Changing Organizational Performance: Examining the Change Process

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Abstract. A survey of hospital chief executive officers found financial challenges to be the most important issue facing their organizations (American College of Healthcare Executives 2007). However, researchers (Griffith et al. 2006; Langabeer 2008) have found that hospitals have been unsuccessful in significantly improving or changing their financial performance. In the present case study, the author reports how hospital leaders achieved cost reductions while maintaining quality patient care in the complex and messy reality of their organization. The author (serving as a consultant to leadership and using an action research methodology) examined the process of leading change in a hospital organization and the associated reactions of individual organizational members to change interventions. The author tried to link current theory and practice while identifying those factors most crucial to leading this financial change initiative, the major challenges faced, and what seemed most effective in addressing those challenges. The author also examined 4 phases of the change process: realizing the need to change, planning the change, implementing the change, and sustaining the change.

Keywords: change process, leadership, organizational change, organizational performance, resistance to change, turnaround

In a survey of 390 hospitals by the American College of Healthcare Executives (ACHE; 2007), 70% of the CEOs ranked financial challenges as among the top three most important issues facing their organizations. (The second and third most pressing issues—care for the uninsured and physician–hospital relations—received rankings by only 38% and 35% of the executives.) Healthcare does not appear to be alone in this matter: The results of a different survey of 1,536 executives involved in performance transformation efforts in numerous industries indicated that the top three categories of change initiatives in their organizations included reducing costs, improving performance, and turnarounds. Only 38% of these executives believed that their initiatives were successful, and only 30% thought these initiatives contributed to the sustained improvement of their organizations (Isern and Pung 2007).

This same lack of successful change appears in hospital organizations, despite the general belief that hospitals are experiencing substantial change. Griffith et al. (2006) studied the performance trends of 2,500 community hospitals over a 5-year period ending in 2003. Those researchers evaluated nine performance measurements constructed by Solucient from data they retrieved from Medicare reports. Solucient provides benchmarking information and comparative measurements of cost, quality, and market performance to hospital organizations (Solucient 2009). They found that 75% of the hospitals had no significant change or trend in each measure. None of the hospitals achieved more than five improving measures, and only five hospitals achieved improvement in five performance measures. Specifically regarding financial performance, 98% of the hospitals experienced no significant improvement in expense per discharge

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(after adjustment for case mix and wages). In fact, 34% experienced significant increased costs. Regarding operating profit margins, 92% experienced either no significant change or deteriorating margins. Griffith et al. (2006, 405) concluded that hospitals were "operating well below benchmark possibilities and without any promising trends for breakthroughs in the future."

Langabeer took this bad news a step further. In his study of community hospitals and major medical centers, he reported, "Analyses of data suggest that the average hospital has significantly poor liquidity, a high degree of debt leverage, and significantly low fund balances." He continued by reporting that of those hospitals experiencing financial distress, most "never emerge from their bleak financial conditions" (2008, 3).

The Present Case Study

In the present case study, I report how hospital leaders achieved cost reductions while maintaining quality patient care in the complex and messy reality of their organization. In particular, I focused on the executive team's leadership of change and the largest division—nursing—that achieved the greatest financial improvement. I used the organizational change models and principles of Lewin and Gold (1948), Schein (2004), and Kotter (1995, 1996), which address the cause–effect process of change, as a framework to link change theory and practices in this case.

The present findings are also consistent with my experiences in working as a consultant with over 20 hospital organizations, and I anticipate that the reported experiences and responses to change will resonate with individual readers who have been involved in any substantial financial-change intervention. Consistent with an action-research methodology, the present case study is intended to advance current organizational change theory and provide practical guidance to leaders and change agents.

The Organizational Change Process

Considerable research in the process of organizational change has been rooted in the work of Lewin and his unfreezing–moving–refreezing model (Lewin and Gold 1948). Lewin's model, aimed at changing the behaviors of groups, involves actions initiated in phases over time. Numerous authors and researchers have expanded on Lewin's (Lewin and Gold 1948) work at the organizational level (e.g., Judson 1991; Kotter 1995, 1996; Armenakis, Harris, and Field 1999; Burke and Litwin 1992; Schein 2004). According to Schein (2004), the unfreezing state involves developing motivation and preparing for change, the moving stage involves restructuring individuals' perspectives, and the refreezing stage involves reinforcing and integrating the change. Kotter's (1995, 1996) model, which is popular in the business literature, has been synthesized into an eight-step process for leading organizational change: (*1*) establishing a sense of urgency, (*2*) forming a guiding coalition, (*3*) creating a vision, (*4*) communicating that vision, (*5*) empowering individuals to act and removing obstacles, (*6*) creating short-term wins, (*7*) consolidating improvements and creating more change, and (*8*) institutionalizing new approaches. Lewin (Lewin and Gold 1948), Schein (2004), and Kotter (1995, 1996) have emphasized that the change process proceeds through phases and that those phases require a substantial amount of time. In subsequent sections of the present article, I compare Schein's (2004) and Kotter's (1995, 1996) theoretical models and principles with my experiences and findings in the present case study.

