core values or needed to. Each team would meet every week for at least an hour and a half and would be accountable for producing measurable results. To support the framework for culture change to a team-based structure, one should remember that “collaboration results from shared understanding of issues, open communication, mutual trust, and tolerance of differing points of view” (Rose et al., 2006, p. 438).

Principle #3: There Must Be Ongoing Development and Coaching of Teams

Management teams, similar to sports teams, need the assistance of ongoing coaching for their development (Coutu & Kauffman, 2009). You cannot simply provide instructions and put them on the field without someone to coach them. In a survey of 140 coaches 48% are hired to facilitate transition and 12% to address derailing behaviors according to Coutu and Kauffman (2009). The CEO set out to hire a coach for the teams and he knew something that very few know about coaches—they *have to share your value system to be effective*. He interviewed several consultants and each time he would ask if they had read the *Fifth Discipline*, or knew Chaos Theory, or knew their Myers-Briggs type. Each time he would hear something resembling the following comment: “Oh yes, I’ve heard of that, but now let me tell you about this great program that we have that is the newest, the best and greatest etc.” He continued the interviewing process until he identified a group that were experts in teamwork *and* shared his value system. After much discussion about experience, values, and

approach, the CEO hired a consulting group to provide ongoing coaching for the teams (The Xaos Group, 1998). The consultants were three psychologists, and one had a business doctorate and had been a practitioner in healthcare for 25 years and all were well versed in team dynamics and development. The consultants provided coaching for the teams in real time. Too often consultants are brought in for training but they never get the opportunity to *observe* the teams at work. This can be equated to teaching the plays but missing execution at the practice. The best learning always occurs in the practice and the games, not in the locker room.

Principle #4. Sometimes a New Face Lends Renewed Energy to the Project

After two years of process coaching, the CEO hired a quality focused consultant to supplement the coaching (Robbins Group, 1999, 2000). This individual was knowledgeable about reengineering, statistical processing, and quality techniques and tools. This consultant taught them how to identify who their customers were and how to define operational excellence. They were instructed on the use of descriptive statistics, fishbowl diagrams, histograms, run charts, scatter diagrams, control charts, Pareto charts, and surveys to collect and analyze data.

The coaching continued as the new consultant became involved in developing the talent of the teams. Coaching is an ongoing activity for now, not a one-time opportunity. Coaches need to pay attention to the process, watching team dynamics and activities, analyzing its effectiveness, and determining what is missing, while identifying the obstacles and limitations to high performance. Team results are to a great extent shaped by group process as much as natural talent (Huszczo, 1996). Even highly competent and committed team members cannot achieve high performance if they are off target and unsynchronized. The constant diagnosis and examination of the team's internal operations is required for the teams to successfully use their resources, make decisions, and solve problems (Nash, 1999).

Principle #5: There Is More to Learn than you Ever First Imagined

In the spring of 1998, it was time for the next annual managers' Advance. This off-site meeting was named *The Advance to the Summit* (The Xaos Group, 1998). The Advances continued from 1998 to the 2011 and are institutionalized in the organizational culture. The CEO started by taking all of the managers to the IMAX presentation of the climb to Mt. Everest. He gave them Margaret Wheatley's book, *Leadership and The New Science*. The off-site meetings focused less on didactic teaching and more on experiential learning. In experiential learning, team members created metaphors and engaged in activities that served as the basis for learning. People received instant feedback on their ideas and behavior. The teams came together to experience success and failure. They created team names and team cheers. They gave each other one-on-one feedback. The learning and insights gained were not possible at the off-site before because the defenses were less and the spirits high. The managers reached a new level of teamwork that they could not have envisioned when this journey began.

In 1999 the *Advance* continued. This year they read *Leadership Jazz* by Max Dupree. Experiential learning and risk taking were encouraged. A fireside chat to bring

out unresolved issues led to healthy conflict and constructive strategies of conflict management were practiced (The Xaos, Group, 1999).

