BRINGING CULTURE INTO FOCUS

ABIM Foundation Forum 2015: Background Paper

By Tim Lynch

Organizational culture in health care is an expansive concept, encompassing how institutions treat their employees, how well clinicians and staff work with one another, how patient safety is emphasized (or not), and many other elements. Although health care leaders may not always mean the same thing when they use the word culture, they do share an increasing recognition of its importance. Culture shapes relationships among clinicians, administrators, patients and families, and affects clinician decision-making, care outcomes and patient experiences.

In a time of reform and transition in healthcare, it is especially important that we refine our understanding of how culture can be used to deliver care in a more effective, patient-centered fashion.

The concept that organizations exhibit culture is a fairly modern one, and the application of "organizational culture" to the health care world is even more recent. Indeed, most of what has been written about culture and health care has been published in the last quarter century, and researchers continue to explore the intersection between the cultural characteristics of organizations and specific aspects of care delivery. Even as that research suggests that certain kinds of cultures— particularly those that are marked by collaboration, innovation and flexibility—can contribute to critical outcomes like patient safety, there are still many questions about how such cultures can be fostered.

In a time of reform and transition in health care, it is especially important that we refine our understanding of how culture can be used to deliver care in a more effective, patient-centered fashion. The *Physician Charter,* which guides the ABIM Foundation's work, calls for physicians to commit themselves to continuous improvement, to work collaboratively and to respect the primacy of patient welfare.[1]

Culture is inextricably tied to these goals and to the larger goal of enhancing professionalism, and understanding how culture can be shaped to make it easier for physicians and all actors in the health care system to achieve them will be our crucial undertaking at the Forum.

We hope that this paper provides useful background for our discussions. It will present definitions of culture, provide examples of research about the relationship between culture and care delivery, and explain, through the words of those who are actively engaged in that effort, how systems and medical groups have attempted to create cultures that enable better care.

Merriam-Webster defines culture as "the beliefs, customs, arts, etc. of a particular society, group, place or time" or "a way of thinking, behaving or working that exists in a place or organization (such as a business)."[2]

Anthropologist Franz Boas described culture as "the system of shared beliefs, values, customs, behaviors, and artifacts that the members of society use to cope with their world and with one another and that are transmitted from generation to generation through learning."[3]

A more modern definition comes from linguist Helen Spencer-Oatey: "Culture is a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioral conventions that are shared by a group of people, and that influence (but do not determine) each member's behavior and his/her interpretations of the 'meaning' of other people's behavior."[4]

Organizational culture, which applies the concept of culture to institutions such as hospitals or health systems, has its own definitions. Edgar Schein, who has written and consulted extensively on the topic, defines organizational culture as

1. ABIM Foundation, American College of Physicians, European Federation of Internal Medicine. The physician charter [pamphlet]. Philadelphia; 2002.

2. Culture [Internet]. Merriam-Webster. 2015 [cited 2015 Mar 23]. Available from: http://www.merriam-webster.com/dictionary/culture

3. Boas F. The mind of primitive man. New York: Macmillian;1961. 254 p.

4. Spencer-Oatey H. Culturally speaking: culture, communication and politeness theory. 2nd ed. New York: Bloomsbury Academic; 2008. 384 p.

"a pattern of shared basic assumptions invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration that have worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems."[5] Schein identifies three levels of organizational culture:

1. **artifacts,** which are visible manifestations of culture such as dress codes, ceremonies and systems of rewards;

2. **beliefs and values,** espoused within the organization, such as a commitment to evidence or to patient autonomy;

3. **assumptions,** which are unspoken and even unconscious beliefs, values and expectations.[6]

Measuring Culture's Impact

The concept that organizations have a culture is less than 40 years old, first appearing in the academic literature in the late 1970s.[7] A greater focus on organizational culture in health care was catalyzed 20 years later by two major Institute of Medicine reports—"To Err Is Human"[8] and "Crossing the Quality Chasm"[9]—that stressed the link between organizational culture and care quality.[10]

