5-2003

# Creating Changes in Organizational Culture: The Role of Three Types of Teaching and Learning

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To the Graduate Council:

I am submitting herewith a thesis written by Sheila Gordon entitled "Creating Changes in Organizational Culture: The Role of Three Types of Teaching and Learning." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Educational Psychology.

John Peters, Ed. D., Major Professor

We have read this thesis and recommend its acceptance:

Mary Ziegler, Ed. D., Kathy Greenberg, Ph.D.

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Acceptance for the Council:

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Vice Provost and Dean of Graduate Studies

(Original signatures are on file with official student records.)

# Creating Change in Organizational Culture: The Role of Three Types of Teaching and Learning

A Thesis Presented for the
Master Of Science
Degree
The University of Tennessee, Knoxville

Sheila Gordon
May 2003

# Dedication

This thesis is dedicated to the staff of the Careville Health System[1] who are creating a change in the culture of their organization.

[1]The actual name of the organization was changed to help ensure confidentiality.

Acknowledgements

I would like to thank Dr. John Peters, Dr. Katherine Greenberg, and Dr. Mary Ziegler for their guidance, counsel, and coaching throughout the experience of applying collaborative learning to my practice.

## Abstract

The purpose of this thesis was to describe my experiences as part of a team that assisted the Careville Health System plan and implement an organizational culture change effort. This was not considered an empirical research study; it was, rather, a recording of my personal experiences, reflections, and served as a documentation of such. This change effort was designed to assist the staff in creating an improved culture of customer service delivery to patients, their primary customers.

This thesis reviewed two theoretical frameworks used to assist the organization's change efforts: Schein's (1992) model of organizational change and Peters and Armstrong's (1998) typology of teaching and learning. I described the training and development plan based on these two frameworks in order to assist the reader in understanding the findings and conclusions of the thesis.

I found, through this experience, that Type II teaching and learning and Type III teaching and learning were the most helpful techniques to assist a staff in changing a culture. I also learned that time was a critical factor in creating both Type II and Type III teaching and learning experiences. I found that the elements of creating dialogue within teams and co-constructing new knowledge are catalysts for the movement of culture. I also learned how my own habits of thought and action contributed to the traditional separation of leadership and staff in culture change initiatives. I concluded with the understanding that staff needed more involvement in articulating the change through dialogue and that their voice was an important part of designing an improved culture of customer service delivery.

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## Prologue

Recognizing massive changes in health care that have occurred in the United States during the past decade, leaders of health care organizations have found it necessary to change several aspects of their organizational culture and operating modes in order to remain competitive while providing the quality of service demanded by patients. In 2001, the Careville Health System, a large hospital located in a metropolitan area of the Southeastern United States, undertook such an initiative in order to improve the hospital's delivery of service to patients, its primary customers. The following description of this initiative is my personal documentation of the experience and includes my observations and reflections. As such, it was not an empirical study.

I served as Manager of Leadership Development for the hospital and played a major role in the change effort. I became a member of a design team formed to help plan and implement the change. I was concerned principally with leadership development activities associated with the organization's change effort. Along with other members of the design team, I identified a conceptual framework to guide our design decisions. Schein's (1992) model of organizational change and Peters and Armstrong's (1998) typology of teaching and learning were selected for this purpose. Schein's model is based on Lewin's (1947) field theory and refers to three general stages of organizational change. Peters and Armstrong's typology refers to ways of being that are experienced by teachers and learners as they enter various forms of relationships with one another in classrooms, workshops, conferences and other formal and informal teaching and learning environments. In essence, the typology describes three different cultures of teaching and learning.

This thesis describes aspects of the organization's change initiative with which I was most closely involved. While I describe the overall change effort, I focus on the three types of teaching and learning and their relationship to the formal and informal training and leadership development aspects of the effort. This document is based on my own point of view. My interpretation of events does not necessarily represent the viewpoints of others involved in the change effort. The goal of this documentation of training and development activities is to help improve my practice and to contribute to my organization's effort to improve its culture of customer service delivery.

This document accounts for activities through June 2002; however, the change effort continued beyond the completion date of this thesis. As I will describe in the final chapter of this thesis, I learned a great deal from my experience, but the long-term effects of the change effort are yet to be understood.

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# Chapter 1

## Introduction

### The Culture of Health Care—From Evolution to Revolution

The advent of health care consumerism has sent health systems in the United States scrambling for service quality reform to combat the Internet-savvy baby boomers who demand both excellent service and technical competence from health care providers. Service quality in health care has been under intense scrutiny in the U.S. since 1996 with the formation of such organizations as The National Coalition on Health Care and independently funded surveys by groups such as the International Community Research, a not-for-profit entity acting as a watchdog for the consumer.

Both of these organizations published data in that year portraying the hospital industry as fraught with problems. Included in the Health Care Advisory Board's 1999 publication on service was a report from The National Coalition on Health Care, How Americans Perceive the Health Care System. This report concluded that care was "not very good – you're likely to get sicker or more injured by mistakes made by poorly trained or overworked staff" (p. 4). In 1999, the Health Care Advisory Board reported that 72% of the respondents to a survey agreed to the statement that "cuts in hospital services endanger patients" (p. 8). Such reports have created an increased level of concern on the part of the health care consumer.

To understand the changes in health care service and care perceptions, it is important to understand how these changes came about. Traditionally, hospitals' approaches to customer service have shown little ingenuity. Most of the consumer's

attitudes around service in health care were created because hospitals and doctors simply did not have to worry about service. The payment environment was largely one of fee-for-service; whatever the hospital and doctor charged the insurance, the insurance paid. Typically, hospitals did not ask customers what they wanted or valued; they simply set up the systems that were most convenient for the doctors and/or the health care professionals. Moreover, health care systems were set up using military models enhanced by the scientific method. In these systems, the patient often felt like a specimen under a microscope. As unappealing as this service approach might be, the customer was *captive*; that is, if the patient did not go along with the hospital or doctor, the insurance did not pay. This could leave patients with staggering bills to pay on their own.

In the 1980's, the Medicare system was redesigned in order to produce one payment for certain diagnosis groups. This paved the way for a major transformation in health care reimbursement. The concept of managed care, with its emphasis on controlling treatment and containing costs, changed the way healthcare services are delivered. Based on the current reimbursement system, doctors and hospitals no longer control care or have free choice in how they treat their patients, the tests and treatment they order, and the services patients receive.

The vast majority of people who participate in managed care programs, including preferred provider organizations, are enrolled through their work. This means employers have become the mediators between hospitals and patients. Large employers now represent huge patient bases. Managed care companies have had to learn to woo, win, and keep contracts of large, powerful employers. They have found that the most effective way to do this is to make sure their subscribers – members of the employers' staff – are

satisfied with their healthcare experiences. This shift in power has led employees to become very vocal about the health system(s) they prefer in their health plans. Their preferences have been greatly influenced by the quality of customer service delivery of the health systems (Zimmerman, Zimmerman, & Lund, 1996). Simply put, the health care consumers of the twenty-first century demand more knowledge and participation in their health care decisions. "They (the consumers) want their health care system to provide them with the same kinds of convenience and mastery they've found with Home Depot, Consumer Reports, and Nordic Track, so that their health status and costs will improve even further" (Health Care Advisory Board, 1999 p. 5).