In 2000, they held the meeting at a rural off-site location in the mountains. This year there were no hairdryers, no hotel bar, and no nearby shopping. It was just the team members in a corporate conference center in the middle of the Colorado Rockies. They continued to grow with an “Orienteering” outdoor experience and a High Ropes Course. They read *Tuesdays with Morrie* and talked extensively about living, dying, and the meaning of their lives (The Xaos Group, 1998).

Throughout the Advances they maintained ongoing commitment to self-awareness through the use of instruments such as the MBTI Form q, MBTI for Teams, FIRO-B, Change Style Indicator, and the Conflict Lens. Team functioning and dynamics were examined with the Campbell/Hallam Team Development Survey to develop action plans to augment performance.

The sharper the insights into each individual, the better the odds were of achieving high performance. Teams thrown together in a haphazard manner might have required recasting. At each off-site, the teams challenged themselves to learn more and risk more. They did not just ask their consultants to design an off-site. They took ownership and worked utilizing a collaborative approach to design meaningful presentations and experiences. The teams were transitioned into a foundation of strength in the effort toward high performance.

Principle #6: Sustained Commitment Is the Hardest Thing to Achieve and Embed

The difficulties in gaining and maintaining commitment to achieve long-term success in radical change in a healthcare organization was addressed in general by Narine and Persaud (2003). They state that it is difficult to maintain long-term change momentum resulting in culture change. They state that each healthcare organization will be influenced by its specific characteristics as we illustrate in this organization.

Commitment takes creativity, follow-up, and a desire to fully achieve the vision. The corporate culture change at the hospital occurred through carefully structured and consistently applied development and training of the hospital leaders to obtain sustainable results (Waldman et al., 2003).

Principle #7: In the End, it Will Be the Results that Matter Most

Identify the operational improvements that are most urgently needed. The idea is not to minimize the importance of intangible factors, as they are vital to the long-term success of the organization. Emphasize the factors that lead to the bottom line or that contribute directly to competitive positioning. For commitment, trust, loyalty, and morale are inextricably linked to team performance and accomplishment. Both the tangibles and intangibles are needed to achieve strategic health. The teams need to understand their responsibilities, state their performance goals, keep monitoring the goals, and providing necessary course corrections (Huszczko, 1996). As noted by Waldman et al. (2003), “focusing on system outputs, not interim outputs of component elements has implications for healthcare” (p. 8). Understand the systemic impact of the corporate culture and its relationship to multiple factors such as patient care, physician satisfaction, and employee engagement, which as this hospital knows, occurs when the patient is

foremost in their hearts and minds, that is when healthcare can become a business first and foremost too.

Conclusion

This paper contributes to the body of knowledge about how leadership and a team-based culture can be used to improve patient satisfaction, employee engagement, physician satisfaction, and overall organizational performance. Furthermore, it provides an additional model for healthcare leaders as they attempt to guide their organizations through environmental complexity and change.

The limitations of this study include the fact that a single hospital was studied and the experiences may not be generalizable to other hospitals of a different size or composition. Another limitation was that the patient satisfaction and employee engagement surveys were self-reported and may not be an accurate reflection of the attitudes held by respondents. Finally, the respondents in the patient satisfaction survey may be more satisfied than those who chose not to respond.

The study provides an example of the integration between theory and practice that underscores the need for multiple perspectives to solve the complex problems faced by teams. We see this integration as an implication of team training because the team-based intervention was built with an applied approach by the organization in the healthcare industry in conjunction with trained psychologists and coaches. Not only did the practical nature of team training make an impact, but the multidisciplinary teams served as a testament to the effectiveness of diverse team composition and the power of teamwork in itself. It may not be easy to work with others who subscribe to different (sometimes opposing) perspectives, yet the implications of team training demonstrate the positive impact on patients, physicians, employees, and the community.

Declarations

Ethical Approval All procedures performed in this study were in accordance with ethical standards.

Informed Consent Informed consent was not necessary for this study.

Conflict of Interest The authors have declared that they have no conflict of interest.

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