A Field Guide to Real-Time Culture Change: Just "Rolling Out" a Training Program Won't Cut It

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Presented as a representative case of how to handle the disruptive behaviors of professionals in healthcare, this article describes the strategies of a systems approach with a five-phase model for culture change. The "large-scale, real-time" culture change process, based on our own evidence-based research on toxic behaviors and the research of others, has been demonstrated to be more effective than one-on-one feedback to change these behaviors. The real-time approach has been applied to other organizational situations—strategy formulation, change management, or service improvement—with more sustainable effects than simply training alone. This article will help your organization with four outcomes: understanding the rationale for a five-phase model for cultural change, describing the advantages of a real-time versus nonreal-time approach to change, identifying the how-to's for application within a systems approach, and articulating a clear evaluation process to sustain successful organizational culture change.

KEY WORDS: Large-scale real-time culture change; evidence-based practice; five-phase model of change; systems approach.

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With a unique subspecialty in disruptive behaviors of healthcare professionals, we often receive calls from desperate healthcare executives to "fix" a high-profile physician who is in conflict with other providers. Those working with these disruptive physicians may exhibit increased absenteeism and a decrease in their own productivity, and, in extreme cases, leave the organization. Naturally, these leaders want a "quick fix" that keeps the disruptive physician in place, modifies his or her behavior, reduces the conflict, and restores the team to smooth functioning. Fortunately, there are strategies that will ameliorate the immediate conflict and reduce tension *in the short term*. However, based on our research,[1] we have discovered that any sustainable change must involve a systemic approach to culture change *over the long term.*

We call this article a "field guide" because it not only introduces a specific case from the field, but also provides a guide of evidence-based practices. This field guide simulates our work with one of our healthcare clients in culture change around what was its key issue—everyday civility. We have fictitiously named this client organization "Northwest Medical Center." (While we have created the name "Northwest Medical Center," it is not meant to resemble any entity with the same or similar name. The events and activities of this case are real albeit disguised to protect anonymity.) We position everyday civility as a rallying cry for two reasons. First, two decades of research from others as well as our own have demonstrated how this impacts a culture of patient safety, employee satisfaction, team performance, and the bottom line.[2] Second, the Joint Commission's revised standard has stated that hospital systems must establish a culture for dealing with the behaviors of professionals that impact patient safety—and civility is one of its top concerns.

REDUCING THE IMMEDIATE CONFLICT BEFORE LONG-TERM CULTURE CHANGE

Our first task with Northwest was to reduce the conflict among the physicians who had disrupted the continuity of care within their teams. The conflict was centered on three

physicians who shared physician assistants, lead nurses, and examining rooms. The tension among these physicians had become visible to patients, and several had spoken to the nurses about their discomfort with the "doctor's meanness" to the physician assistants. Inadvertently, the clinic executive director overheard community members in the grocery store talking about the disrespect that they had encountered at the clinic and were not planning to return for services. Interestingly, this deleterious result has been corroborated by several research studies. In one, people were less likely to buy from an organization with an employee they perceived as rude, whether the rudeness was directed at them or another employee.[3]

These reports made it clear that physician conflict was only the "tip of the iceberg," and the more enduring problem was the "climate of disrespect" that permeated the organization. Nonetheless, we needed to reduce the tension among the physicians and to handle any immediate risk in patient care before dealing with the larger culture change issue. We began with a series of assessment interviews with those identified physicians and key leadership. These interviews were an effort to gain their perception of the source of the conflict and their commitment to a mediation process. We will not go into the details of a mediation process here, given other detailed resources available on this topic, but rather point out the critical aspects of the process that led to our next steps in the culture change process.

WHAT IS MEANT BY REAL-TIME CULTURE CHANGE?

When you hear the term "culture change," what does this conjure up for you? Customer service training? Leadership development? Organizational restructuring? Snappy banners and buttons with catchy slogans? As ubiquitous as these strategies are, they will not sustain culture change over the long term because they do not engage a critical mass of multilevels and multidisciplines *very early on* in three arenas: diagnosis, action planning, and implementation.

Many culture change efforts, while large-scale, are often not conducted in "real-time." Even though many physician leaders know what "large-scale" means in terms of involvement from multiple stakeholders, they do not have significant experiences with *real-time* change—which refers to the fact that assessment and interventions are integrated into one seamless process with providers and other leaders participating simultaneously in the creation of the culture change process and plan.