Between 1997 and 1999, numerous reports were written that examined two major themes of health care: loss of public trust in hospitals, and consumers' increased involvement and influence in a system needing improvement (Health Care Advisory Board, 1999). These reports stressed the importance of service in health care. The health care consumer's focus on service was understandable, given that it was an aspect of business that the average consumer experiences daily in various industries. The question on the health care consumer's mind became, "What is missing in health care service that I receive from other service industries?" The answer, unfortunately, was they were missing a great deal. In fact, in 1998, Fortune magazine ran a customer satisfaction study that revealed a consumer who saw less satisfaction with hospitals than with Solid-Waste Disposal (Healthcare Advisory Board, 1999).

The consumer's poor perception of health care is also exacerbated by the health care industry, specifically the hospitals which have spent a decade cutting costs as a result of the introduction of Diagnoses Related Groups (DRGs), Health Maintenance

Organizations (HMOs), and Preferred Provider Organizations (PPOs). These new systems have dramatically reduced insurance reimbursement to hospitals, causing them to reduce staffing levels. This in turn created overworked, "burned-out" nurses and other professionals. One result is a culture of low morale in hospital staff across America (Healthcare Advisory Board, 1999).

As the vast level of consumer dissatisfaction suggests, the service problems in health care are quite complicated. In order to fix these problems, the leadership of health care systems must focus on curing the ills of health care from the inside out; meaning, the systems within health care must rededicate themselves to providing improved service to the end-users, the patients, as it is no longer acceptable to do otherwise.

The Approach at Careville

In the Strategic Plan of fiscal year 2002 (July 1, 2001 through June 30, 2002), the leadership of the Careville Health System identified a need to improve the culture of service delivery in order to meet the System's vision "to be a national leader in health care quality" (Careville, 2001, p. 8). The Strategic Plan is a planning document of the Careville Health System that is written, revised, and updated every year by the leadership of Careville with input from staff in non-leadership positions. Leadership at Careville is defined as those staff responsible for personnel management and budget functions, specifically those with the titles of managers, team leaders, directors, vice-presidents, and the Chief Executive Officer. During this strategic planning process, leaders identified several goals aimed at improving service delivery:

- Improve staff satisfaction as a key to patient satisfaction
- Develop staff skills and abilities related to customer service delivery

- Identify customers' requirements for service and ways to build loyalty
- Improve upon existing customer satisfaction measurement systems
- Develop leadership to improve leadership's ability to support and serve staff in creating a culture of service excellence.

An important first step in improving service was to learn what patients valued from Careville as their health care provider. A consultant was hired to conduct research on customer values. "The primary objective of the research was to identify how value is created for customers of Careville. The study specifically focused on identification of the critical dimensions that impact a patient's perception of value" (Bryant, 2001, p. 3). Also at this time, a design team was appointed and asked to create a system of service excellence and a plan for implementing that design, incorporating information learned through the customer value research.

In the meantime, the design team members examined best practices from both inside and outside the health care industry and met regularly to discuss the results, exploring how approaches used by "best practice organizations" could be applied at Careville. After approximately two months in conversations, the team identified the following steps they needed to take before proceeding any further:

1. Design a training and development plan to drive the vision of a culture of service excellence, including information learned from best practice organizations, customer value research, and ways for staff to become involved in the planned change.
2. Establish three important subcommittees to influence the cultural change:
    a. A Measurement subcommittee to assess current customer satisfaction

measurement systems and future improvements in customer service delivery after the initiative was begun.

b. A Celebration/Recognition subcommittee to identify ways to celebrate and recognize staff's accomplishments as they related to service delivery.

c. A Leadership Development subcommittee to identify training and development needs of the leaders in the culture change.

Next, the design team identified a framework to be used as a plan for improving the culture of service delivery at Careville.

Using the Three Types of Teaching and Learning as a Framework

As the design team and its subcommittees began to discuss the topic of service excellence, it became clear that we were dealing with a complex set of issues that influenced the culture of service delivery at Careville. There was early interest in involving the staff in the decisions and activities that would take place as the change was initiated. In doing this, the design team hoped to learn the staff's views on the state of customer service at Careville and generate ideas about how to best improve customer service. Isaacs (1999) states that people who wish to innovate or develop new knowledge, who seek effective strategic choice making, or who are engaged in organizational learning efforts must come to see their work in terms of the quality of what he calls conversational fields rather than as the product of individual action or willpower alone.

As a leading member of the design team responsible for creating and implementing a framework for change, I introduced the concept of the three types of

teaching and learning (Peters and Armstrong, 1998) to the members of the design team responsible for training and development early in their work together. I presented the types to suggest an approach to creating the organizational learning needed to produce cultural change. The design team endorsed the selection of the three types of teaching and learning as a part of our conceptual framework.

We also agreed that Edgar Schein's (1992) model/theory of cultural change was a framework that promised to help us conceptualize how the overall change process could occur. Schein's model describes three steps leading to cultural change in an organization. Taken together, Schein's model and Peters and Armstrong's typology offered a useful way of thinking through the decisions that faced the design team as we designed training and development activities necessary for implementation of the organization's change effort. As the next chapter illustrates, the process of applying this conceptual framework to the change initiative provided a structured plan that led to the cultural change at Careville.

## Chapter 2

## Conceptual Framework and Approaches

### The Three Types of Teaching and Learning

The three types of teaching and learning describes the relationships of teachers and students in a learning situation. Type I teaching and learning refers to teaching by transmission and learning by reception (Peters, Armstrong, 1998). In Type I, the primary relationship is between the teacher and the students. Communication occurs between the teacher and the students but usually does not occur between the students. The teacher establishes the relationship, and the assessment of the experience of the learners is usually accomplished according to the teacher's expectations. Student's reflections are personal, private, and not shared with the group. The teacher is viewed as the primary source of knowledge about the subject matter involved (Peters & Armstrong, 1998).

In Type II teaching and learning, teaching is by transmission and learning is by sharing. In this type, the teacher not only transmits information but also facilitates the transmission and reception of information between and among the students. The goal of this type of teaching and learning is to expand the range of interpretation and application of the subject matter by students. The student can be both a learner and a teacher, transmitting information as well as receiving it (Peters & Armstrong, 1998). Type II teaching and learning has also been compared to cooperative learning. In cooperative learning, the teacher sets up conditions in which students learn from each other (Brufee, 1999). In cooperative learning, as with Type II teaching and learning, the "authority remains with the instructor, who retains ownership of the task, which involves either a

closed or closable problem, where the instructor knows or can predict the answer" (Panitz, 1996, p. 2). Cooperative learning tends to be more teacher-centered, as the Type II model suggests. The approach is structured so there is a series of steps, with prescribed behavior at each step, controlled by the teacher (Panitz, 1996). In the case of Type II or cooperative learning, the student takes an active part in the process of learning, even with the focus on the end product. Bruffee describes cooperative learning as "helping students learn by working together on substantive issues"(1999, p. 83). A potential problem with cooperative learning lies in the fact that there are still boundaries for the learner in terms of his or her learning. The teacher is still the expert and the decision-maker; the student or participant is required to co-operate within the confines the teacher sets to complete the task although each member is accountable for a final outcome with the teacher (Brufee, 1999).

