Practicing What We Preach

A Kansas City Organization Aligns Day-to-Day Practice with Espoused Beliefs

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People come to health care providers to be healed and comforted. They come willing to entrust their well-being or that of family members to us, to strangers. This is a unique and sacred relationship, far different than what we experience in other day-to-day business transactions. Health care is not, contrary to what some may think, just another business.

Unfortunately, not all health care organizations recognize this, and many that do recognize it have difficulty living up to their own mission statements. This creates a gap between an organization's espoused values and its actual practice. Given the imperfect nature of human beings, even the best organizations experience this shortfall. The danger, however, is not in having a gap, but rather in failing to acknowledge and confront it. When leaders fail to acknowledge and address a culture gap, employees tend to lose their commitment to the organization's mission and values and standards gradually drift lower.

On the other hand, willingness to recognize that a culture gap exists can lead to a disconcerting case of cognitive dissonance—a clash between belief and actual practice. In trying to evade the pain that inevitably accompanies such dissonance, organizations often display a phenomenon that might be called "organizational denial." Organizational denial can take many forms: Patient or employee complaints are discounted. A culture of finger-pointing and blame develops. Or the organization promotes slogans and programs that do not reflect reality—for example, "People are our most precious resource," when, in fact, employees are treated as disposable goods, not valued assets.

Organizational denial springs from a disinclination of the people involved to acknowledge the gap and their personal contributions to it. I once witnessed a situation in which groups of nurses identified "lack of teamwork" as a major problem, but could cite nothing they had done as individuals to contribute to that problem. In the same way, hard-working, dedicated leaders often have difficulty recognizing their contributions to the prevailing organizational culture.

Leaders are subject to a variety of pressures that, arising out of organizational denial, conspire to maintain the status quo. Consider, for example, the tendency of information to be "sanitized" as it moves up through the organization; the pressure to be a "team player" (to conform rather than challenge); or the paralyzing belief that the organization is incapable of real change. The larger the gap between espoused values and actual practice, the stronger these forces are.

Organizations can choose to deal with cognitive dissonance of this kind in one of two ways:

- Change the way staff members think or believe (e.g., by telling them: "We're really not so bad." "Times are hard." "We're better than XYZ Medical Center." "It's the nature of health care").
- Change staff members' behavior to align with the organization's beliefs or mission.

Changing Behaviors

Carondelet Health, a five-facility health care system based in Kansas City, MO, found itself experiencing cognitive dissonance of this type in the late 1990s.* In 2001 its leaders decided to deal with this dissonance through the second method, promoting a change in staff members' behaviors to better align them with Carondelet Health's

*Carondelet is part of Ascension Health, St. Louis.

espoused beliefs and mission.

However, before describing Carondelet Health's initiative, I need to say something about organizational culture and behavior change in general.

Of course, all people are guided by values, assumptions, and beliefs. But I believe it is more fruitful to talk about *behavior*. How people actually behave determines an organization's culture. When considering "good care" or "compassion," a patient will judge a health care organization according to how well its staff behaved with him or her, not by the mission statement on the wall. Staff members will in turn judge their leadership—and, therefore, the organization itself—according to how leaders behave. Staff members who are treated insensitively, as cogs in a health care machine, are unlikely to be able to provide compassionate, patient-focused care.

Why are there so many ineffective leaders and organizations?

Organizational denial at the leadership level can result in endless talk about the "new realities" of health care, a deer-in-the-headlights focus on "dashboard indicators," constant restructuring, or any other activity that allows leaders to avoid looking at behavior. Such leaders will find pursuing joint ventures and new service lines much more comfortable than assessing their own behavior—or the influence of that behavior on the organization and, ultimately, on patient care.

Organizations plagued by such denial need cultural transformation—a closing of the gap between the organization's present culture (how, that is, people currently behave) and what the organization would like it to be. Let's leave aside for the moment the question of what a culture "should" be. We'll assume that we are talking about organizations that want to move in the direction of "goodness" by achieving their missions, maintaining acceptable margins, and actualizing their expressed values in everyday behavior.