Sometimes it is easiest to understand what real-time change is by addressing what it is *not*. The opposite of real-time change is one that is *sequential,* in that involvement from others occurs in separate phases. For example, there may be a formal assessment process including a survey; then a core team determines how to process this information in follow-up focus groups. Then this information funnels to a core team that identifies the significance of these data and how to use them to improve the culture—with this team being the decision-makers with little input by any of the participants in the formal assessment process. While we certainly use the data from these methods, these are not enough to create momentum and buy-in from all levels of the organization.

People support what they help create.

With Northwest Medical we chose a *nonsequential,* real-time, large-scale process. "Real time" refers to "now" in which key stakeholders engage each other—together in one room over the course of one, two, or three days. There is extensive research evidence that this moves the culture change process much more quickly and effectively than in an entirely sequential approach. Of course while some of the work even in a real-time perspective must be sequenced, greater focus is on combining assessment, action planning, and implementation during the same event.

THE FIVE PHASES OF CULTURE CHANGE AT NORTHWEST MEDICAL

We have found that it is almost impossible to do any effective culture change without understanding the views of diverse stakeholders. The "old" way of doing this incorporated the following model: leaders designed a plan, told others what it was, and tried to get buy-in along the way. Based on strong research evidence, people support what they help create and therefore they must be brought into the process of change in the initial stages. While key leadership at Northwest Medical was quite resolute in wanting to create a more patient-centered culture, the leaders weren't aware how patient-centeredness was related to norms of employee civility and respect. It took a real-time, large-scale effort to understand that being patient-centered was about patients and a whole lot more. The five phases are summarized in Figure 1 and described here:

- Phase 1: *Planning-to-plan team.* Known as the P2P team, this is a small multidisciplinary, multilevel group that designed the overall culture-change process, ensured its momentum forward, and ran interference as appropriate.
- Phase 2: *Everyday Civility Training.* This is a workshop that educates all employees on the importance of respectful engagement and its effect on job satisfaction, productivity, and patient service.

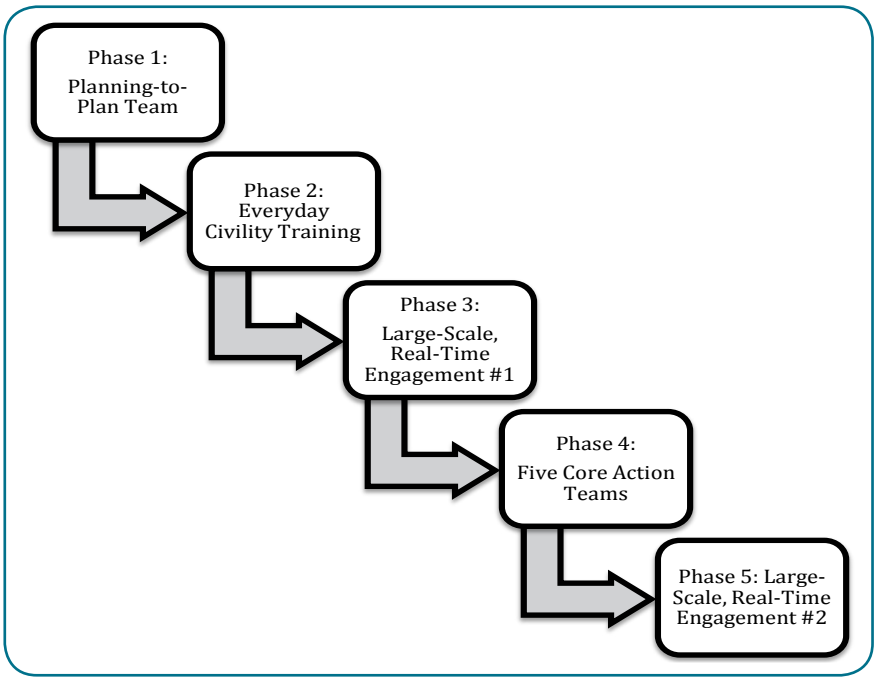

Figure 1. The five phases of the large-scale, real-time change process.

- Phase 3: *Large-scale, real-time engagement #1.* The agenda from the P2P team was enacted at Northwest Medical with 75 diverse stakeholders from multilevels and multidisciplines in one room over two days. The end result was a large-scale *organizational* commitment to five newly created goals represented by five corresponding action teams—each led by dual coordinators and an overall leader of all the action teams (more later on how this is inherently different from an executive group or a planning team creating these five action teams).
- Phase 4: *Action team work.* The five core action teams established in phase 3 worked for the next nine months. Each action team met twice per month, coordinated by a team leader. The work of all five action teams was coordinated by one overall leader who made sure the teams were communicating critical information with the other teams, sharing progress *with* the organization, and receiving continual feedback *from* the organization.
- Phase 5: *Large-scale real-time engagement #2.* At the nine-month mark, all the action teams came together for a final one-day event to reach consensus on movement forward and how to address obstacles encountered along the way.