Researchers and theorists writing about organizational culture in health care have often employed the Competing Values Framework.[7] That framework suggests that the relationship between an organization and its environment can be characterized along two perpendicular axes: structure (the degree to which an organization emphasizes centralization and control over organizational processes vs. decentralization and flexibility) and focus (the degree to which an organization is oriented toward its own internal environment and processes vs. its relationships with the external environment and outside entities).[11,12] Classifying organizations along those dimensions yields four culture domains:

1. *Group* or *family/clan* culture is marked by collaboration, empowerment, participation and shared beliefs;

2. *Developmental* or *entrepreneurial* cultures prioritize innovation, flexibility, risk-taking and growth;

3. *Hierarchical* or *bureaucratic* cultures emphasize stability and are characterized by structured processes, standards and regulations designed to promote efficiency and predictability; and,

4. *Rational* or *market* cultures are focused on goals and competitive advantage and have high pressure to produce quantifiable results.[10,11]

Institutions contain mixes of all cultural types to varying degrees,[10] but researchers have developed questionnaires and other means to analyze which cultures are most dominant at a given institution.

A number of studies have applied this Competing Values Framework to particular elements of care delivery. Although the findings are not universal, both a strong group orientation and an entrepreneurial culture are generally associated with better outcomes, with hierarchical and rational cultures largely associated with negative outcomes.[11]

5. Schein EH. Organizational culture and leadership. 4th ed. San Francisco: Jossey-Bass; 2010. 464 p.

6. Scott T, Mannion R, Marshall M, Davies H. Does organisational culture influence health care performance? A review of the evidence. J Health Serv Res Policy. 2003 Apr;8(2):105–17.

7. Zazzali JL, Alexander JA, Shortell SM, Burns LR. Organizational culture and physician satisfaction with dimensions of group practice. Health Serv Res. 2007 Jun;42(3 Pt 1):1150–76.

8. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. Washington (DC): Institute of Medicine; 1999.

9. Crossing the quality chasm. Washington (DC): Institute of Medicine; 2001.

10. Brazil K, Wakefield DB, Cloutier MM, Tennen H, Hall CB. Organizational culture predicts job satisfaction and perceived clinical effectiveness in pediatric primary care practices. Health Care Manage Rev. 2010 Oct-Dec;35(4):365–71.

11. Hartmann CW, Meterko M, Rosen AK, Shibei Zhao, Shokeen P, Singer S, Gaba DM. Relationship of hospital organizational culture to patient safety climate in the Veterans Health Administration. Med Care Res Rev. 2009 Jun;66(3):320–38.

12. Scammon DL, Tabler J, Brunisholz K, Gren LH, Kim J, Tomoaia-Cotisel A, Day J, Farrell TW, Waitzman NJ, Magill MK. Organizational culture associated with provider satisfaction. J Am Board Fam Med [Internet]. 2014 Mar-Apr;27(2):219–28. Available from: http://www.jabfm.org/cgi/doi/10.3122/jabfm.2014.02.120338

Scholars initially focused most of their work at the hospital level. One study examined the role of culture in quality improvement efforts at a set of 61 hospitals, and found a "significant association between hospitals with group/developmental cultures emphasizing teamwork, support, development of everyone's potential and a willingness to undertake some degree of risk and the degree of reported QI implementation."[13] The authors suggested that

> Numerous researchers have found a link between culture and hospitals' performance on patient safety, from inpatient outcomes to reducing readmissions.

their findings presented a particular challenge for larger hospitals, which were more likely to have bureaucratic or rational cultures, as they sought to adopt continuous quality improvement.[13]

Numerous researchers have found a link between culture and hospitals' performance on patient safety, from inpatient outcomes[14] to reducing readmissions.[15] In reviewing how culture affected safety, researchers studying the Veterans Health Administration found that VA hospitals with stronger group and entrepreneurial cultures performed best on safety, while hospitals with stronger hierarchical cultures performed more poorly.[11] The researchers theorized that the mutual respect and civility that is associated with group culture made it easier to discuss safety problems openly, while an entrepreneurial culture empowered local initiatives to improve safety.[11] In contrast, hierarchical cultures place a strong emphasis on adherence to standard operating procedures and rank, potentially creating atmospheres in which workers were reluctant to raise safety issues.[11]