Type III teaching and learning, or collaborative learning, is distinguished from the other two types by a focus on joint construction of knowledge. In this type, the teacher assumes the role of a co-learner or member of the group (Peters & Armstrong, 1998). The four elements of collaborative learning have been described as:

1. Dialogic space – Isaacs (1999) defines dialogue as "a conversation with a center, not sides" (p. 19). A dialogic space would be a "field of conversation" that is made in the moment, derived from the "ideas, thoughts, and quality of attention of the people involved here and now" (Isaacs, 1999, p. 236). A key element to creating a dialogic space is listening with an intention to understand the other person(s). Dialogue "asks us to listen for the already existing wholeness, and to create a new

kind of association in which we listen deeply to all the views that people may express" (Isaacs, 1999, p.20). In seeking to understand, one may need to "ask back" to determine the understanding of the message. Part of creating a dialogic space involves all participants being actively engaged in the practice of asking each other questions such as, "Is this what you meant?" or, "Why did you ask?" to clearly describe the wholeness that is generated within the dialogic space.

2. Cycles of Action and Reflection – Critical to collaborative learning is the ability to become a student of one's own actions and to study these actions in a systematic, analytic manner. In this way, the practitioner of collaborative learning becomes a student of "the relationship between thought and action" (Peters, 1991, p.90). This inquiry into one's own actions also involves thinking critically—challenging one's own assumptions about his/her ideas and sometimes revising them based on reflection. In this manner, "learning and growth usually occur when. . . critical reflection and a subsequent revised action occurs " (Peters, 1991, p. 90).

3. Ways of Knowing – Knowing can occur in multiple ways. For example, Reason (1998) describes four ways of knowing as:

- *Experiential knowing*- occurs through "face-to-face encounter with a person, place, or thing; it is knowing through empathy and resonance, and is almost impossible to put into words" (p.4).

- *Presentational Knowing*- "emerges from experience, and provides its first expression through forms of imagery such as poetry and story, drawing, sculpture, movement, dance, and so on" (p. 4).
- *Propositional Knowing* – "is the knowing *about* something. It is usually experienced through ideas and theories, and is expressed in abstract language or mathematics" (p. 4).
- *Practical Knowing*—"is the knowledge of *how to* do something and is expressed in a skill, knack, or competence" (p. 4).

Shotter describes three ways of knowing to include *knowing that*—theoretical knowledge; *knowing how*—the technical knowledge of a skill or a craft; and a *knowing from within*—a joint knowledge, a knowledge-held-in-common with others, and judged by them in the process of its use (Shotter, 1994).

4. Focus on Construction – Collaborative learning is concerned with joint construction of knowledge. All knowledge is constructed within the context of social interaction at some level. As Wenger & Snyder (2002) describe:

> You know the earth is round and orbits the sun, but you did not create that knowledge yourself. It derives from centuries of understanding and practice developed by long-standing communities.. . it is through a process of

> communal involvement. . . that a body of knowledge is developed. (p. 10)

In social constructionism, there is a central assumption that "the continuous, contingent flow of communicative interaction between human beings, as they cope with each other in different, everyday circumstances is the central focus of concern" (Shotter, 1994, p. 7). Gergen and McNamee (1999) describe social constructionism as being based on the premise that "meaningful language is generated within processes of relationship. . .From this perspective, there can be no moral beliefs, no sense of right and wrong, no vision of a society worth struggling for without some basis in relational process"(p. xi).

In collaborative learning, participants strive toward a participative worldview. "Worldviews may be viewed as sets of basic beliefs about the nature of reality and how it may be known" (Reason, 1998, p.3). First, participants define and form the nature of their reality, and what they know about it; through dialogue, participants co-construct the knowledge between them, which one can term "X." Type III teaching and learning involves "people laboring together to construct new knowledge—the 'X', which becomes knowledge for the group and the individual" (Peters & Armstrong, 1992, p. 80). Collaborative learning is more than a classroom technique. It is a personal philosophy advocating people coming together in groups, respecting and highlighting each group member's abilities and contributions. Group members share both accountability and authority for group actions (Panitz, 1996).

The next section is devoted to explaining the cultural change model used to understand culture change and the influence the three types of teaching and learning could have on change.

A Framework for Cultural Change

Using a framework for cultural change was critical to creating a culture of service excellence at Careville. The work of Schein best facilitated this framework. Schein's (1992) theory of organizational change adapted from Kurt Lewin's (1947) original model of change, introduces the concepts of *unfreezing*, *cognitive restructuring*, and *refreezing.* These are the three main steps Schein identifies as being involved in change, and he provides details of each step based on his own research and experience.

Unfreezing is the initial stage important to a system or organization to create a disequilibrium or motivation to change. According to Schein (1992), unfreezing is composed of three different processes that must be present to a certain degree for a system to develop a motivation to change:

> (1) Enough disconfirming data to cause serious discomfort and disequilibrium;
>
> (2) The connection of the disconfirming data to important goals and ideals causing anxiety and/or guilt; and,
>
> (3) Enough psychological safety, in the sense of seeing a possibility of solving the problem without loss of identity or integrity, thereby allowing organizational members to admit the disconfirming data rather than defensively denying it (p. 298-299).

Cognitive Restructuring involves individuals within the system who experience redefinition of the core concepts in their cultural assumptions. This must happen for cognitive structures to adapt to and rationalize the behavior change that is occurring. Schein claims that, in change, individuals must be able to come to terms with and feel safe when behaving in different ways. For example, if working hours change for an individual, he or she must feel that his job/position will not be threatened; that his or her personal life will not be unduly disrupted; that his personal values will stay intact; and, that his or her social relationships will stay safe. This cognitive restructuring takes place dynamically within each individual, but it is also influenced by the interpersonal relationships an individual maintains (Schein, 1992).

Refreezing is the reinforcement of the new behaviors and cognitions to once again produce confirming data. This process is an integral part of human behavior in that all human systems attempt to maintain equilibrium and to maintain the integrity of the system in the face of a changing environment (Schein, 1992). When change is introduced, an individual's new behaviors must be reinforced by peers, leaders, and significant others for their behaviors to become permanent. Additionally, the infrastructure of systems and processes of the environment must support the changed behaviors in order for the culture to truly evolve into new behaviors (Schein, 1992). For example, even the individual that has personally gone through the unfreezing and cognitive restructuring stages of change and has demonstrated new behaviors could revert to old behaviors if his or her peers do not support and endorse these behaviors. For the service excellence effort at Careville, this idea was critical. The Careville design team had to discover how to successfully transform the service culture to facilitate an improved system of delivery. Also, if the

processes of service delivery do not permit the staff to practice at another level of service excellence—for example, if staff cannot physically address a customer upon arrival because of the design of the facility's waiting area—the refreezing of behaviors is lost.