Phase 1: Planning-to-Plan Team

What Is It?

At Northwest Medical, we formulated a P2P team consisting of the president, executive vice president, the quality administrator, two clinic site physician directors, one nurse leader, one nurse practitioner, one nurse, one clerical supervisor, and two physicians. While large for a planning team, we suggested this because it is important that representation on this committee be multilevels and inclusive of key disciplines. This P2P team planned what the culture-change event will look like, *not* what the strategies and implementation of these strategies are for everyday civility.

Some may look at the work of the P2P team and say, "It appears to be a steering team." It really is not. There are two primary differences between a steering team and the P2P team:

- The first difference is that the steering team does not engage directly in the change event. This is not the case for Northwest Medical. Here, the P2P team does plan the change process *but also* engages in the culture change activities that occur in other phases.
- A second difference is one of direction. Typically, a steering team is not a decision-making body; it simply provides guidance to upper management that decides. In contrast, the P2P team is a default decision-making mechanism should the large-scale participants be unable to reach consensus.

Kinds of Decisions the P2P Team Makes

We have divided the kinds of the P2P team makes into two categories: *Content* and *Process* (see "*Content* Decisions of the Northwest Medical P2P Team" and "*Process* Decisions of the Northwest Medical P2P Team" on page 298). We have found that no decision-making item should be left to chance. What can ruin the critical engagement of the stakeholders in a real-time format is a misunderstanding

about who will make final decisions and what the process for decision-making will be for the large-scale event.

At Northwest Medical, the P2P team had some critical discussions that pertained exclusively to the difficulty of large-scale work in healthcare. Because 75 of their most talented and committed professionals would be engaged in culture change, there was a significant question that emerged: How can we rationalize a large-scale, real-time process if medical providers attending would have to have their patients rescheduled? This appeared antithetical to the goals of good patient service—cancelling patients to find ways to enhance everyday civility to better serve our patients! Ultimately, two decisions were made that would accommodate patient needs and the desire to move forward with the culture change.

First, the timing of the phase 3 event would be two months in advance such that many patients would not need to be rescheduled. Second, for those patients who would need to be rescheduled because their provider would be in the session, the P2P team decided that this was best for the long-term strategic outcomes of culture change. They concluded that there would be some important tradeoffs and inconveniences in order to create an even more patient-centered culture.

The minute you start discussing or monitoring something, changes may begin to occur.

The subsequent action of clearing the schedule for six hours and making it feasible for all levels of employees to attend had a powerful impact at Northwest. People understood that the organization was putting its money into changing the culture and were highly committed to having input from all. This shift to recognizing not just the leaders, but all providers and support staff was a significant shift in demonstrating the potential contribution of all members of the organization. Researchers have actually discovered that the minute you start discussing or monitoring something, changes may begin to occur. And that's exactly what happened at Northwest Medical. People began talking about "clearing their schedules" within the organization, and energy started mounting toward this culture change process even before many were formally engaged in the phased actions!

What if it is really not feasible to clear the schedule? As an alternative to the P2P decisions made here of one large-scale event with representation from all groups, and then shifting patients' schedules, other clients have decided to conduct two large-scale events in which *everyone* in the organization attended but at two different points in time—with no shifting of patients' schedules. In this latter approach, there was a debriefing session of a small group of representatives from each of the two events, with a merging of the results of each of the two days of work. At Northwest Medical, while they discussed this option, they chose one large-scale event.

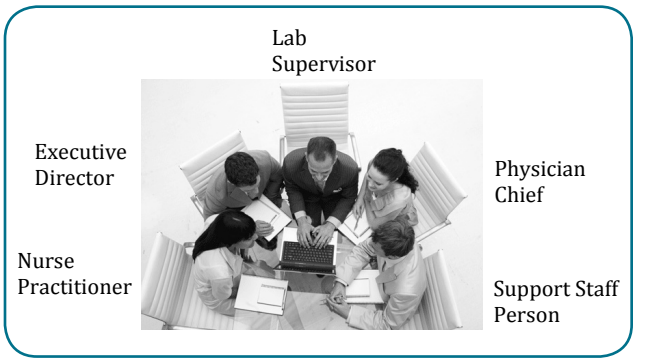

Figure 2. Maximum-mixture groups for the large-scale event.