METHOD

The present case study was not designed to identify and examine a finite number of independent variables or measure their covariation with an outcome variable: There were too many confounding factors that cannot be eliminated by research design. The present case study was also not designed to suggest that the analysis of this series of "isolated observations combined with deductive inferences" (Gerring 2007, 176) allows us to draw specific conclusions about the outcomes. Rather, I used an action-research approach to study this organization's financial transformation as it unfolded. This approach involved consultant participation with the leadership, management, and staff of the client organization for the purpose of solving practical problems and generating new knowledge (Lewin and Gold 1948; Reason and Bradbury 2001; Coghlan and Brannick 2005).

Participating with client organization members while serving as a consultant, I facilitated an action-research methodology that involved an iterative process of jointly identifying and analyzing issues and problems, developing plans for action, implementing those plans, and evaluating the actions as a basis for a new round in the action-research cycle. Data were jointly

gathered and evaluated with organization members through (*1*) personal observations of and continual interactions and discussions among the executive team, managers, staff, and myself; (*2*) observations of group discussions during participative workgroups; (*3*) examination and analysis of documents such as financial reports and measures of patient satisfaction, employee–associate satisfaction, and hospital process of care; and (*4*) semistructured interviews conducted with 35 managers at all levels—executive, director, and manager—and from most departments of the organization.

Meeting weekly over a period of 18 months, I used an action-research process, emphasizing in-depth observation of the change process, analysis of the effects of interventions, discussions of values and norms surrounding acceptable performance and behavior, and the comparison of existing change theory to practice in this real and emerging organization. The issues that arose each week were documented and systematically discussed and challenged with and among members of the executive team, managers, a consulting associate, and myself. Documentation and quantitative information, such as financial reports and measures of performance, were regularly reviewed and reconciled with observations and individual perspectives.

During the last month of this 18-month engagement, I conducted semistructured interviews with 35 managers at all levels—executive, director, and manager—and from most departments of the organization. These managers reflected on and provided their insights and perspectives regarding the issues they believed to be most relevant to the financial transformation of the organization. The interviews and management reflections helped to support the prior analysis and emphasized those issues deemed most relevant by the executive team members, a consulting associate, and myself. They also provided language for articulating reactions, perceptions, and findings. In the present article, I use numerous quotes, which seemed to capture and articulate the predominant themes. I designed the triangulation of observations, multiple perspectives, and quantitative data to instill methodological rigor to the analysis of evidence and provide validity and relevance to both the findings and the process.

Reporting Format

First, I present a brief history and the background of the hospital organization. Then, the reporting and analysis are divided into four phases of the change process: (*1*) realizing the need to change, (*2*) planning the change, (*3*) implementing the change, and (*4*) sustaining the change. For each phase, I present brief context and chronology information, preceding a section reflecting on practice and theory. In each section reflecting on practice and theory, I attempt to answer the following research questions:

Research Question 1: What were the key executive and leadership action steps in this phase of the change process?

Research Question 2: What have Schein (2004) and Kotter (1995, 1996) said on the topic of organizational change in this phase?

Research Question 3: What were important observations, findings, and challenges faced by executives and managers in this phase of the change process?

Research Question 4: What seemed most effective in addressing those challenges faced during this phase?

Case Study Background

The present case study involves a 200-bed community hospital in the suburbs of a major Midwestern metropolitan area. In a mature and stable market, the hospital competes in its primary service area with four other hospitals for patients, physicians, and clinical staff—particularly nurses. The hospital is part of a multibillion-dollar, nonprofit health system, which provides financial and capital spending oversight and support to the hospital. However, strategic and operational decision making tends to be decentralized and is located at the local hospital site level. The hospital's chief executive officer (CEO) reports to the health system's chief operating officer (COO), but the hospital maintains a local governing board comprising individual members of the community. This board serves in an advisory role to the CEO and to garner community support.

Over the preceding 20 years, the hospital had been headed by two successive CEOs who were both long-term employees and rose through the ranks of the organization. Both were employees of the hospital prior to its acquisition by the health system and were accustomed to operating independently without the kind of financial accountability required by the system. They were popular with employees, their governing boards, and the local community, but after the acquisition they

promoted an antisystem attitude within the hospital. Although they were politically savvy, neither was perceived by executives and managers as having strong strategic or operational skills. Their styles of management were perceived as hierarchical, directive, and protective of the status quo. Few managers were hired from the outside, and it seemed that personal loyalty and relationships were the criteria for promotions.

Managers indicated they were aware of the deterioration of the organization's financial performance, but that it was only superficially discussed at senior management meetings, governing council meetings, and employee town hall meetings. It was suggested by executives and managers that negative information tended to be glossed over because it reflected poorly on the hospital leadership. The hospital leadership often blamed the system leadership for not providing adequate financial support and for burdening the hospital with overhead costs. Hospital leadership also argued that the organization was the victim of a changing payer mix and the general healthcare economic environment.