It was important for the design team and leadership of Careville to understand the perceived stages that individuals must experience in order to personally change. Enhancing and accelerating change was of interest to the design team in view of the state of health care and the need for an improved response to patients as well as all other customers. The emotional component of the learning—that is, the level of "buy-in" of staff that is so critical in the cognitive restructuring of service behaviors—could not be discounted because its power seemed to be a critical aspect of the change. The design team was not sure the staff would *hear* each other when discussing new ways to provide customer service unless they could protect the staff's emotional safety. As Schein indicates, staff must be psychologically comfortable and feel safe for them to be optimistic and supportive of the change (1992).

The Relationship between Types of Teaching and Learning and Schein's Model

The design team devoted a great deal of discussion to exploring methods of enhancing the rate of culture change in the current environment at Careville. Schein's model emphasized the importance of *ownership* in change: the use of Type II and Type III teaching and learning typologies promised to deliver the kind of ownership the leaders of this effort desired. The design team felt it was very important for the staff to be able to see their own hands in the designs of new service/performance expectations. The design team understood that this would entail considerable dialogue about current service behaviors between and among staff. The staff would need to get collectively

uncomfortable while admitting the existence of certain inferior service behaviors occurring at Careville, and then compare those inferior behaviors to more desirable behaviors, such as those found at best practice organizations. The design team also believed that using Type II and Type III teaching and learning typologies would help accelerate staff through the unfreezing, cognitive restructuring, and refreezing stages. The Careville staff needed to create new knowledge about how to serve the customers and to describe the behaviors that would exceed customers' expectations. They also needed to reach a common understanding of the systems and processes of service that were broken, so that new behaviors could be collaboratively designed and modeled to refreeze the culture.

Application of the Conceptual Framework and Approaches

Upon review of the service excellence strategic initiative, the design team found that they needed to use all three types of teaching and learning to create cultural change. The key to their thinking was based on Schein's theory: there was a definite need to create psychological discomfort and anxiety to motivate the change and encourage staff to see the need for change. They chose to use Type I teaching and learning to implement that aspect of the change. Here, Type I teaching and learning would allow the design team to use facts about health care service trends and customer preferences as a way to unfreeze staff attitudes concerning current service behaviors. Through the introduction of best practice information learned from other health care organizations as well as feedback from patients and staff using Type I teaching and learning, the staff would hopefully begin to question their current service habits (See Appendix A – Customer Value: Mission Possible Training Model). It was important that Careville staff reflected on their

current behaviors and identified gaps between those behaviors and what the patients and staff members wanted, while also considering what the industry leaders were doing. Type I teaching and learning was the logical choice to introduce this information (given that this was new information), although Type II teaching and learning was used with Type I to facilitate the sharing of reflections for the purposes of adding information to the group's current understanding.

The design team decided that the Type II teaching and learning approach was the best method for the training facilitators to use to create discussion groups around topics/challenges of service with staff. Given the nature of the topic, there was general consensus that a great deal of service-related experience could be shared by every staff member in each training group. Facilitating discussion between staff members about current service behaviors was instrumental in the unfreezing of staff's ideas. The design team hoped that these discussions would become the basis for cognitive restructuring and give voice to a new culture of service. Additionally, the introduction of Type II teaching and learning early in the training and the work around service paved the way for Type III teaching and learning, or collaborative learning, to occur.

Because of the collaborative character of the work of service improvement, the design team concluded that a Type III approach was an excellent choice to co-construct the elements of the culture change as it related to service behaviors. Type III teaching and learning strongly emphasizes relationships between individuals, especially respect and trust. "People in collaborative relationships take a risk when opening their thoughts and feelings to one another, and trust is built when the risk taker receives positive regard from the others for ideas expressed, inquiries made, and feelings shared" (Peters & Armstrong,

1998, p. 83). Consequently, the design team saw this approach as being most likely to foster two of the most critical values in relationships required in a culture of service excellence: “trust and commitment” (Anderson and Narus, 1998, p. 65). Through the customer value research at Careville, we discovered that patients wanted greater respect. They wanted to be recognized as more than a diagnosis. The design team felt like collaborative learning was the best way to develop and understanding of the behaviors needed, and the team hoped that staff skills would be put to use in the delivery of service excellence to patients and other customers.

Collaborative learning also took place during the authorship of the Interaction Standards that would become the *brand* of Careville’s interactions with customers. The design team recognized that the staff needed to share a common language of customer service to practice. There was strong interest from the design team and the leadership that this language be constructed in groups so the behaviors used to improve service at Careville would contain the views of all staff. As a dialogue of Schein’s model of successful change occurred during several meetings, the design team and leadership came to agree that joint construction of Interaction Standards could provide the psychological safety needed for cognitive restructuring, especially if staff could achieve a sense of ownership of the Interaction Standards. In the next chapter, I will describe the Customer Value Training Model created by the design team.

## Chapter 3

## The Training Model for Customer Value

Overview

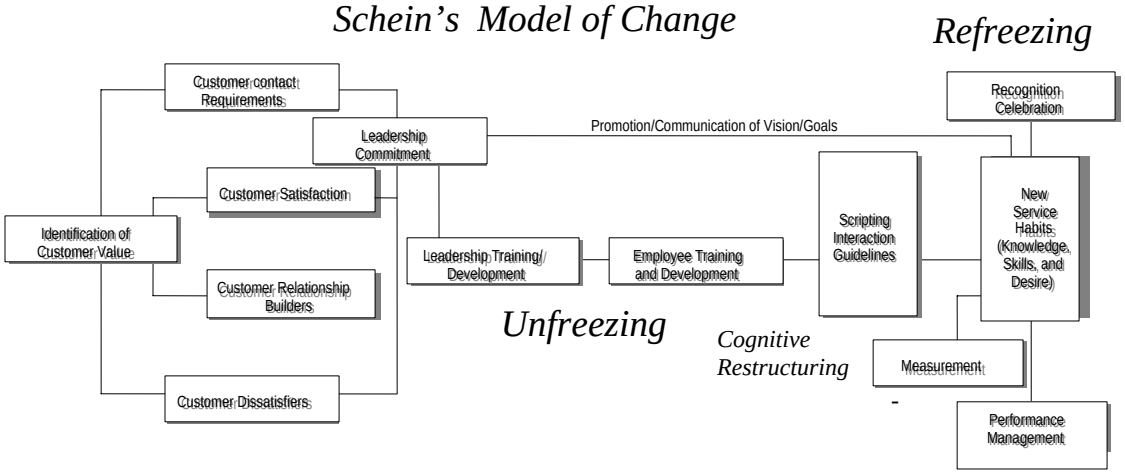
In October 2001, the team was ready to unveil the plan for facilitating the growth of a culture of service excellence (see Figure 1). The Customer Value Learning Model was designed as a map of the significant stages the design team felt was important at Careville to create a culture of service excellence delivery. Schein's (1992) Model of Change describes the actions of Careville in terms of his dynamic steps of change. The following is an overview of the team's use of the Model.