The P2P team emerged with many decisions related to the content and process logistics. Essentially, the plan to enhance everyday civility would be formulated in one large room with several small groups at separate tables—created from a *maximum-mixture* of stakeholders from the entire organization, commonly referred to as "max-mix" groups.[4] For example, each max-mix group may consist of a key leader, a support staff member, a nurse practitioner, a physician, a manager, etc.—designed to simulate the broad spectrum of staff in the organization. Multiple *round* tables of this maximum-mixture of stakeholders are distributed throughout the room. We strongly urge round tables because there is no formal "head"—everyone is of relatively equal footing. Figure 2 provides an illustration of this max-mix group.

We can't accentuate enough the power of this large-scale, real-time approach where we often hear such things as, "I never thought about it from that perspective," or "Now I get it," or "I wish I had heard this a year ago because I wouldn't have been such a roadblock here." We recommend that the entire P2P team discuss who should be at each table rather than leaving it to random chance. We do help the P2P team identify what we refer to as "mini-facilitators"—individuals who were part of the max-mix groups and whom we trained to keep the discussions on track, monitor time, make sure all are participating, and in general adhere to the goals of the prescribed activity.

How the P2P Team Makes Decisions

There is often a fair degree of initial anxiety associated with this large-scale, real-time approach. One of the areas of anxiety for many of our clients when considering this large-scale approach can be formulated into a question: What if we hear suggestions at this large-scale event that we can't do? This is one of the key concerns that Northwest Medical leaders had that is addressed by a continuum of shared leadership.[5]

Content Decisions of the Northwest Medical P2P Team

1. What are the goals of culture change regarding everyday civility at Northwest Medical in concrete and behaviorally specific language?
2. What current documents exist associated with patient satisfaction and culture change that will inform us about everyday civility? What should be shared and in what format (i.e., full document or summary) at the large-scale event?
3. What will be the specific agenda of the large-scale culture change event, including all the detailed activities and timeframes for each?
4. How should we integrate the work already done at Northwest Medical that relates to patient service and everyday civility (e.g., the Medical Climate Survey, the Staff Culture Inventory, past work of the Quality Engagement Committee, aesthetic changes at the sites, etc.)?
5. How and by whom will it be announced to the organization?
6. What will be the decision-making vehicle(s) used, with a default mechanism should a decision not be able to be made in an expeditious fashion?

Process Decisions of the Northwest Medical P2P Team

1. Who should be involved in the large-scale event? What will be the selection process (e.g., hand-picked, voluntary, and/or random)? What are the pros and cons of each? Should the entire board of Northwest Medical be present, or just board representation, or no board members?
2. How will the participants be divided into small groups within the large-group format, such that there is representation from all levels and all disciplines within the organization?
3. Who will be the "mini-facilitators" during each of the small-group activities within the large group to make sure discussions stay on track and don't get derailed? Do we need to train these mini-facilitators, and, if so, what is the best way to accomplish this?
4. Who will be the facilitator from outside the organization?
5. Who will be the coordinator to make sure all materials have been ordered for the large-scale event, such as:
   - Easels, flipchart paper (with masking tape, if not self-adhesive paper), and dark-colored markers at each max-mix table?
   - Round tables?
   - Refreshments and meals?
   - DVD player, LCD player, and TV monitor, large screen, as needed?
   - Laptop recorder with high-speed printer and enough paper for copies of all flipchart work for each participant?
   - Nametags and name tents (preprinted or not)?
   - Number and type of microphones needed (e.g., one table-top microphone for each max-mix team for reporting to the large group; one lapel microphone for facilitator)?

First, the P2P team may use the large-scale event as input and others may decide, based on this input. Second, we helped them understand that if they choose the consensus route, this does not preclude their own input. Leaders (and P2P members) contribute in the max-mix groups and have a voice just like everyone else. The important message here is that the decision-making vehicle should not be left to chance. Beyond input and consensus, there are other decisions we help our clients understand in the context of large-scale change. In the box "The Primary Contexts of Decision-Making Within the P2P Team" on page 299, we highlight the primary kinds of decision processes used in both the P2P process and in the large-scale event. Let's examine each of these further.

The decision-making vehicle should not be left to chance.