Phase 1: Realizing the Need to Change

Context and chronology. In early 2006, a new CEO was hired by the healthcare system to address the substantial financial losses of the hospital. The new CEO, with MBA and MD credentials, was perceived by executives and managers as having strong management, clinical, and operational skills.

The new CEO spent the first months meeting with staff and becoming familiar with the management team, physicians, members of the governing board, and organization. The CEO's inquiries into the causes of the organization's losses were met with responses about how past initiatives—such as training costs due to the implementation of a computer physician order entry system, the renegotiation of payer contracts, deterioration of payer mix, and the system allocations of too much overhead to the hospital—had all been causes of the losses. After more investigation, the CEO found that most of these perceived causes had not influenced the current losses. When asked about benchmarking metrics, or comparing the hospital's financial performance with that of comparable hospitals, managers spent time discrediting such data and attempting to prove that they were wrong.

Announcement of the need to change. In March 2006, the hospital sustained a large operating loss, which served as the new CEO's platform for change. The CEO's message focused the hospital's priorities on clinical excellence, physician engagement and renewal, and the need to grow. The message was also accompanied by a forthright assessment of the organization's financial challenges: that it could neither continue to sustain such losses nor conduct business as it had in the past. The message continued to be communicated consistently by the CEO in weekly e-mails to staff and in meetings of the senior management, medical executive committee, governing council, and staff at large.

Reactions to the message. Early on, many managers indicated that the message was perceived as refreshing, in that it was honest and transparent. Most expressed their belief that the organization needed to change, and they provided numerous examples of how departments other than their own needed to change. Later, as managers began to recognize that they were being challenged to accept responsibility and become accountable for changing their own areas, many responded that the hospital was a nonprofit organization and therefore did not need to make a profit. They also responded that it was the system's obligation to make up any financial shortfalls because it was part of a larger healthcare system. Others indicated that the current healthcare reimbursement structure simply did not allow hospitals to operate profitably.

Identifying financial opportunities and managers' reactions. After unsuccessful challenges of the executive and management teams to uncover savings possibilities, the new CEO asked an associate and me to help identify financial opportunities. Substantial cost savings and growth opportunities were identified throughout the hospital. All of the managers pointed out inefficiencies and concerns with patient-care quality in various areas of the hospital, but it seemed difficult for them to embrace the idea that there were opportunities for improvement in their own departments. Numerous clinical managers reacted by indicating that addressing such matters was not their responsibility, but rather that of administration—the executive team. Managers often responded to the idea of ensuring the financial viability of the hospital as a matter of urgency by

commenting that the care of patients as opposed to financial matters was most urgent: They had become healthcare workers to serve patients, not to be administrators or businesspeople.

Most respondents indicated that they would be willing to implement changes if provided specific directions about how to do so but acknowledged little responsibility for evaluating their department's financial performance and developing action plans to create improvements. However, because most departments were clinical, executives could provide general guidance, but the specific change initiatives required the expertise and support of the managers of the areas. Thus, the responsibility for developing change plans fell to clinical managers who had little experience and preparation for creating substantial financial change.

Research Question 1: What were the key executive and leadership action steps in the phase of realizing the need to change (Phase 1)? The initial step in leading the change process involved recognizing that the organization needed to change its financial performance to remain viable and sustainable. The next steps included clearly communicating and establishing financial improvement as a priority and focus of the organization, and objectively analyzing the organization's operations to identify opportunities for improvement. After executives and managers recognized the need to change and identified the areas of opportunity, it was necessary for the CEO and the executive team to enlist the support and motivation of those executives and managers who were most capable of creating the specific action plans to change and improve performance.

Research Question 2: What have Schein (2004) and Kotter (1995, 1996) said about recognizing the need to change? During this phase, Schein (2004) emphasized developing motivation by providing disconfirming data showing the need to change, diagnosing the gaps between existing and desired states, and using guilt and anxiety to motivate, while creating a safe context in which individuals sense that they can solve the problem without a loss of identity or integrity. Kotter (1995, 1996) proposed establishing a sense of urgency, forming a guiding coalition, creating a vision, and communicating the vision during this phase. Both Schein and Kotter proposed that each of these steps is crucial to moving the change process forward and that each step takes a significant amount of time and effort.

Research Question 3: What were the important observations, findings, and challenges faced in the phase of realizing the need to change?

Objectively evaluating information and monitoring the environment. Even when incurring losses and using benchmarking as a tool to identify opportunities for improvement, this management team could not evaluate the information objectively and accept that they needed to change their financial performance. Individuals ignored, denied, or rationalized away the information with arguments that (*1*) the organization didn't need to make a profit because it was a nonprofit organization, (*2*) the organization couldn't make a profit because it was a victim of payer mix and the healthcare environment, and (*3*) financial performance was not their responsibility. The management team was not experienced in recognizing the need to respond to competition, monitoring the external and internal organizational environments, or thinking about issues of financial viability; rather, they had major blind spots in objectively addressing such issues when they did arise.