The design team strongly believed that Careville's customers needed to define health care value from their perspective, including their requirements for service and contact, what satisfied and dissatisfied them, and how Careville staff could build long-term relationships with them. Using that information, the design team and leadership could then identify the elements that would lead to unfreezing, and staff could identify the gaps where they did not meet the customers' needs for service. The information from the customers, along with best practice information, was a central issue in the training of both leadership and staff. Writing Interaction Standards became a key activity in all training classes. These Interaction Standards served to *brand* service behaviors at Careville, and, they were written through the use of Type III teaching and learning (See Appendix A – Customer Value: Mission Possible Training program).

*Figure 1*

## Customer Value Learning Model

*Schein's Model of Change*



As the model shows, the Interaction Standards were designed to be reinforced by recognition and celebration of the demonstration of these behaviors by staff and the measurement and communication of customer satisfaction results. The plan also included a method to compensate staff through performance incentives for the continued practice of these Interaction Standards and measurable improvements in service.

As shown in Figure 1, the facts around best practice health care organizations, along with patient feedback, were used to unfreeze existing attitudes and behaviors of staff. The design team members were aware that all staff adhered to certain paradigms or worldviews of how service should be delivered in health care. The design team applied Type I teaching and learning methods when presenting this information to provide different worldviews that proved more effective. This included demonstrating how customers' worldviews were often in conflict with some of the staff's worldviews.

Following the presentation of that information, Type II teaching and learning was used to create discussions with the staff about the differences between Careville and the best practice organizations. Staff's participation was important in creating a different worldview that could also represent the culture at Careville. Type III teaching and learning was used to co-construct Interaction Standards. The design team felt that if the staff did not experience and co-create that worldview, the cognitive restructuring of a new worldview would be flawed at best. While there were certain non-negotiable changes that needed to occur in the Careville Health System (presented through Type I and Type II teaching and learning methods), there was an excellent opportunity to provide staff with an opportunity to feel safe participating in the co-construction of those

behaviors that would represent their brand of interaction. The design team also felt that, in this way, refreezing would occur more successfully.

Customer Value Research

Part of the Type I teaching and learning planned for the staff training entailed learning more about what the patient valued in the health care market. This customer value research was conducted for Careville by an external consultant who identified what patients valued from their health care providers. Also, the design team considered this research to be valuable information for the staff to use as they co-constructed Interaction Standards. Because this information was an important part of the training as well as the construction of Interaction Standards, it is necessary to give a brief overview of the consultant's results in order to explain some of the approaches used within the context of the plan.

This research was conducted by a market researcher with experience in the kind of qualitative interviewing approach needed to determine patient customer value. In September and October 2001, 40 in-depth qualitative interviews were conducted. Twenty patients were randomly selected from Careville Hospital of ABC County and twenty from Careville Hospital in XYZ County, representing a variety of patient experiences, ranging from inpatient to outpatient with experiences in the Emergency Department. This customer value research involved the use of two approaches: grand touring and laddering. In grand touring, the patient was asked to describe the health care experience as if he or she was taking the interviewer on a "grand tour" of the experience, describing all the things the patient heard, saw, smelled, touched, and felt emotionally. The laddering approach involved identifying the levels of value a patient experiences

using questions that explore importance. These levels included attributes of care, consequences when attributes were present or absent, and the patient's desired end states, or what he or she desired or valued from health care providers above all else.

The purpose of this research was to define value from the patient's point of view, to identify the levels of the patient's value hierarchy, and to determine how these were linked (Bryant, 2001). Three significant ladders were identified in this research at Careville. The researcher expressed these ladders in the following fashion:

> The *Attribute* (demonstrated through staff behavior) of health care that results in *Consequences* of that behavior that ladders (or brings) the patient to the *Desired End State or Value***.** The ladders were described as they were presented to Careville, using an approach as if the patient was speaking. To paraphrase Bryant (2001) in the report:
>
> *Ladder 1*
>
> If health care providers *tell me what is going to happen* (Attribute), *I feel less stressed, respected, more comfortable and reassured that the staff cares about me* (Consequences), and that results in my *peace of mind and treatment as a "real" person* (Desired End State).
>
> *Ladder 2*
>
> If health care providers *talk to me, make conversation with me, and joke with me* (Attributes), it *distracts me from the procedure that equates to "I must not be that bad off," and they care about me* (Consequences), and that results in the feeling that *I am going to be returned to good health* (Desired End State).
>
> *Ladder 3*

If health care providers *listen to what I say* (Attribute), I feel *my medical history is shared, treatment is initiated faster, I have less pain, the treatment makes me better* (Consequences), and this results *in my ability to return home faster and take good care of my family* (Desired End State).

The patients described twelve critical behaviors identified by the researcher as they repeatedly laddered patients to the desired end states or values described above (Bryant, 2001).

The customer value research was important to Careville for several reasons. First, in order to move the organization culturally, the design team felt like they had to start with those whom Careville served—the patients—and to clearly understand what patient's expectations were. Additionally, the design team knew that all staff, including the leadership, had worldviews that could be different from the patients' views of value. Therefore, the team recognized the importance of using clear, up-to-date, factual information from the customer to initiate the unfreezing of current staff beliefs and attitudes. The design team also knew it was critical that the leaders should serve as role models and lead by example. As the Customer Value Learning Model indicates, leadership commitment, training, and development was the next step in this cultural change effort.

Leadership Commitment, Training, and Development

The design team believed that the leadership of Careville played a key role in creating a culture of service excellence. "Deciphering cultural assumptions and evaluating their relevance to some group purpose must be viewed as a major intervention in the group's life and must, therefore, only be undertaken with the full understanding

and consent of the leaders of the organization" (Schein, 1992, p.149). The design team was aware that leadership had to set the tone for the culture change and, especially in the case of service culture, be the primary role model. In a service industry such as health care, "staff have to know they come first in terms of concern, compassion, being listened to, communicated with, become part of the decision-making, and – most of all – trusted. . . Outstanding service in an organization starts with servant leadership at the top" (Zimmerman, Zimmerman, & Lund, 1996, p. 109). The best practice organizations the design team had researched identified the importance of the role modeling of leadership as a key strategy in moving to a culture of service excellence (Health Care Advisory Board, 1999). Furthermore, the ways that leaders communicated and influenced culture were important aspects of the change for leaders to understand.

Figure 2 describes the key mechanisms important to the successful transformation of culture according to Schein, along with a corresponding strategy identified by the design team to address each mechanism. The left column represents Schein's (1992) mechanisms, which he described as necessary for "transmitting and embedding culture" (p. 231). The right column represents the attitudes, beliefs, and behaviors the design team felt were important to implement in communicating and influencing the development of a culture of service excellence at Careville.