Recent research has focused on the culture of group practices and other smaller units, with some arguing that as medical groups adapt to changes driven by health care reform, their success will depend on their cultures.[16] A number of studies have linked provider satisfaction to culture.[7] One study of primary care pediatric practices found that group cultures contributed to provider satisfaction and perceived clinical effectiveness, while hierarchical and rational cultures detracted from both.[10] The authors of the study wrote: "Our findings suggest that for small organizations, a managerial approach that emphasizes authority and control to achieve efficiency may undermine provider and staff job satisfaction and perceived clinical effectiveness."[10] Another study of primary care practices found that primary care teams that had a greater degree of daily interactions were associated with higher quality of care for patients with cardiovascular disease, including a reduction in hospital days.[17]

Other researchers, looking at the relationship between culture and the adoption of the patient-centered medical home (PCMH) model, found that no one type of culture was "better" than others in the transition to the PCMH approach. The researchers reviewed the relationship between how providers viewed the culture of their practice and their satisfaction on a series of topics ranging from the quality of care their practice provided to their workload. Among other things, they found that:

- practices marked by group culture were less satisfied by the amount of administrative work entailed by the shift to a PCMH model;

- entrepreneurial cultures were positively associated with providers' satisfaction with the amount of time they spent working;

13. Shortell SM, O'Brien JL, Carman JM, Foster RW, Hughes EF, Boerstler H, O'Connor EJ. Assessing the impact of continuous quality improvement/total quality management: concept versus implementation. Health Serv Res. 1995 Jun;30(2):377–401.

14. Pronovost P, Weast B, Rosenstein B. Implementing and validating a comprehensive unit-based safety program. J Patient Saf. 2005;1:33–40.

15. Hansen LO, Williams MV, Singer SJ. Perceptions of hospital safety climate and incidence of readmission. Health Serv Res. 2011 Apr;46(2):596–616.

16. Nembhard IM, Singer SJ, Shortell SM, Rittenhouse D, Casalino LP. The cultural complexity of medical groups. Health Care Manage Rev. 2012 Jul-Sep;37(3):200–13.

17. Mundt MP, Gilchrist VJ, Fleming MF, Zakletskaia LI, Tuan WJ, Beasley JW. Effects of primary care team social networks on quality of care and costs for patients with cardiovascular disease. Ann Fam Med. 2015 Mar;13(2):139–48.

- rational cultures were positively associated with satisfaction about quality of care and leadership in facing economic and strategic challenges; and,

- hierarchical cultures were negatively correlated with provider satisfaction related to relationships with staff and resources.[12]

The researchers suggested that a concrete lesson of the study was that as health care redesign leads to larger, more integrated and more hierarchical organizations, management should be conscious of the need to strengthen provider-staff relationships and provide adequate resources, recommending "attention to effective methods for changing organizational culture in a way that enhances provider satisfaction."[12]

Although the Competing Values Framework is commonly applied in culture studies, other studies have considered the impact of culture through a different lens. For example, one set of researchers found that organizational culture was the key factor distinguishing hospitals with high and low 30-day mortality rates for patients with acute myocardial infarction (AMI).[18] The study leaders reviewed participating hospitals on six domains: hospital protocols and processes for AMI care; organizational values and goals; senior management involvement; broad staff presence and expertise in AMI care; communication and coordination among groups; and problem solving and learning.[18] While high- and low-performing hospitals differed significantly in five of the six domains, their protocols and processes for the actual delivery

of care were substantially the same.[18] In other words, the difference between the best and worst performers came down to cultural elements such as communication and coordination, values and goals.

To be sure, not every study finds a clear relationship between culture and outcomes, or is able to easily disentangle culture from other factors. One study found no significant relationships between culture and the implementation of evidence-based medicine in physician organizations.[19] Another found that a hospital's supportive group culture was associated with some good outcomes (e.g., shorter postoperative intubation times) but also some poor ones (e.g., longer operating room times).[20] Another study analyzed the relationship between culture and prescription drug errors considering nine cultural dimensions: collegiality, information emphasis, quality emphasis, organizational identity, cohesiveness, business emphasis, organizational trust, innovativeness and autonomy.[21] The authors found that physician autonomy was the only one of the nine dimensions that was significantly related to the error rate, with increased autonomy associated with a lower rate of errors.[22]

A meta-analysis of early studies of culture and health care found that the evidence base linking culture and performance was "suggestive but far from definitive."[23] The authors reviewed 10 studies, classifying four as having found plausible evidence for a link between culture and performance, four as finding little evidence for a link and two providing unclear findings due to methodological concerns.[23] They did note, however, that none of the studies found evidence against such a link.[23] Although

18. Curry LA, Spatz E, Cherlin E, Thompson JW, Berg D, Ting HH, Decker C, Krumholz HM, Bradley EH. What distinguishes top-performing hospitals in acute myocardial infarction mortality rates? A qualitative study. Ann Intern Med. 2011 Mar 15;154(6):384–90.