Regarding the first item—***leader(s), expert(s), or team decide(s) with no input***—they often ask us why in the world would we be engaging others if we are not seeking their input? Our response is that there may be some items that are "givens" or "off limits for discussion." For example, with one of our healthcare clients, it was already determined that there would be a merger with another medical center. While the leadership entertained how to operationalize the merger (and this was a significant discussion at the large-scale event), there would be no discussion regarding whether they "should" merge, but rather how *best* to merge.

The second item—***leader(s), expert(s), or team decide(s) with input***—may seem pretty clear, but it does have some built-in contention. For example, has anyone ever asked you for your input but you know his or her mind is made up? That's the kind of contention we're talking about here. Leaders need to be authentic in this regard and not ask for input on something that is a "given." This authenticity is a benchmark of everyday civility—one where leaders model respectful engagement. We often say to leaders that it's far better to be autocratic than lack integrity! With this being said, we suggest that if your mind is made up, be authentic about it. State the reasons. Invite discussion to clarify. But clearly, let people know that the decision has been made. If the decision has not been made, ask for input and inform others that while you may not be able to do what everyone

The Primary Contexts of Decision-Making Within the P2P Team

1. Leader(s), expert(s), or team decide(s) with no input;
2. Leader(s), expert(s), or team decide(s) with input; and
3. Consensus among all in attendance.

wants, you will at least close the feedback loop by relating how and why you have decided what you have These actions around decision-making begin the very practice of the values of everyday civility-enacting behaviors of integrity and transparency in decision-making.

In the case of Northwest Medical, they chose ***consensus*** to be the preferred mechanism for all decisions made at the large-scale event. Consensus is often misconstrued—both in definition and process. Consensus should be about support, not necessarily agreement. One can actually be in consensus even though everyone may not agree. What we helped Northwest understand is that if people cannot consent, it is important that they speak up at the time and not engage in any "passive-aggressive" behavior later (e.g., downplaying the decision, stating that you never really intended to go along with it, etc.). When we help others understand why consensus is preferred in certain circumstances, there is a higher likelihood of both acceptance of this method *and* respect for the process. We have three process guidelines for consensus that we outline in the box "Process Guidelines to Speed Up Consensus, Help Others Better Understand this Method, and Ultimately Increase Everyday Civility"above.

The definition of "consensus" is support, not agreement.

We have already stated the definition of "consensus" is support, not agreement. Don't assume others in attendance know this. When we use the same terms but understand them differently, everyday civility is eroded because unnecessary conflict and bad feelings can escalate. We also helped Northwest Medical understand the importance of placing a time parameter around consensus, along with a default mechanism. We recall one discussion in the large-scale event where time ran out for one activity, and consensus was close but not achieved. The group knew that if this should occur, the default mechanism was that the P2P team would decide.

While no default mechanism is perfect, and all are fraught with benefits and deficits, we would like to provide a caution to one default mechanism in particular: majority rules. There's a fair amount of evidence that majority rules may have a tendency to polarize the group into "winners" and "losers." Just think about what happens after a major election—again, winners and losers. In a team-oriented structure such as large-scale change with everyday civility as a goal, you want to avoid this if at all possible.

Process Guidelines to Speed Up Consensus, Help Others Better Understand this Method, and Ultimately Increase Everyday Civility

1. Make sure everyone operates from the same definition; when we say the same things but understand them differently, everyday civility is eroded.
2. Place a time parameter around consensus.
3. Have a default mechanism should consensus not be achieved, such as:
   - Leader(s) decide(s);
   - Other(s) decide(s) (e.g., expert(s), person most interested, P2P team); and
   - Majority rules.

Phase 2: Everyday Civility Training

Some critical questions that the P2P team considered in mandating the Everyday Civility Training were:

- Is such a focus on employee civility really that important to good patient care?
- Why are we working at civility? Aren't we all pretty much respectful, with a few exceptions?
- Why not just go after those who aren't very respectful?

The relationship of statistics related to patient safety and disruptive behaviors is a critical part of motivating individuals to understand that changing disruptive behaviors is not just about "being nice" (see the box "Research Data on Incivility and Its Organizational Impact" on page 300.)