However, we first need to ask: Why is this process so difficult? Given the available wealth of leadership and organizational materials and an abundance of consultants, why are there so many ineffective leaders and organizations and so many failed efforts at transformation? We know the "Seven Habits of Highly Effective People" and we know what distinguishes "Good from Great" organizations. We study service excellence and performance improvement, and we have the Joint Commission on Accreditation of Healthcare Organizations and the Baldrige National Quality Award to guide us. A knowledge deficit isn't the problem; changing behavior is. It's a matter not of *what*, but *how*.

Many organizations fail in their well-intentioned attempts at transformation because their leaders are looking for a "quick fix." When, six months or a year after trying the quick fix, transformation hasn't occurred, such leaders find themselves frustrated and disillusioned. Such "programs" take their toll by burning out managers responsible for implementing them and by creating an increasingly cynical workforce. Employees dismiss the initiatives as "flavor of the month." In the end, the programs fail because the leaders see neither themselves nor their organizations as needing change and because they lack the skills necessary to lead. They fail because they are just that—programs, not fundamental transformation. Both managers and employees have learned how to wait out "programs."

If an organization's culture is determined by the behaviors of its members, those who seek to change the culture must identify the behaviors they want and then determine how best to reinforce those behaviors and integrate them into the existing culture. Of course, nearly everyone who works in health care believes that patients should be treated with dignity, respect, and caring. And most would agree that the same consideration should be extended to fellow employees. Unfortunately, health care has lacked a way to monitor and support behaviors likely to result in dignity, respect, and caring for both patients and co-workers.

Health care leaders are skilled at looking at capital expenditures, lengths of stay, and productivity indexes. They apply critical thinking skills in doing elaborate root-cause analyses. Yet they rarely apply the same scrutiny to the quality of their interactions with others. I believe that this lack of scrutiny is at the root of many failed efforts in organizational transformation.

It is in the realm of interpersonal relationships that the culture gap in organizations is most glar-

ing. What is needed is not knowledge but, rather, taking what most people consider to be common sense—treating patients and each other with dignity, respect, and caring—and making it common practice. Unfortunately, most managers are unskilled in, or uncomfortable with, giving and receiving feedback. And the health care environment—with its intense, perfectionistic, life-or-death culture—can be particularly unforgiving for those who make mistakes.

Of course, accountability is critical in health care. But *how* health care organizations make staff members accountable is just as critical. Knowing how to seek, frame, and deliver feedback in a compassionate, mutually gratifying, "win-win" manner is a key component of professional development.

Introducing BQA

However, a process called "Behavioral Quality Assurance" (BQA) could help fill that need.[1] BQA was developed by I. M. Rubin, a principal of Temenos, Inc., a Honolulu-based consulting firm.

BQA is not a new process, but it is new to health care. There are two arguments for using it to close the behavioral gap in order to achieve organizational transformation:

The Business Case Health care organizations that achieve high levels of BQA (defined as effective communication and mutually gratifying interpersonal relationships) are more likely to have decreased patient lengths-of-stay and lower death rates.[2] They are also more likely to have lower turnover rates, fewer employee relations issues, and greater patient and employee satisfaction.

The Human Dignity Case Creating a healing environment for patients and staff is simply the right thing to do. It is what health care is about. Treating fellow human beings with dignity and respect and developing "win-win" relationships are what make people, and hence mission statements, come alive. The gap-closing inherent in organizational transformation is a result of people becoming engaged in their work and transforming themselves by closing their own individual gaps.

Health care is unique because its business and human dignity cases are inseparable. They constitute a matter of "both and" (mission *and* margin), not "either/or." Indeed, trying to treat them as if they were separable is at the root of the culture gap problem. Although the business case certainly justifies organizational change, it will not succeed without the human dignity case. And the human dignity case requires *fundamental* transformation. Left to itself, the business case eventually becomes just another management attempt at strategic change. It does not capture the hearts and minds of the staff members who actually sustain a healing culture. Providing health care is about relationships and, as experts have pointed out, relationships are at the heart of all reality.[3]

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BQA is part of an overall performance-management system; and, just as the business case is not separable from the human dignity case, BQA and performance management are not separable. We find, however, that the two are often treated as distinct. Again, this occurs because leaders are more comfortable dealing with strategic indicators than with their own and others' behaviors. I believe that any organization that strives to have a high-performance, strategically aligned culture must build BQA into its performance-management system.