Challenging beliefs, autonomy, and professional status as healthcare workers. Motivating executives and managers to accept responsibility for improving financial performance seemed hindered by beliefs that all reductions in costs had to reflect a compromise of the quality of patient care or the elimination of services and that they could not be more efficient. Others indicated discomfort in discussing any balancing or trade-offs between the cost and benefits of care, or considering that there might be savings gained by improving quality.

A few individuals were somewhat self-righteous about their status as healthcare workers, expressing allegiance to their professions—particularly nursing—and resentment about anyone infringing on their autonomy by challenging how they managed their departments or cared for patients. Managing the costs of providing medical care was not viewed as a performance issue affecting them. Rather, as professional healthcare workers, they seemed to feel that they knew what was best for the patient and how to best provide care and that it was the responsibility of the administration,

healthcare system, and healthcare payers to provide the financial resources for them to operate the organization as they saw fit.

Leadership and management. Perhaps most striking was the dearth of individuals stepping up to take leadership roles and the lack of understanding of basic leadership and management principles. Despite ample communication that there were opportunities to assume leadership roles in the transformation initiative, individuals continued to protect their departments and the organization from changing. Kotter (1995, 1996) pointed out that a common challenge in creating organizational change is that a management team may be paralyzed by having not enough leaders and too many managers. Kotter (1995, 1996) defined *leaders* as agents of change and *managers* as protectors of the status quo.

Challenges faced during Phase 1. Three factors—(*1*) the lack of objectivity in evaluating the financial performance of the organization; (*2*) the mindset that they did not have the abilities or responsibility to improve financial performance; and (*3*) the lack of motivation, experience, training, and leadership and management skills to recognize the need to change—presented the executives and managers with significant challenges. Pressure by the CEO to analyze the organization's performance and develop solutions created substantial defensiveness and anxiety in the executive and management ranks. Presenting disconfirming data, identifying gaps in performance (Schein 2004), and developing a sense of urgency (Kotter 1995, 1996) did not create enthusiasm for leading the needed change.

Research Question 4: What seemed effective in addressing the challenges faced in the phase of recognizing the need to change?

Open discussion of issues and establishing common values. A crucial starting point in this transformation initiative was bringing financial problems to the surface and requiring executives, managers, and staff to openly discuss financial performance. Combining these discussions with the CEO's approach of communicating financial performance improvement as part of a more comprehensive set of priorities for hospital improvements—such as clinical excellence, physician engagement and renewal, and the need to grow—provided the right balance of values to prevent the message from being rejected. Consistent with Schein's (2004) suggestion, it was essential to have a balanced message of reconciling financial performance with quality patient care to avoid compromising managers' integrity and identities as patient caregivers.

Clear, consistent, and persistent communication of priorities. Persistence in emphasizing that financial performance and improvement had become organizational priorities, not passing fads, and that not changing was not an option both seemed important in helping individuals to adjust their thinking about the organization's goals and direction. Many executives and managers indicated that they initially had taken a wait-and-see posture to determine whether this was just another temporary initiative. These same individuals pointed out that the CEO's relentless message that financial performance was a priority made it clear that the initiative was not going to disappear. Kotter (1995, 1996) stressed the importance of (*1*) providing clear communication of the organization's direction and (*2*) ensuring that the message is not undercommunicated.

Weighing personal costs of not changing and of creating anxiety. Communication of priorities by itself did not provide the motivation for executives and managers to initiate change. Only after the CEO declared and impressed on them that the many justifications and not changing were simply unacceptable did the executives and managers begin to comprehend that future change was a reality and not an option. Considering the personal costs of not changing made employees uncomfortable. Many interpreted it as not being nice and this created substantial anxiety. However, creating this high level of anxiety seemed essential to gaining the attention of executives and managers and to getting them to begin considering their alternatives. Most executives and managers initially wrestled first with whether they wanted to change as required and then with whether they had the capabilities to do so. Kotter (1995, 1996) and Schein (2004) emphasized the importance of strong-line leadership, powerful coalitions, and persuasive coercion as important elements in overcoming the opposition to the efforts to change. Schein (2004) suggested that once individuals have endured their denial and defensiveness, they then feel survival anxiety or guilt.

Redefining responsibilities and new learning. Most executives and managers deemed themselves successful on the basis of their longevity with the organization and the achievement of their positions or roles within the organization. However, during the hospital's change process, the expectations of their roles were being changed: The hospital was requiring them to accept responsibility for improving financial performance. Accepting this responsibility meant they had to dispel myths about the organization—its inability to change and its being a victim of the healthcare structure—to objectively evaluate the performance of their departments, and to identify opportunities for improvement. Schein (2004) proposed that individuals experience learning anxiety as they begin to accept the need to change and develop new skills, values, and ways of thinking.