*Figure 2* – How Leaders Communicate and Influence Culture

| Culture Mechanism | Careville Leadership<br><br>Attitudes/Beliefs/Behaviors |
|---|---|
| Primary<br>What leaders pay attention to, measure, and control on a regular basis | 1) The Careville Health System systematically measures and analyzes customer satisfaction measures of:<br>▪ Patient satisfaction<br>▪ Staff satisfaction<br>▪ Physician satisfaction.<br>2) Leaders must take appropriate action based on results and create an accountability for improvement. |
| How leaders react to critical incidents and organizational crises | Leaders must demonstrate zero tolerance for poor service performance. |
| Observed criteria by which leaders allocate scarce resources | Allocation of Careville resources toward service improvements should be a priority. |
| Deliberate role modeling, teaching, and coaching | All leaders should perform facilitation of Leadership Support Modules and Interaction Standards. |
| Observed criteria by which leaders allocate rewards and status | Staff recognized for service excellence and rewarded by:<br>▪ Reward and Recognition System<br>▪ Performance Evaluations. |
| Observed criteria by which leaders recruit, select, promote, retire, and excommunicate organizational members | Leaders set Careville criteria to include:<br>▪ New staff screened for service excellence<br>▪ Service excellence used as criteria for promotion. |
| Secondary<br>Organizational design and structure | Leadership drives Careville's team-centered organization. |
| Organizational systems and procedures | 1) The Guest Services department addresses service needs, customer complaints.<br>2) Staff members who contact patients after discharge staff the Service Connection program. |
| Organizational rites and rituals | The Celebration/Recognition Committee's work is supported by leadership. |
| Design of Physical space, facades, and buildings | Careville will make improvements in guest waiting areas. |
| Stories, legends, and myths about people and events | Stories of service excellence are published in newsletters/corporate publications. |
| Formal statements of organizational philosophy, values, and creed | Mission, Values, and leadership through role modeling and teaching leads Vision. |

As Figure 2 indicates, there are primary and secondary characteristics that successful leaders possess both individually and as a group to create a culture's behavior (Schein, 1992). According to Schein, primary characteristics include those behaviors that leaders pay attention to, measure, and control. For example, if leaders in a culture measure and hold as critical the satisfaction of its customers, then the attitude of all staff, including leaders, would be supportive of that measure. Likewise, the way leaders respond to critical incidents such as customer complaints would set the tone for whether the rest of the culture would take customer complaints seriously and move to resolve them, thus preventing complaints when they could.

In October 2001, the design team held a workshop for the leadership of Careville. They were introduced to the Customer Value Model and asked to assist in detailing the plan. A combination of teaching and learning approaches was used. The design team agreed on a motivational theme of "Customer Value: Mission Possible" and used several of the themes from the Mission Impossible television series and movie to entertain and train. A guest speaker, who had been part of the leadership at Careville, Pensacola, set the tone for the day, using a Type I teaching and learning method, to describe his experience in leading culture change toward a system of service excellence in health care. Next, a combination of Type I and Type II teaching and learning methods, which included lecture and discussion, were used to determine where the Careville Health System leadership felt the organization's culture could be defined in terms of service excellence. The training plan was introduced in an overview with a facilitated discussion and a training schedule. At the end of the workshop, the participants broke into topical small groups and used a Type II teaching and learning approach to generate ideas for

structuring and developing the culture in the areas of celebration and recognition, leadership development, and measurement of service. The facilitators of each small group were encouraged to have participants "listen without resistance" to each other, and suspend their opinions in order to remain open to new ideas (Isaacs, 1999).

Based on the feedback from this workshop, the team modified their plan, including the identification of eight generic behaviors the leadership felt all staff routinely perform in serving customers; that is, behaviors all staff had in common as they related to customers. These eight generic behaviors were identified with a Type III teaching and learning or collaborative approach. Leaders were asked to engage in dialogue to determine the behaviors most common to all service areas within the organization. There was no leader, simply a recorder. Eight groups identified their top behaviors and the lists were compared to determine the most common behaviors identified. The leaders decided that Careville staff would be asked to design the specific behaviors into Interaction Standards during the training, and a collaborative approach would be used to brand Careville interactions to more clearly define service at Careville. The leadership identified the following as behaviors that would serve as Careville Interaction Standards:

1. Meeting and Greeting Customers
2. Giving Directions
3. Addressing a Customer Who is Waiting
4. Addressing a Customer Complaint
5. Personal/Professional Conversation
6. Maintaining Privacy
7. Conducting Telephone Business

8. Personal Appearance/Dress Code

The leaders agreed that, in order to capture all staff ideas around the specific behaviors they believed were appropriate within each standard, they would begin comparing and matching staff responses after approximately one-half of the staff members completed training. They also agreed that a significant number of staff responses (around one-half) would suffice to represent the collaborative responses of the staff, though the remainder of the responses would be double-checked to ensure continuity. Furthermore, the leadership agreed that the draft Interaction Standards would be tested against the critical behaviors identified through Customer Value Research and best practice sources (Careville, Pensacola and Executive Hotels). This would ensure that Careville staff's ideas of best practice within the Interaction Standards would coincide with the service ideals practiced by the best organizations both inside and outside of the health care industry.

The Training Experience

Appendix A contains the content outline of the four-hour training program required for all Careville staff, indicating not only the corresponding learning objectives for each area of the training, but also the types of teaching and learning used. Learning objectives were used to describe what participants were supposed to learn as a result of attending the training session (Caffarella, 2002). The learning objectives also helped distinguish the context of the session and align the training with the overall goals of the cultural initiative.

The "Customer Value: Mission Possible" workshops began in November 2001. Leadership training was introduced first; this included the four-hour staff version of the

training program, in which they reviewed best practices, customer value research, an example of a service excellence business (FISH philosophy, not detailed in this thesis), and the writing of Interaction Standards. The leaders also received training in facilitating a set of support modules (see Appendix B), fashioned in a Type II format, that the leaders would facilitate within their departments every month to "keep the skills alive." For example, the first support module explored the topic of "The Personal/Business Model", emphasizing how one should begin and end a customer interaction with a personal statement. Using a Type II teaching and learning approach, the leader facilitated a staff team discussion about what personal statements they could use when performing a procedure. For example, staff suggested calling the patient by name, asking the patient about his or her trip to the hospital, and then proceeding to give the business information about the procedure. The leader then asked the group to develop statements to use when ending the procedure. Group members suggested statements like the following: "It was a pleasure to meet you," or "Thank you for allowing Careville to serve you," or "Is there anything else that I can do for you?" There was general consensus among leadership that these modules served to actively facilitate continuous learning around service excellence and constantly kept service on everyone's minds.