BQA at Carondelet

For Carondelet Health, embarking on a process of BQA was a natural extension of its mission. As the system's mission statement says, "Carondelet Health consists of Catholic organizations dedicated to the healing ministry of Jesus Christ. Our commitment to human dignity compels us to provide compassionate quality care for body, mind, and spirit, with a special concern for the poor. We are responsible stewards serving the needs of all people from conception to death. We are united in this mission."[4]

Carondelet Health is a successful organization that both patients and employees find very good at being caring and compassionate. However, being a "very good" organization is not good enough. Both patients and employees desire and deserve excellence. If a health care organization is

to be a healing environment and provide compassionate, high-quality care, it must have a high level of BQA.

Carondelet Health began its cultural transformation effort by reexamining its vision and values. The system's CEO and executive vice president for mission conducted focus groups among more than 400 staff members. From these groups emerged the system's vision ("service excellence") and core values ("integrity," "compassion," and "unity"—or "ICU," for short). All employees underwent a reorientation to Carondelet's mission, vision, and values. This process included looking at what those values meant behaviorally in terms of providing service excellence to patients and how staff members treat each other as co-workers.

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A health care organization should pay particularly close attention to BQA when it considers leadership competencies. Most leadership competency models agree that a good leader should be able to manage change; communicate effectively; manage conflict; and coach, counsel, reward, and praise. Not only do personal and interpersonal skills comprise a major portion of most such models; the successful exercise of almost any competency depends on these skills. It is also apparent that all interpersonal competencies have a common, underlying core competency—the ability to give and receive feedback.

In 2001, Carondelet Health contracted with Temenos to help with the next stage of cultural transformation. Using what Temenos's Rubin calls the "ABCs of Effective Feedback" model, the system's leaders participated in "ABCs" (awareness of behavior and its consequences) training. A crucial part of ABCs training is a 360-degree assessment tool that participants use to obtain feedback from others.

Carondelet Health's leaders wanted a process that would foster open and honest communication. They decided against using the traditional "360" tool because the feedback it provides is aggregated—and therefore anonymous—and does not give participants face-to-face interaction. Anonymous, aggregated feedback is of questionable value in improving relationships or providing clear direction on how to improve specific behaviors.[5] In my own experience, "anonymity" in a survey instrument does not guarantee a respondent's honesty. Temenos's ABCs tool focuses not on what people do well or do poorly but rather on what they need from each other in terms of specific behaviors and on the flexibility of their behavioral styles. The ABCs process requires participants to have follow-up discussions with those who complete the 360-degree questionnaires. These discussions both enhance communication and provide practice in giving and receiving feedback.

The ABCs process is not used everywhere. When I discuss it with colleagues at other health care organizations, usually in conversations about leadership development, I am typically told: "We're not ready for that," "The level of trust here isn't high enough for us to try that," or "Senior management would never go for it." But if health care leaders are unable or unwilling to have face-to-face conversations with each other, how can they encourage staff members to have such conversations with patients and colleagues?

At Carondelet Health, however, the leadership staff underwent ABCs training, as did several hundred other employees.

Testing the Results

Carondelet Health has documented the progress that the ABCs model has enabled it to make.

In September 2001, just before the system began the ABCs process, it underwent an organizational-effectiveness survey. That 48-item survey, which was directly linked to the individual feedback model, identified 14 behaviors that had "deltas"—perceived differences between actual and preferred behaviors—of more than 70 percent.

A second survey was conducted June 2004, following ABCs training. This survey showed no item with a delta higher than those in the 2001 survey (see **Table,** p. 77). A number of items had deltas in the 40 percent to 60+ percent range, but it was clear that behavioral gaps were closing. Between 2001 and 2004, for example, the item "Tell people what we like about what they are doing"—decreased from a delta of 91 percent to one of 60 percent. The item "Remain patient and receptive when someone disagrees with or chal-

lenges our point of view" had a delta that dropped from 76 percent to 48 percent.