19. Shortell SM, Zazzali JL, Burns LR, Alexander JA, Gillies RR, Budetti PP, Waters TM, Zuckerman HS. Implementing evidence-based medicine: the role of market pressures, compensation incentives, and culture in physician organizations. Med Care. 2001 Jul;39(7 Suppl 1):162–78.

20. Shortell SM, Jones RH, Rademaker AW, Gillies RR, Dranove DS, Hughes EF, Budetti PP, Reynolds KS, Huang CF. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. Med Care. 2000 Feb;38(2):207–17.

21. Kralewski J, Dowd BE, Kaissi A, Curoe A, Rockwood T. Measuring the culture of medical group practices. Health Care Manage Rev. 2005 Jul-Sep;30(3):184–93.

22. Kralewski JE, Dowd BE, Heaton A, Kaissi A. The influence of the structure and culture of medical group practices on prescription drug errors. Med Care. 2005 Aug;43(8):817–25.

23. Scott T, Mannion R, Marshall M, Davies H. Does organisational culture influence health care performance? A review of the evidence. J Health Serv Res Policy. 2003 Apr;8(2):105–17.

considerable work has been done since that analysis was published, the authors' strongest critique continues to merit consideration: "[A]ttention has focused on how culture affects performance, [but] it is equally plausible that certain cultures emerge from high-performing organizations. That is, performance may drive culture. More likely still is that culture and performance are created together in a reciprocal and mutually reinforcing manner that is thoroughly dependent on wider context and influences."[23]

Fostering Cultural Change

As described in the preceding section, there is significant evidence supporting the idea that hospitals and medical groups with cultures marked by collaboration, empowerment, flexibility and other key attributes provide care that is better in important respects. This section will include descriptions of how some leading experts have gone about building these kind of cultures, from primary care practices to large systems and academic medical centers. Common themes that emerged from interviews with them included the importance of leadership, team-building and actively engaging patients and communities.

Leadership

Alan Manning's job is to help health care institutions change their cultures. As the Chief Operating Officer at Planetree, Manning consults with hospitals and other care providers about how to build more "patient-centered" cultures and provide better care. Many of the institutions he works with are facing severe challenges that threaten their ability to achieve their missions. Manning stressed that the active involvement of executive leadership is critical to achieving culture change. "If you don't have good leadership out front, it is a very uphill battle," he said, arguing that staff throughout the institution will take cues from the level of participation and engagement of senior management.[24]

Chuck Kilo, MD, Chief Medical Officer at Oregon Health & Science University (OHSU), has been leading efforts at OHSU to improve ambulatory care by uniting faculty around performance improvement, including the implementation of Lean principles and other tools. (Lean is a performance improvement approach pioneered by Toyota that focuses on improving processes to increase value and eliminate waste.)[25] This "practice optimization" effort began in 2012 with support from the Dean of the School of Medicine and leadership in the Faculty Practice Plan and the Vice President of Ambulatory Practices.[26] "Most health care leaders use the word 'culture,' but don't understand that culture is something that needs to be managed, or how to manage it," said Dr. Kilo.[27] He said that culture change will be implemented "a lot faster if all the executive leaders are really on board, and slower if they're not." The OHSU plan targets leadership at multiple levels, including department chairs, department administrators and practice managers and supervisors, and has performance targets in safety, quality, service and affordability.

Wisconsin's ThedaCare has relied on Lean since 2003 to pursue cultural transformation, and Mark Hallett, MD, the Chief Operating Officer for two of the system's regional medical centers, discussed the nature of leadership that he thought was needed to succeed. "The style of leadership that's required to achieve change is markedly different from what physicians learn in training," he said, describing the traditional "experience-based deference" to the senior-most member

24. 24. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Alan Manning (Chief Operating Officer, Planetree, Derby, CT). 2015 Feb 10.