Phase 3: Large-Scale, Real-Time Engagement #1

The large-scale, real-time event was ready to launch! The room was filled with sunlight and round tables covered with brightly covered tablecloths inviting participants into a cheery environment to begin their engagement. By each table stood a flipchart and pens ready for attendees to record top ideas that emerged from the discussion. As planned, the president began the engagement with a brief comment on his praise for all those in attendance and an inspirational note for a fruitful and energetic day. The facilitators were introduced, and they quickly began the day's agenda as planned by the P2P team. Upon completion of each set of activities, each small group reported to the full group, and the top three ideas from every group were recorded by the transcriptionist. These were then quickly printed out in a high-speed portable printer, and the consolidated list was given to every table. This

Research Data on Incivility and Its Organizational Impact

- 70% to 80% of medication errors are due to disruptive behaviors.
- 51% of nurses reported patient errors from physician abuse.
- 65% of nurses reported abuse from nurses; 77% reported abuse from physicians.
- 50% of targets of incivility stated that they "can't handle the incivility."
- 30.7% of nurses quit as a result of toxic abuse.
- Intimidation caused 49% of medication errors; 27% of patient mortality.
- Only 1% to 6% of targets of incivility ever filed a complaint.
- 92% of leaders rated the severity from 7 to 10 on a 10-point scale.
- 45% said the uncivil person lashed out two to three times per week.
- 51% of victims said they would likely leave as a result.

The Five Core Action Teams with Target Goals

- **The values action team:** Determine behavioral values around everyday civility, ways to reinforce, and ways to garner commitment.
- **The physician compact team**: Develop a compact of professional physician behaviors with corresponding expectations and consequences—both positive for adherence and "zero tolerance" for violations with a progression through a three-step due-process method.
- **The staff compact team:** Co-develop with union representation a compact of professional staff behaviors with corresponding expectations and consequences—both positive for adherence and zero tolerance for violations with a progression through a three-step due-process method.
- **The whole-patient encounter team:** Design, implement, and evaluate a system for discovering patient needs, communicating them throughout the organization, and reinforcing successes.
- **The organization experience team:** Develop a greater understanding of what individuals and teams need to be both successful *and* have work-life effectiveness (previously called "balance").

process of moving from small group to large group occurred for each question that the P2P team designed. At the conclusion of this process, there was a break, and the P2P team met to identify the major themes that emerged from the discussion. In this section, you will see the decisions the P2P team enacted with the entire group of key stakeholders. One of the first results of this engagement is delineated in the box "The Five Core Action Teams with Target Goals" above, with the development of five core action teams.

As you can see from this agenda, we are precise regarding the activities and the timing of them. The primary results from the event were that momentum started rolling regarding the process of change around everyday civility and its impact on patient safety, patient service, and performance. Many more individuals were engaged than were ever anticipated, and they arrived at a plan going forward. This plan entailed structuring another large-scale event to incorporate specific next steps in a real-time format, localizing the process at each of the clinic sites, and engaging in consistent communication throughout the organization about this process and results. There were some expected cynics in the group who said for sure that this "management fad" would soon be over. They were surprised to find that they were wrong and that this was just the beginning.

Phase 4: The Work of Five Core Action Teams

Following the work of the large-scale, real-time event was the work of each of the five core action teams. As culture change consultants, we were engaged to continue our work with the P2P team and the large-scale, real-time event. We did this by having face-to-face quarterly meetings with each of the five core action teams. In addition, we had conference calls every other week with each of the teams. The purposes of these meetings were to address any concerns, redirect the teams as appropriate, connect them with needed resources, and to make sure the team coordinators were meeting with each other to identify economies of scale and ways to better communicate to, and receive feedback from, the organization.

An interesting discovery of each of the teams was that physicians were the first who needed to understand the impact of everyday civility on patient service and, ultimately, on the overall performance of Northwest Medical. The reason that physicians were the first call to action is that there is extensive research evidence that people model those with positive influence (and power) in the organization. For example, the research conducted by Safe Medication Practices[6] has demonstrated that 49% of people have reported that an intimidating physician has influenced the way they have handled clarifications regarding a medication order. And 75% have reported that they have asked a colleague to interpret a medication order as opposed to interacting with an intimidating physician! Further, Rosenstein and O'Daniel[7] found that a whopping 67% believed that disruptive behaviors were linked with adverse effects,

Accomplishments of the Large-Scale, Real-Time Change Process at Northwest Medical at 12 months

Development of Core Values Associated with Everyday Civility Seminar as Demonstrated by Principles of Partnership for Northwest Medical

These core values incorporate the following:

- Excellence and safety in all patient care;
- Respectful engagement with all members of the staff and patients;
- Individual and organizational transparency;
- Collaborative team problem solving for the patient's benefit; and
- Organizational citizenship behaviors that promote a culture of courteous and civil behavior.