Training of Facilitators

In January 2002, staff training began (as described in Appendix A) and was completed for 2500 staff in June 2002. The executive leadership of Careville decided that training of the entire Careville system staff should occur within the 2002 fiscal year ending on June 30, 2002. In order to accomplish this objective, sixteen facilitators were recruited within the organization to offer approximately 100 training sessions over an

eight-month period. The facilitators were given the model of types of teaching and learning developed by Peters and Armstrong and part of their training was dedicated to learning and differentiating between the types of teaching and learning.

The following key principles, paraphrased from Peters and Armstrong's (1998) descriptions of Type III or collaborative learning, were included in the training of these facilitators:

- Get facilitators/leaders involved in an episode of collaborative learning as early as possible;
- Take every opportunity to point out when collaborative learning occurs;
- Show and model utmost respect for everyone's opinions and responses;
- Model and promote team trust;
- Help the group focus on what occurs between collaborators;
- And, identify and describe "X" (the new knowledge co-constructed by the group) and then translate "X" into what is being created in the service excellence initiative (in this particular case, the Interaction Standards).

I was responsible for training the facilitators. During the training, the other facilitators and I took turns being the facilitator of the group and practicing Type II and Type III teaching and learning methods within the context of the training. I used Peters's "Art of Questioning" (2000) to help the facilitators effectively use questions to stimulate the learners' participation. We then gave each other feedback on what questions worked well and offered ideas for alternative approaches. Our group was particularly concerned with developing ways to structure collaboration in the writing of Interaction Standards. I coached the facilitators in how to "melt," or become a co-learner/member of the group.

All new facilitators had a team facilitator for the first class who helped them reflect on whether they were creating a Type II or a Type III teaching and learning experiences and when each was appropriate to the situation.

The facilitators and I also co-constructed a feedback approach to help the participants accelerate discussion and created a *license to ask back* around the suggested Interaction Standards that were written in each training session. The experience was structured so the participants would rate the behaviors written by participants in terms of the following criteria:

- *Wow* – Meets customer's standards and brings customers to neutral. This is a behavior that must be included but does not necessarily delight or surprise the customer.
- *Wow – Wow* – A behavior that delights and astonishes the customer. This behavior is so unexpected that they will probably remember the behavior and brag about it to others.
- *Bow-Wow* – A behavior that is missing from the standard but should always be included or a behavior that should be carefully screened before including in any interaction.

This process began by having small groups within each training session write an Interaction Standard. Following the writing of a standard, the groups rotated and rated all the Interaction Standards using the above criteria. The decision for how to rate each behavior was always a group decision. After this rating step, the facilitator became a part of the group and acted as a group member to ask questions and assist the entire group (of 25 or more participants) to express their views on the Interaction Standards and their

ratings. Descriptions of behaviors were changed based on these discussions. Final responses were recorded on flipcharts, and ratings of participants were included and tabulated in the final compilation of the Interaction Standards.

This training initiative differed greatly from Careville's usual approach to facilitating groups to engage in discussions around how to change the culture. To propose to the staff that they come together in groups and design the specific behaviors they believed should be the way staff interact with customers was quite different than how cultural initiatives had been approached in the past. Traditionally, Careville leadership had created cultural initiatives with small to moderate numbers of staff participation, but Careville leadership had never before involved all of the staff, as they did in the enterprise-wide writing of Interaction Standards. The point was to have staff share thinking in a way that generated new ideas and broke down some institutional walls between departments. All facilitators were coached in the concept of *asking back,* and they realized how important it was to seek everyone's views in group discussions. For instance, when a nurse from the Emergency Room reacted negatively to a group's suggestion that patients be updated every fifteen minutes while waiting for service, the facilitator asked back using probing questions. The facilitator asked the group to further explain their suggestion of that particular behavior in the standard. Then, the group was encouraged to *ask back* to the nurse why she objected to the fifteen-minute time frame. There were some groups that had great success with catching on to the process of dialogue in order to suspend assumptions and seek to understand each other. This process of asking back included in the training initiative was intended to demonstrate relational responsibility. As Gergen and McNamee (1999) describe, relational

responsibility entails the "valuing, sustaining, and creating forms of relationships out of which common meanings can be found; that is, attending to other's views so that one might sustain and support the process of constructing meaning as opposed to terminating it" (p. xi). "If human meaning is generated through relationship, then to be responsible to relational processes is to favor the possibility of intelligibility itself—of possessing selves, values, and the sense of worth" (Gergen and McNamee, 1999, p. 18-19).

In order to measure the progress and reinforce the culture change, the design team knew they needed to develop and enhance existing measurement systems as well as strengthen and reinforce the employee recognition system at Careville. The following briefly describes the measurement and recognition systems designed in this initiative.

Measurement and Recognition Systems—The Measurement Subcommittee

While the system-wide training was conducted, the measurement subcommittee was busy designing their plan. Using Type II teaching and learning methods, this subcommittee first reviewed the Customer Value Research. Then, with the help of the external consultant, they revised the current patient satisfaction measurement system to reflect critical behaviors identified by patients. To initiate this process, the consultant presented the data from the customer value research to the subcommittee. These data were then reviewed in a discussion facilitated by the leader of the subcommittee. Then, the committee concluded that service needed to be measured in ways different than the traditional methods historically used at Careville (which were infrequent and delayed in terms of feedback to staff). Subsequently, the measurement subcommittee identified areas of measurement and drafted action plans to align the measures of customer value with the cultural initiative.

Measurement and Recognition Systems—Celebration/Recognition Subcommittee

The second subcommittee identified by the design team also began their work during staff training. Again, using Type II and some aspects of the Type III teaching and learning approach, this group reviewed the staff satisfaction surveys and feedback from approximately 27 sessions of staff training (representing about 675 staff members). As before, the leader of the group led a discussion on the results of the staff satisfaction survey with the discussion occurring from leader-to-member and member-to-member (Type II). The leader became part of the group, initiating a dialogue concerning the ideas for celebration and recognition the staff had produced in those 27 sessions. This subcommittee consisted of membership from all aspects of the Careville Health System, and staff and leadership were equally represented. The group created a focus on construction, creating their "X" of what events, activities, and reinforcement could produce motivation for the culture change to excellence in customer service delivery. This was based not only on their experiences, but also on the rich comments from the staff training sessions. As a result, this subcommittee decided to institute a series of recognition activities for service excellence, including:

- Cash awards for immediate recognition of exemplary customer service,
- The Spring Fling, a large appreciation celebration for the staff's hard work and positive contributions (held in May 2002),
- Post-it notes for use by leadership and peers to immediately recognize positive service behaviors,
- An activity every month and/or every quarter to show appreciation to staff,
- And, the reactivation of the Careville staff reward and recognition system.

The design team also decided to ask staff to reflect on these activities in the future to determine whether these activities impacted the improvement of customer service delivery.

There was a great deal of infrastructure in place at Careville to provide information to all staff about customers and service practices as well as the systems and plans for measuring future progress. Most of these *end-products* were created by using Type I and/or Type II teaching and learning methods. The next chapter will focus on describing Careville's unique experience with the Type III teaching and learning typology in the enterprise-wide writing of Interaction Standards.