25. A brief history of Lean [Internet]. Cambridge (MA): Lean Enterprise Institute; 2015 [cited 2015 Apr 22]. Available from: https://www.lean.org/WhatsLean/History.cfm

26. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interviewed via e-mail: Judith Carlson (Practice Optimization Manager, Oregon Health & Science University, Portland, OR). 2015 Mar 10..

27. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Charles Kilo (Chief Medical Officer, Oregon Health & Science University, Portland, OR). 2015 Jan 22.

of a section or institution to make important decisions. "The leader in a Lean system is much more of a servant leader, supporting people at the front line."[28]

The importance of leadership in driving and sustaining cultural change is hard to overstate. John Kotter, a Harvard Business School professor and leading authority on transforming corporate cultures, has written about a series of errors that can derail cultural transformation projects. Many, if not all, of these errors trace back to a failure of leadership; they include not establishing a great enough sense of urgency, failing to assemble a powerful guiding coalition to support change, lacking a vision for change or undercommunicating that vision, not removing obstacles to that vision, not systematically planning for and creating short-term wins, declaring victory too soon, and not anchoring changes in an entity's culture. As Kotter writes, "A renewal process typically goes nowhere until enough real leaders are promoted or hired into senior-level jobs."[29]

Building Teams

Active leadership may be a critical first step, but leaders must still decide where to prioritize. One common goal, which is supported by the research summarized previously, is to create more egalitarian, team-based institutions.

For example, a team approach is essential in developing a patient safety culture, perhaps the most important way in which cultural change can serve patients. Tejal Gandhi, MD, is an internist and the head of the National Patient Safety Foundation, which she joined after leading patient safety efforts at Brigham and Women's Hospital and Partners HealthCare. Echoing the findings of the study of the Veterans Health Administration cited earlier in this paper, Dr. Gandhi said that patients are safer if they

receive care from hospitals or medical groups that have developed cultures marked by teamwork and open communication, in which "people feel comfortable speaking up when they see something that's not right."[30] She stressed the value of converting senior clinicians to the patient safety cause, pointing out that "more senior doctors

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and nurses really drive the culture," and that unlike their more junior colleagues, an explicit focus on patient safety as a discipline was not part of their education and training.

Part of this team-building process can involve simple steps to expose people playing different roles in the care delivery process—from physicians to clerks—to the demands their colleagues face. Stuart Pollack, MD, created a new primary care practice, Brigham and Women's Advanced Primary Care Associates in Boston, as a demonstration project to test a team-based approach to primary care. While it offers fairly standard care for healthy patients, it provides intensive team-based care for those with serious or chronic illnesses. Care teams include up to seven or eight caregivers, including pharmacists and social workers, and one or more team members are in contact with patients on a weekly basis.[31]

Dr. Pollack said that "the cool thing of opening a practice was being able to design the culture instead of the processes."[32] Building the right culture involved a wide range of activities designed to instill a team atmosphere at the practice, which includes eight physicians (3.75 FTE) and about 35 total staff members. This includes regular huddles, co-location of physician and staff and 360-degree performance

28. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Mark Hallett (Chief Clinical Officer, ThedaCare, Appleton, WI). 2015 Feb 17.

29. Kotter J. Leading change: why transformation efforts fail. Harv Bus Rev. 1995 Mar-Apr:57-60.

30. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Tejal Gandhi (President, National Patient Safety Foundation, Boston, MA). 2015 Feb 17.

31. Hochman M. Improvement happens: team-based primary care, an interview with Stuart Pollack. J Gen Intern Med [Internet]. 2015 Apr;30(4):521–8. Available from: http://link.springer.com/10.1007/s11606-014-3119-z

32. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Stuart Pollack (Physician, Brigham and Women's Hospital, Boston, MA). 2015 Feb 10.

reviews in which personnel are reviewed by everyone with whom they work. It also includes a program he calls "Walk a Mile in My Shoes," in which staff groups, such as medical assistants, talk with the rest of the team about their duties and what they like (and don't like) about their jobs. Dr. Pollack said he thinks this addresses a particular challenge to building truly collaborative teams in health care. "Obviously a lot of industries have done culture better than us," he said. "But there are very few businesses where the teams really include both people with only high school degrees and people with four years of college, four years of medical school and four years of residency."