Approval by the Board of a Physician and Staff Compact Delineating Requisite Behaviors of Everyday Civility for the Organization and the Individual

This is what Northwest Medical agrees to do in order to promote everyday civility through such contexts as:

- The safest work practices possible;
- A mentoring program;
- A leadership development program that includes everyday civility as a core practice;
- An employee development program that includes everyday civility as a core practice; and
- An on-boarding program that introduces the concept and practice of everyday civility.

This is what each employee agrees to do to promote everyday civility:

- Treat everyone with the respect that one would want to receive in return;
- Use respectful dialogue as taught in the leadership development and employee development programs;
- Engage in shared decision-making whenever possible;
- Acknowledge the effective work of others; and
- Deliver on promises made and, if not possible, provide time and space for dialogue about this.
- Demonstrate flexibility in understanding the needs of others:
  - — A Flow Chart of Physician Consequences and a Flow Chart of Staff Consequences—both of which described consequences of behavior for not living up to the Physician and Staff Compact;
  - — A zero-tolerance policy for violations of everyday civility;
  - — A revised on-boarding program that included everyday civility as a core focus with periodic conversations for new employees in two venues:
    - Within team meetings, team leaders would use a structured conversation approach around everyday civility and integrate into their daily team's work; and
    - Monthly meetings of all new employees coordinated by selected managers from throughout the organization—with focus on challenges and opportunities associated with everyday civility.
  - — Revamped hiring procedures to address not just competencies, but values-based experiences related to everyday civility;
  - — A revised performance management system that reinforced performance based on a 70%-30% split associated with task work and values-based work, respectively;
  - — A revised performance appraisal form in which 70% of the items related to task work; 30% related to the value of everyday civility;
  - — A three-pronged approach to feedback in which three categories of performance feedback were engaged by leaders to enhance performance for:
    - The poor or mediocre performer;
    - The high performer; and
    - The disruptive, uncivil person.

including 27% who believed this was associated with patient mortality. Among pediatric nurses, 57.6% reported a decreased ability to engage in critical thinking as a result of disruptive physician behaviors.[8] More than 80% of perioperative personnel reported loss of concentration, reduced communication and collaboration, and impaired relationships with other team members as a result of disruptive behaviors.[9] These data, along with those cited previously in "Research Data on Incivility and Its Organizational Impact," were catalysts for engaging physicians in this way. The P2P team believed that if physicians could be models of new ways of thinking about the importance of the value of respect, positive changes would emerge more quickly and more effectively.

It is important to mention that we don't want to single out physicians. While they are a primary group because of their influence, other professionals play a part in the significance of everyday civility. For example, there is evidence of "horizontal abuse" among the nursing profession, with 65% witnessing disruptive behaviors among nurses.[10] With this research as a backdrop, Northwest Medical determined that after physicians had an opportunity to engage in this learning, the next group to receive this would be nurses. Northwest believed that the probability of robust discussions would increase with partners who were peers. There are no easy answers to this, and we have found that "baby steps" to change are better than no change at all. Thus by involving peers first and multidisciplines second,