Providing support and continuing to communicate priorities and new responsibilities. Because of the inexperience and lack of training in leading change initiatives, consistent with Schein's (2004) proposal, providing support to executives and managers in addressing the challenges of their new responsibilities seemed important. When the CEO engaged me to support the management team in identifying areas for financial improvement, the executives and managers initially attempted to discredit the presented opportunities and recommendations. Again, the CEO had to declare that the numerous justifications and other reasons why the organization couldn't change were unacceptable and that declaration encouraged executives and managers to at least pay lip service to the need for change by appearing to support the change initiatives.

Phase 2: Planning the Change

Context and chronology. In moving to Phase 2, the phase of planning the change, numerous challenges from Phase 1 continued. Executives and managers continued to struggle with objectively evaluating the performance of the organization and their departments. Their lack of motivation for and inexperience with creating financial change, along with reconciling these new roles and responsibilities with their autonomy and status as healthcare workers, continued to perpetuate anxiety and defensiveness.

This planning phase involved hospital executives and department managers in determining ways to improve efficiency, increase revenue, and reduce costs while ensuring quality patient care. For example, the largest division of the hospital, nursing, was identified as having substantial challenges and financial opportunities. I facilitated meetings to provide support to nursing executives and managers in reviewing the financial and management aspects of their departments. In these meetings, nursing managers reviewed and agreed on acceptable staff–patient ratios; targets for hours per patient day; variable budgets for each unit; and policies for scheduling, use of agency, and overtime. They developed reporting tools to monitor performance, such as daily reports of productive hours per patient day and variable budgets based on patient volumes. Related to these tools were the establishment of monitoring procedures, which would require managers to assess and explain any variances from the targeted performance and to develop action plans to respond to any variances.

This summary of the planning process seems straightforward. However, the actual process was chaotic, long, and arduous. Each element of the process had to be sold to and negotiated with executives and managers, requiring considerable patience and endurance. Most executives and managers had achieved their positions on the basis of their education and experience as clinicians and their longevity. They had limited experience and training in matters involving leadership, management, creating change, performance improvement, finance, and budgeting.

Their reactions included arguments about a lack of need for change, how there was not enough time to participate, how the change was not a priority, how the numbers and process were invalid, as well as a plethora of other distractions. Managers often returned to meetings without having completed their assignments and with complaints about the facilitators, the executive team, physicians, and the organization. Later, these same managers described their feelings and reactions during this period of time or phase as anxious, defensive, fearful of disappointing, and concerned about their ability to achieve expectations.

Research Question 1: What were the key executive and leadership action steps in the planning phase (Phase 2)? The planning phase involved leading groups and departments in establishing goals and objectives and ensuring they were aligned with those of the organization, determining ways to provide greater value and

quality in meeting the needs of those served, improving efficiency, and enhancing revenue or reducing costs. It also involved identifying and making decisions about the required action steps necessary to achieve the goals and objectives, establishing time frames for completing the steps, assigning responsibility to appropriate individuals, creating appropriate measurements and tools to monitor performance, and gaining the necessary support and resources from executives or stakeholders to implement the plans.

Research Question 2: What did Schein (2004) and Kotter (1995, 1996) say about planning the change?

Schein (2004) proposed that this stage requires the restructuring of individuals' perspectives to align them with the new vision and evaluating new information about the influence of the change. Kotter (1995, 1996) proposed empowering others, removing obstacles, and planning short-term wins.

Research Question 3: What were the important observations, findings, and challenges faced during the planning phase?

Planning, motivation, experience, and skills. Because of the clinical and technical nature of the various departments, senior management was unable to be directive in informing managers about how specifically to change their operations to achieve cost reductions. Rather, the various departments had to identify and plan their own cost-savings initiatives. Most managers and even some executives confessed that they had never been particularly concerned with financial performance and that they had not perceived planning, finance, and budgeting skills as important in their roles. They viewed themselves as managers of caregivers and providers of patient care, but were not motivated as managers who were responsible for operating a business.

Participation. Most managers wished to be involved in the planning process. At the same time, they requested to simply be provided protocols or procedures. Particularly in nursing, managers seemed accustomed to being trained in specific protocols and procedures. They seemed to believe that changes in policies and procedures could solve all problems and tended to reject the idea that they needed to lead and manage their departments better. Having to critically explore alternatives, make decisions about changes, and consider managing their units differently was challenging for them.

Anxiety about jobs, learning new skills, and loyalty. Most managers indicated they were anxious about whether they (*1*) would be able to maintain their jobs if they didn't perform, (*2*) had the capabilities to perform, and (*3*) had the desire to learn and apply the required new management skills. Many, particularly in nursing, were concerned that learning nonnursing skills and making changes might be disloyal to other nurses. Much as with these findings, Schein (2004) proposed that these anxieties emerge from fear of incompetence, punishment, loss of personal identity, and loss of group membership.