ThedaCare uses a similar technique to the "Walk a Mile in My Shoes" approach. For example, Dr. Hallett asked physicians who were frustrated by scheduling issues to spend a half hour watching the schedulers do their jobs and "see how hard it is to get it right." Consultant Alan Manning said improving a hospital or practice staff's sense of team and shared mission requires creating "new depths of understanding among colleagues." "Much of the training I do right now is talking to doctors and nurses about how to hold each other accountable, without hurting one another's feelings," he said.

Manning said that although culture change involves the declaration of values—such as a commitment to teamwork—and the adoption of policy changes, those are only the beginning. In the end, as Manning put it, "cultures change because of behaviors." For example, as part of creating a team-based culture, Manning advocates celebrating examples of the kind of culture you want to promote. "You need to create excitement and energy," Manning said. "Health care—caring for the sick and dying —is a heavy industry. It is important to find ways to be celebratory." He suggested approaches both modest, such as employee or team of the month awards, and intensive, such as an effort by one of his clients to record the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) phone surveys it conducted with patients and send CDs to employees' homes that included positive comments about them.[24]

Engaging Patients and Communities

Another critical aspect of improving culture is engaging patients and communities. ThedaCare tries to engage patients in helping drive changes to enhance their experience of care. "Everything about the Lean approach is designed to create value for patients," ThedaCare's Dr. Hallett said. He recounted how ThedaCare interviewed hundreds of focus group participants about their desires, preferences and goals when seeking medical care, and used that data to create a prototype patient named "Lorie" whom they consider in designing care.[28]

This focus on patient engagement was manifested in a Lean "rapid improvement event" to revise how breast cancer diagnoses are delivered to patients. The project team included a mix of patients and physicians, including Dr. Hallett. The physicians all came into the process believing that patients who had cancer wanted to hear that news from a physician, even if it meant prolonging the period of uncertainty that they had to endure. The patients on the project team expressed the opposite view, saying they wanted the information as quickly as possible, even if that meant someone else delivering the news. "When these patients told us that, you could have heard a pin drop," Dr. Hallett said. As a result of this workgroup's findings, ThedaCare's protocol was wholly revamped, and specially trained nurse coordinators were charged with ensuring that patients promptly received the news that they had breast cancer and were engaged in a discussion about next steps.[28]

Diane Meier, MD, also stressed the importance of engaging with and listening closely to patients. Dr. Meier, a geriatrician at Mt. Sinai Hospital in New York City and a leading practitioner of and advocate for palliative care, said that physicians often blame patients' families for seeking futile care for their loved ones without asking them for the reasons behind their requests. She told the story of the mother and sister of a man at Mt. Sinai who was dying from AIDS, whom they insisted should receive futile care. When Dr. Meier spoke with them, she learned that they incorrectly believed artificial feeding would make him heavier

and mask his disease when he appeared in an open casket at his funeral, as their faith required. "The entire team was blaming the family for torturing him," Dr. Meier said. "No one had ever asked what they were hoping for."[33]

Dr. Pollack has tried to shape his staff with patient relationships foremost in mind. In interviewing potential clinicians and staff, he looks for a quality as simple as being "nice," and he believes this search for civility and kindness has created a much different patient experience. "If you look at the comments we get on our patient satisfaction surveys, the word 'nice' appears several times a month," he told the Journal of General Internal Medicine.[31] "And 'nice' has worked really well for us. Nobody feels bad that they're bothering the doctor or the nurse when they call." OHSU's Practice Optimization efforts are also focused on improving the patient experience of care, which is referred to as the plan's "True North." Early results are positive, with its Press Ganey ambulatory overall patient experience scores increasing from the 20th percentile in December 2013 to the 56th percentile in January 2015.[26]