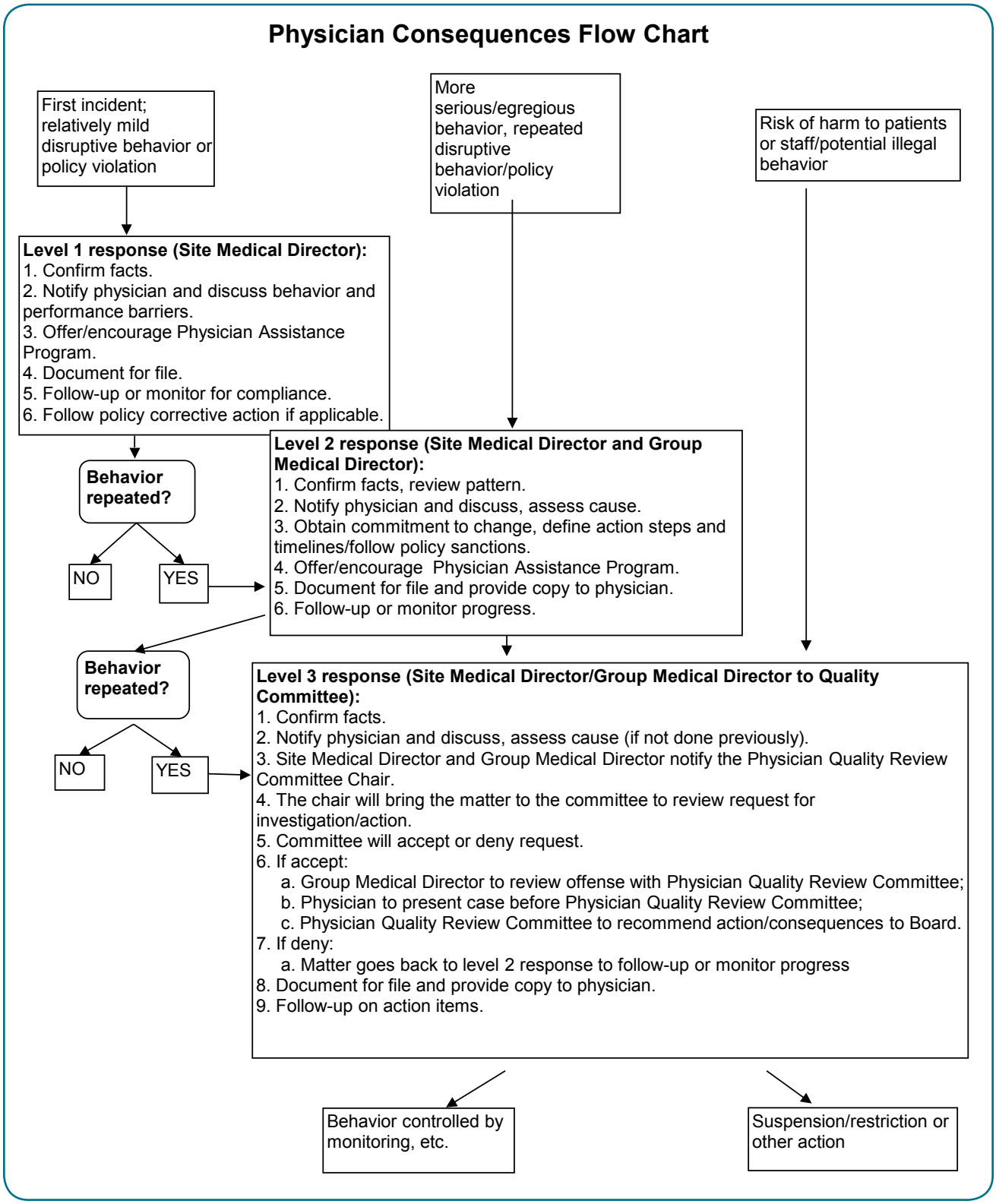

Figure 3. Flow chart of physician consequences, three-step model.

the Northwest was positioning itself to begin significant changes in the organization.

Phase 5: Twelve-Month Large-Scale, Real-Time Engagement #2

At the nine-month mark, the P2P team again brought key stakeholders to the table to reinforce the outstanding culture change work done to date, problem-solve how to address key obstacles, and review the process needed in moving forward.

There were significant accomplishments reported by Northwest Medical Center (see "Accomplishments of the Large-Scale, Real-Time Change Process at Northwest Medical at 12 Months," on page 301). Of special significance was the establishment of a process to handle the disruptive behaviors of physicians and staff (see Figure 3).

Of significance in any healthcare change program is the effect that the organizational and individual changes have on the patients. Northwest was a part of a parent organization that collected patient satisfaction scores every quarter for all its site locations throughout the United States. Based on its "key driver analysis" system, which measured the impact of patient satisfaction defined in this context as: "a patient's likelihood to recommend your practice to a friend or family member," Northwest Medical was the only practice that significantly improved within the entire system. Scores showed significant improvement in four categories:

- Courteousness/helpfulness of receptionist;
- Care provided by nurse;
- Courteousness of physician; and
- Level of staff concern for your comfort.

MORE THAN "ROLLING OUT" A TRAINING PROGRAM!

We firmly believe that if you are "rolling out" a training program, you have likely missed the culture change boat. Hopefully, it is evident that culture change moves far beyond this roll-out strategy. And it's beyond simply restructuring your organization. While these may be part of the culture change methodology, it is only part and probably not the most significant.

True culture change is about the critical engagement of others from multidisciplines and multimethods in real-time. It's work, no doubt! But the benefits are significant in terms of patient safety, patient service, organizational performance, and the bottom line. Some upfront work in this regard in the short term will serve your healthcare organization in the long term. Leaders must be willing to challenge the status quo and see culture change as engagement in a real-time format. People support what they help create!

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