Individual responses to the planning initiative. Although planning participants began to verbally acknowledge the need to change organizational performance, it was still necessary to patiently negotiate with them to resolve their concerns and anxieties. Executives and managers were wary of any changes that might influence their areas of responsibility or require them to confront their staff about changes in their behaviors. Responses by managers to the change initiatives included avoiding planning meetings and not completing assignments; creating distractions by arguing over each detail of the process; contending that information used in the planning was not reliable; blaming other departments for their performance; and complaining about the facilitators, administration, or physicians. Schein (2004) had similar experiences, and he suggested that such responses come in stages, which he characterized as denial, scapegoating, maneuvering, and bargaining.

Research Question 4: What seemed most effective in addressing the challenges faced in the planning phase?

Credible approach and support in planning and participation in the process. Some of the defensiveness and concerns of the executives and managers were addressed by assuring them that the evaluation and planning processes were not aimed at embarrassing them for their historical performance, reducing the quality of patient care or the services provided to patients, or arbitrarily attacking or reducing their staff. Providing planning support and communicating the planning process to them in advance, gaining their agreement on the steps, and then

involving them in all decision making seemed to help gain some cooperation.

Confronting inappropriate behavior. It was particularly difficult for executives and managers to confront those who did not complete assignments and behaved inappropriately. However, most individuals modified their behaviors after seeing that their ideas and concerns were adequately addressed and that inappropriate behavior would no longer be tolerated. Kotter (1995, 1996) proposed that most inappropriate behaviors continue to occur because executives tolerate them.

Continuing communication and pressure. The continuing communication of priorities and pressure from the executive team helped individuals to understand that change was neither a passing fad nor an option. This seemed to be one of the most important factors in influencing individuals to work toward change.

Phase 3: Implementing the Change

Context and chronology. The transition from planning to implementing the change proved to be as challenging as the entire planning process. Developing plans and communicating them to those involved in the change process were not the same as achieving the goals.

Presenting and implementing change plans. Each division or department was responsible for the implementation of its plans. In nursing, presenting the change plans started with the chief nursing executive's communicating the need to enhance financial performance without compromising patient care to all managers and staff. Key goals involved the achievement of targeted hours per patient day, budgets, the minimizing of incidental overtime, and the use of agency–contract nursing, while working to improve clinical performance and outcomes measurements. Nursing managers met with each other and their staff members to discuss how to best achieve these goals and ensure compliance with policies (e.g., overtime, vacation, education).

Monitoring performance. After reporting the first deviations from the targeted goals, executives and managers were required to analyze their own performance, address the variances, and develop proposed action steps to resolve those variances. This kind of rigorous analysis and transparency had not been part of the regular management practice and discipline. Many people who considered themselves to be competent clinicians and managers felt that the results were embarrassing and humiliating. Employees also perceived being required to state the reasons for the variances and what action steps would be taken to remedy them as harsh and confrontational. It was often uncomfortable to hold managers accountable for achieving performance measurements, and conversations regarding accounting were either avoided or conducted in such an indirect manner—to avoid hurting anyone's feelings—that they were not understood and had no influence on employees' behaviors.

Performance varied substantially from department to department. A few managers quickly jumped on board with the changes, but many initially ignored the changes and then (*1*) argued that the goals could not be achieved or were too aggressive or (*2*) blamed others for their performance. Several simply cried in frustration. In many instances, individual managers attempted to rally the support of physicians or a group of individuals to challenge the changes. Numerous executives and managers left the organization or were asked to leave because they would or could not adapt to the performance requirements.

Outcomes. During the 2.5-year period between January 2006 and June 2008, despite a 2% decline in admissions and an 8% increase in case-mix index, the hospital's financial performance improved. Reductions in the number of full-time equivalent employees by 7% and average length of patient stay from 4.3 to 4.0 days contributed to a decline of losses from operations from over 4% of net revenue in 2005 to almost breaking even in 2006. However, improvement then slid backward to a loss of 2% of net revenue for 2007 and then moved forward once again to a profit of 3% of net revenue for the first 6 months of 2008—a 5% change in net revenue. By January 2008, with one exception, all nursing units had achieved their hours-per-patient-day targets, maintained nurse staff–patient ratios (e.g., 1:2 in intensive care, 1:4 in telemetry, 1:5 in medical and surgical units), and reduced annual expenses by over $6,300,000.

At the same time, hospital employee turnover, patient satisfaction, and employee–associate

satisfaction remained stable: Employee turnover remained at about 15.0%, and patient satisfaction (measured by Press Ganey surveys [Press Ganey Associates 2009]) increased from 81 to 83 in inpatient areas, from 80 to 81 in the emergency department, and from 90 to 93 in the outpatient areas. Employee–associate satisfaction (measured by Morehead Associates surveys [Morehead Associates 2009]) scores improved from 3.875 to 3.966.