On rare occasions, clinicians and systems can engage entire communities in culture change. In LaCrosse, Wisconsin, 96 percent of adults who die have completed an advance directive, compared to 30 percent nationally.[34] This is due to the work of Bernard Hammes, MD, and the Respecting Choices® Advance Care Planning program he leads at Gundersen Health System. With training from Hammes, Gundersen's nurses began talking with healthy patients about their preferences related to end-of-life care, and asking them if they wanted to fill out advance directives. Hammes, a medical ethicist, was inspired to do this after years of counseling families who were struggling to make end-of-life decisions for their loved ones. "The moral distress these families were suffering was palpable," he told NPR last year. Although the system had to devote

millions of dollars annually in uncompensated care to working with patients about their living wills, that effort created a seismic cultural shift in which having an advance directive is a community standard.[34]

Education

The institutions that educate physicians are a particularly important site for change. When Richard Frankel, PhD, and Thomas Inui, MD, arrived at Indiana University School of Medicine in 2002, the school's leadership asked them to lead an effort to transform its culture. At the time, Indiana's student satisfaction scores ranked below the national average, and relationships among faculty were weak.

> "If you frame the question as 'how can we get more of what's going right?' instead of 'how can we fix what's broken?,' you find yourself in a different place," Frankel said.

Frankel and Inui used an "appreciative inquiry" process, which asks participants to explore what is working within an institution and build upon those positive elements to create change. "If you frame the question as 'how can we get more of what's going right?' instead of 'how can we fix what's broken?,' you find yourself in a different place," Frankel said.[35] Twelve faculty members with an interest in culture change volunteered to interview a cross-section of the faculty; they met with 80 professors and asked them to share a story about a time when they felt they were at their best. When the project leaders analyzed the 80 stories, Dr. Frankel said they found four basic themes that were common among them: the capacity of all people to grow and learn, the importance of connectedness, passion for the work and the wonderment of medicine. They then held town hall meetings where medical school personnel could tell positive stories, which led to what Frankel calls "positive gossip" that sustained the effort.

33. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Diane Meier (Director, Center to Advance Palliative Care, New York, NY). 2015 Mar 10.

34. Shapiro J. Why this Wisconsin city is the best place to die [Internet]. NPR. 2009 [cited 2015 Apr 7]. Available from: http://www.npr.org/templates/story/story.php?storyId=120346411

35. Lynch, Timothy (Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with: Richard Frankel (Associate Director of the VA HSR&D Center for Health Information and Communication, Indiana University, Indianapolis, IN). 2015 Jan 20.

Frankel and Inui also worked with the admissions committee in an attempt to shape Indiana's culture by enrolling a student body with different skills and attitudes. The committee agreed to give weight to previously un- or under-recognized attributes such as communications skills, moral and ethical reasoning, or attitudes toward professionalism. Frankel says that this effort "began to change the composition of the class; we got better team members with a strong sense of moral and ethical obligations."

Students then became active participants in the culture change campaign. A group of students undertook their own effort to collect stories through appreciative interviewing; they then created a book featuring 20 inspirational stories, which was placed in the pockets of the coats given out at the annual white coat ceremony. This has become an annual tradition, now in its tenth year. Students also responded to a cheating issue by working with faculty and administrators to develop an honor code that is now signed by all students and faculty.

Starting in 2004, two years after the culture change effort began, student satisfaction (as expressed in surveys administered by the Association of American Medical Colleges) rose sharply to a level well above the national average.[36] And after having declined for a decade, applications to the medical school doubled, rising significantly faster than applications to its peers.[36]

Conclusion

The wide scope and multiple meanings of culture make it a challenging topic to discuss. Yet there is increasing evidence that various aspects of organizational culture make a significant difference in the quality of care delivered and the patient experience of that care. The examples discussed here highlight just some of many approaches to culture change, and many additional stories will be told at the Forum, where participants will consider how culture affects care in a variety of settings for a broad cross-section of patients. Inspired by discussions that bring together viewpoints from across the health care system, Forum participants will surely put forth innovative ideas for improvement, and work to advance those ideas after the Forum concludes.

36. Cottingham AH, Suchman AL, Litzelman DK, Frankel RM, Mossbarger DL, Williamson PR, Baldwin DC Jr, Inui TS. Enhancing the informal curriculum of a medical school: a case study in organizational culture change. J Gen Intern Med. 2008 Jun;23(6):715–22.

Notes