Reinforcing the Process

Integrating a feedback process with a performance-management system is critical. According to one expert, "only one in ten leaders takes action on his or her multirater feedback. . . . Both experts and practitioners agree that multirater feedback is far from perfect in motivating recipients to take meaningful action. And not much has been done to improve the usefulness of the process."[6] To avoid these pitfalls, Carondelet Health has worked to integrate BQA into its performance-management system by making the ABCs process a part of every manager's assessment and development. Each year, as part of the performance review process, managers send out questionnaires and develop leadership goals based on the feedback they have received. This process has been automated and is available via the system's intranet. In addition, the assessment process for leaders has been reworked. The system has replaced its annual year-end review with a process that includes goals and measures tied to the strategic plan and is part of a larger ongoing process that in turn includes planning, coaching, and periodic reviews. As a next step, the system plans to bring this process to all employees.

Carondelet Health sponsors a variety of activities and initiatives that support BQA. One program enables managers to reward employees with gift certificates, cash awards, and movie tickets for displaying behaviors that support the system's values. In another, senior leaders send thank-you notes to staff members. "Value stories" are told

CLOSING THE GAP BETWEEN ACTUAL AND PREFERRED BEHAVIORS, 2001-2004

The following are high-importance items demonstrating significant change at Carondelet Health:	Deltas 2001	2004
Tell people what we like about what they are doing	91%	60%
Express our appreciation when someone does something well	68%	44%
Remain patient and receptive when someone disagrees with or challenges our point of view	76%	48%
Tell one another clearly what we want from one another	89%	61%
Use well-reasoned arguments to support our proposals	65%	41%
Apologize for our mistakes	81%	58%
Tell people what we don't like about what they are doing	70%	58%
The following are high-importance items that did not show as much change:		
Gracefully accept feedback	62%	61%
Openly provide information that another might not normally have	62%	60%
Face up to important issues	70%	63%
Focus on "What can we learn from this mistake?" not on "Who is to blame?"	65%	60%
Stress the importance of pulling together to achieve common goals	54%	50%

Note: The lower the delta, the closer the perceived match between actual and preferred behavior.

during staff meetings to celebrate behavior that supports the system's mission and values. Carondelet Health has also developed an intranet process that enables employees to send "ICU" messages to colleagues, recognizing them for values-oriented behaviors. Since July 2003, more than 16,500 such messages have been sent. The system is currently working to engage staff members in planning and implementing initiatives intended to enhance patient satisfaction and employee work life.

Many of these efforts focus on supporting and rewarding desired behaviors. Although such work is critical, organizational transformation also requires leaders to coach and provide feedback to staff members who are not living up to the desired standards. Nothing is as demoralizing to staff and as toxic to the environment as leaders' inability or unwillingness to deal with undesirable behavior. High-quality health care cannot survive in such an environment. Leaders need to recognize that there is a direct correlation between behavior in the boardroom and that at the bedside.

Seeking the Ideal

Health care leaders are often greatly tempted to rationalize or compromise by saying, for example: "Be a realist." "There are too many constraints." "We have to show results quickly." "You are chasing dreams." "It would never work." "We have no time for it." "It will cost too much." However, in a time of dynamic, revolutionary and continuous societal change, we should be unsatisfied with anything less than the design of an ideal system and a continuous pursuit of the ideal. Anything less is a waste of time. The ideal system may itself be revolutionary, but the journey toward it can be evolutionary. Nothing less than the ideal is worth the effort.[7] ■

For more information about BQA, contact Temenos, Inc., at temenos@lava.net or www.temenosinc.com.

NOTES

1. See I. M. Rubin, "Total Quality Management: Care Dealers vs. Car Dealers," *Physician Executive*, vol. 18, no. 5, September-October 1992, pp. 15-20.
2. I. M. Rubin, "Interpersonal Economics: How the 'Soft Stuff' Affects Hard Bottom Lines," *Health Forum Journal*, vol. 42, no. 5, September-October 1999, pp. 42-44.
3. See, for example, M. J. Wheatley, *Leadership and the New Science: Learning about Organization from an Orderly Universe*, Berrett-Koehler, San Francisco, 1992.
4. See "About Carondelet Health" at www.carondelethealth.org/about/.
5. T. J. Campbell and I. M. Rubin, *The ABCs of Effective Feedback: A Guide for Caring Professionals*, Jossey-Bass, San Francisco, 1998.
6. W. C. Byham, "Fixing the Instrument," *Training*, vol. 41, no. 7, July 2004, p. 50.
7. B. H. Banathy, *Designing Social Systems in a Changing World*, Plenum, New York City, 1996, p. 88.