Hospital process-of-care performance (measured by the Hospital Consumer Assessment of Healthcare Providers and Systems survey [Hospital Consumer Assessment of Healthcare Providers and Systems 2009]) showed substantial improvements during this period: The acute myocardial infarction core measure sets increased from 75 to 97, the heart failure core measure set increased from 71 to 85, the pneumonia core measure set increased from 26 to 83, and the surgical care improvement and surgical infection prevention core measure sets increased from 45 to 86.

Perhaps most significant was the turnover of the executive team. In June 2008, of those executives who were in place at the time of the appointment of the new CEO in January 2006, only one remained. In the Discussion section, I discuss and reflect on these executives' inexperience in creating change and their inability to adapt to new roles, responsibilities, and values.

Research Question 1: What were the key executive and leadership action steps in the implementation phase (Phase 3)? The implementation of the change plans started with the executives' communicating to all staff the need for change, the goals and objectives of the change initiatives, the needed restructuring of departments, the required changes in behaviors, and the time frames for implementation. The implementation also involved executives assigning responsibilities for performing action steps, revising policies to support changes and behaviors, and using measurement tools to monitor performance. Monitoring performance involved identifying variances from the plan and developing and taking necessary action steps to correct them. Consistent monitoring, revising initial plans and actions steps when appropriate, and confronting those whose behaviors were not consistent with new policies and achieving the plan were important elements of this phase of the change process.

Research Question 2: What did Schein (2004) and Kotter (1995, 1996) say about implementing change? Schein (2004) proposed that the move from planning to implementation involves continuing to align with the new vision, evaluating new information about the impact of the change, adopting new behaviors, testing the reactions and rewards from the new behaviors, and determining how the change fits with organizational relationships. Kotter (1995, 1996) has suggested that implementing change involves empowering others to act, removing obstacles, creating short-term wins, consolidating improvements, and institutionalizing new approaches.

Research Question 3: What were the important observations, findings, and challenges faced in the implementation phase?

Changing practices and behaviors. Executives and managers were inexperienced in executing their plans. Many who considered themselves competent clinicians and managers indicated they felt their performance results were embarrassing and humiliating. Leadership and management skills were required, rather than the political skills of appeasing and getting along. In nursing, nursing executives and managers attempted to communicate their goals and action plans by issuing directives, which did not result in changed performance. It was very uncomfortable for them to engage their staff members in the kind of collaborative and team-building activities necessary to achieve the required changed behaviors.

Accountability. In the implementation phase, executives and managers who previously operated autonomously (*1*) were being challenged and questioned by the CEO and executive team members about their performance and (*2*) were challenging each other and their staffs to change their behaviors. Holding staff accountable for new levels of performance required managers to wrestle with their new roles, with the reactions of their staff, and often with changes in the long-term working relationships that they had with their staff members. Many managers perceived being asked to explain the reasons for their variances from targeted goals and the action steps that they intended to take to correct the variances as harsh and confrontational. Direct conversations were very uncomfortable for most executives and managers, and conversations

were either avoided or conducted so indirectly that they had no influence on behavior.

Short-term wins. When change did occur and the organization members enjoyed a short-term success, executives and managers seemed surprised and sometimes skeptical that their actions caused the changes. For example, when the patient length of stay began to decline on the basis of managers' gaining the support of physicians and changing the discharge activities of nurse managers and staff, many managers suggested the change must be attributable to some aberration in the acuity of patients or some other factor that they did not understand. Thus, the win provided some confidence, but because pressure and efforts eased, confidence soon dissipated when the patient length of stay increased as new behaviors were not sustained. Similarly, Kotter (1995, 1996) found that improvements quickly deteriorated when pressure and focus were not maintained.

Monitoring performance and addressing variances. Managers continued to struggle with understanding how their actions influenced financial indicators of performance. Analyzing their departmental financial performance and continually modifying their actions to make corrections were new practices. The ambiguity of such trial-and-error management was difficult for them: They seemed more accustomed to and comfortable with being directed to follow a protocol or procedure than continually analyzing the results of their activities and then making modifications as necessary. A backsliding of performance occurred in almost every instance where continual monitoring and follow-up did not occur.

Removing obstacles. Perhaps the most prominent obstacles to change were several of the long-term executives and managers. Much as with Kotter's (1995, 1996) findings, many executives and managers seemed to inadvertently attempt to undermine the change initiative by paying lip service to the change efforts while (*1*) not changing their own behaviors and (*2*) continuing to allow their staff to behave in ways that were inconsistent with the goals of the change initiative. Several months after leaving the organization, one of these executives confessed to being a major barrier to change. Although the executive agreed with the need to change, it was too difficult and painful for the executive to adapt to the new skills, requirements, and values of the organization and to let go of the idea that changing would somehow harm employees or destroy the organization.

Research Question 4: What seemed most effective in addressing the challenges of the implementation phase?

Participative work groups and coaching. Participative work groups seemed to reinforce financial priorities and provide a forum for hearing concerns and developing appropriate responses to those concerns. Working on a professional-to-professional level, the managers listened to each other and were able to challenge each other about some existing inefficiencies and opportunities to improve the management of their departments. Managers in the group who were particularly proficient in certain activities emerged and began supporting others in analyzing financial performance, finding ways to approach staff about performance, and addressing productivity issues. Identifying individuals who were most successful in achieving their goals and using them to coach and support others on a professional-to-professional level appeared helpful, although in several instances those selected for coaching were accused of interfering or stepping beyond their boundaries.

Honest, clear communication, monitoring performance, and confronting issues. Managers who most rapidly achieved their goals attributed their success to direct conversations with individual staff members about expectations. They indicated these conversations were honest, open, straightforward, and transparent. They also reported that they were consistent in monitoring their performance and confronting staff to change behaviors and address performance issues.

Removing barriers to change. Clearly, the greatest challenge to change was dealing with individuals, particularly executives and managers, who simply couldn't adapt to the change or were unwilling to endure the anxiety and pain associated with it. After many discussions, arguments, and tearful sessions, some individuals left or had to be asked to leave the organization. Surprisingly, there were few objections by remaining staff when individuals were asked to leave. Treating those leaving the

organization fairly, compassionately, and with dignity seemed important to maintaining the support of those individuals remaining.

Phase 4: Sustaining the Change

Phase 4 involves continuing to improve and sustaining the change.

The organizational leadership's ability to continue and sustain performance improvement will only be determined after more time has passed. Thus, examining this phase of the organization's change process is not possible. The organization's executives and managers did report that they were pleased with the progress that had been made so far, but most expressed concern and anxiety about the long periods of time needed to achieve these changes and their abilities to sustain the hard-won improvements.

Schein (2004) and Kotter (1995, 1996) have proposed that change is only sustainable when the new ways of thinking about change become part of the culture. These new ways of thinking must result in new behaviors and approaches that become institutionalized.

DISCUSSION

After 2.5 years, the organization's performance had substantially improved. The hospital's performance had moved forward, slid backward, and then improved again. Performance seemed to improve when efforts were focused in a particular area and slid backward when that focus moved to other areas. Then, performance improved once again when efforts were refocused.

Several issues seemed most prominent during this change process and appeared to be the greatest challenges that the CEO and members of the organization will face in their efforts to continue to improve and sustain the performance improvements already achieved. The first challenge is the lack of leadership, desire, skill, and discipline in the individuals in the organization who are necessary to continually identify, plan for, and implement the necessary change. The second and more subtle challenge is the basic thinking or assumption of organization members that financial performance is neither important nor the responsibility of healthcare workers and that improvements in financial performance are incompatible with quality patient care and loyalty to one's profession and staff. The last and perhaps most important challenge is maintaining the commitment, energy, and patience to endure the considerable amount of time, anxiety, and pain necessary to achieve sustainable performance.

Addressing the first issue, the lack of the leadership and discipline necessary to implement change, the ACHE, the National Center for Healthcare Leadership, and healthcare leadership authors (e.g., Garman, Tyler, and Darnall 2004; Dye and Garman 2006) have pointed out the need for leadership and management development in the healthcare industry. They have also done substantial work to identify the particular competencies needed to implement the change and have provided some development guidance.

With regard to the second issue, basic individual frameworks for thinking about financial performance, Schein (2004) and Kotter (1995, 1996) have proposed that change is only sustainable when new behaviors become part of the organization's culture or part of its members' basic values, beliefs, or ways of thinking. In the present article, I have addressed many of these cultural issues and their implications. They seem to form a ripe area for further studies of hospital environments. A cultural assessment and further exploration may be fruitful for future researchers to identify cultural issues and develop strategies for cultural change (e.g., Schein 2004; Kotter and Heskett 1992).

Last, change takes not only strong and skillful leadership, but also individuals who are willing to invest both (*1*) the considerable amount of time and (*2*) the patience and courage necessary to endure the anxiety and pain that are integral to the change process.

Conclusion and Limitations

In the present case study, I identified key leadership action steps that hospital staff and associates took to improve the performance of the hospital's organization. I identified and discussed my observations and findings, the challenges that the organization faced in the change process, and what seemed most effective in addressing those challenges. Although the findings are generally consistent with Schein (2004) and Kotter's (1995, 1996) theories, in the present case study I identify several differences and provide specific details that may be more directly related and helpful to leaders and managers in hospital organizations.

Consistent with an action-research methodology, I intended the present case study to advance current theories on organizational change and

provide practical guidance to leaders and change agents. However, the present case study does not enable researchers to draw definite conclusions. It also had several limitations. First, it was limited to the examination of one hospital organization. Second, there were too many confounding factors to enable the identification and examination of a finite number of independent variables and their relations with an outcome variable. Last, the present findings rely on the observations, analyses, and inferences of myself as a consultant and participant in the change process and the organization's leadership and management to identify those factors that appeared most relevant to the change process. However, I did not design the study to enable researchers to draw specific conclusions about the causal connections and outcomes of those factors.

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