## Chapter 4

## Interaction Standards

Description

Type III teaching and learning was used to facilitate the writing of Interaction Standards with the first leadership training class and continued with remaining leadership throughout the training of staff members. The enterprise writing of these Interaction Standards was intended to give the staff ownership in the standards to be adopted system-wide. In each training session, the eight generic Interaction Standards titles were introduced by the facilitator and written on flipchart pages. Then, the facilitator asked the participants to choose the Standard that most interested them (with an equal number of participants to each Standard depending on the number in the class). Small groups of three to four participants each were then asked to create what they believed, collectively, was the best way to perform that Standard. In this way, they became co-authors of the Standard and became involved in how this Interaction would be performed at Careville.

The facilitators of each training session joined the group and became members. There were no leaders appointed in the groups, although one participant did serve as recorder for the purposes of sharing the Interaction Standard with the entire class. In this way, learning became a matter of "practical authorship and teachers and students, managers and workers, researchers and practitioners, all co-constructed what it was they created and learned together" (Shotter, 2002, p. 9).

As mentioned previously, the process of comparing and matching of staff responses began after one-half of the staff had attended the "Customer Value: Mission

Possible" workshop. All of the Interaction Standards were coded for like responses in order to represent the collaborative efforts of the Careville staff. For example, almost every staff group that wrote the Standard "Meeting and Greeting Customers" determined that staff members should always introduce themselves to the customer and address the customer by their formal name (Mr., Mrs., Ms) until instructed otherwise by the customer. Therefore, these like responses became one of the steps in that Interaction Standard.

The final Interaction Standards (Appendix C) reflect the co-construction efforts of 2500 Careville staff members. The next step was to *test* the culture and see how many of the behaviors described in the Interaction Standards were actually being performed by the staff at Careville in key customer service areas.

Mystery Observer Assessment

Even before the introduction of the staff-designed Interaction Standards, the design team recognized the importance of assessing how frequently these behaviors occurred in the culture and giving feedback to all staff, including leadership, about the challenges ahead in the implementation of these Standards. With full disclosure and cooperation of staff, a behavioral assessment, known as the Mystery Observer Assessment, was designed. The goals of the Mystery Observer Assessment were to:

1) Identify areas of strength in Interaction Standards; that is, identify which Interaction Standards occurred frequently; and,
2) Identify areas of improvement/development for a specific department; meaning, identify which behaviors/interactions described in the Interaction Standards did *not* occur or occurred only sporadically.

The design team worked with Kratochill's (1993) notion that "behavioral assessments refer to the identification of meaningful response units and their controlling variables for the purposes of understanding and altering behavior" (p. 350). All of the Interaction Standards were included in the assessment too. The assessors used an interval recording technique. In this technique, assessors recorded the occurrences or non-occurrences of the Interaction Standard behaviors in three sample 20-minute time intervals at different times of the day and/or evening (McCallum, 2001). For example, the assessors would observe the staff to determine if staff introduced themselves to the customer and called the customer by name. The Mystery Observers were asked to unintrusively observe the interactions between staff and customers in the natural environments (such as waiting areas and registration areas) where such interactions routinely occurred. The results represented the aggregate of 27 customer contact areas within the Careville Hospital campus from May through June 2002. The results were shared with all staff represented in those customer contact areas and, at a later date, with the entire staff of Careville. Results were anonymous with only total occurrences or non-occurrences within the observed time frames shared.

The design team learned a lot about the service habits in the culture from the Mystery Observer Assessment, and it was useful in helping Careville staff re-examine their approach to customers. The design team felt it was important for the Careville staff to have a "picture" of how the current behaviors and the culture of Careville compared to or differed from the actual practice of these Interaction Standards. For that reason, the

design team presented the Interaction Standards and the results of the Mystery Observer Assessment *together* to the leadership of Careville for them to communicate to all staff.

Interaction Standards Presented to Leadership

In June 2002, the final Interaction Standards and results of the Mystery Observer Assessment were shared with leadership. These two sets of information were coupled to more effectively unfreeze Careville staff beginning with leadership, and provide enough disequilibrium to show the gaps in the actual practice of these Interaction Standards in the culture. Throughout this project there had been some expressed differences in the way leaders and staff saw themselves in terms of customer service. Some departments did not see their inconsistencies on a daily basis and believed the gaps did not exist in their departments. Many departments had felt that the service issues were "not about them", as they certainly did not see their behaviors in the way the customer did. The Mystery Observer Assessment enabled staff to "play" customer briefly in order to see service through the customer's eyes. The assessors who performed the Mystery Observer Assessments all described their experiences candidly, expressing their observations through presenting facts, details, and descriptions. Some leaders were surprised by these results; and many of them began to see the culture differently almost immediately after the presentation of the Mystery Observer Assessment results.

After the presentation of the Interaction Standards and Mystery Observer Assessment results, leaders were asked to facilitate the use of these Interaction Standards within their departments in a Type II teaching and learning approach (given that all Standards needed to be customized to each individual service/department, depending on the nature of the service). For example, the Standard Meeting and Greeting Customers

does not elaborate on how the staff will process a patient's procedure. The leaders facilitated discussion and asked the staff to design the next steps with the understanding that this greeting would serve as a common language to be used with every patient as well as other customers.

Members of the design team were assigned to each department to act as "an extra pair of hands" during this implementation. There was a consensus among leadership that the Mystery Observer Assessment was a great learning tool that could be effectively used within departments to assess and to document progress toward the goals of implementing these staff-designed, best practice-tested Interaction Standards. Staff within each department volunteered to play Mystery Observers and give feedback to each other, sharing their observations in the role of customer/observer.

Even as I bring this narrative to its conclusion, the leadership at Careville remains in the process of facilitating and coaching their staff to practice these new Interaction Standards. So far, the Careville staff has determined some physical and process barriers that have made it difficult for some members to use the Standards. For instance, the design of the Outpatient Registration area makes it very hard not to "cattle call" patients' names across the waiting area. Yet, despite this design issue, the staff decided to draft the Interaction Standard to require Careville staff members to greet the customer personally and introduce themselves. At this time, there is a team at Careville working to determine what approaches might be used as alternatives to calling out customers' names in this "cattle call" fashion.

Careville staff volunteered to be a part of the Mystery Observer Assessment experience, which has led me to believe they have felt safe with this tool. They have

even teased each other and members of the design team about the process, asking questions like, “Are you my Mystery Observer today?” Staff member’s sincere lightheartedness about this work led the design team to believe that the staff members feel safe doing this work together. Design team members have had numerous conversations with the staff involved in this assessment and the staff have described the experience as being “eye-opening.” Mystery Observer staff recommended that this process become something all staff should do. This being said, it may be too soon to appreciate whether these behaviors have become a part of the Careville culture enough to refreeze the culture into a new set of behaviors, beliefs, and attitudes.

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# Chapter 5

## Observations And Reflections

### Overview

Experience as an integral member of this cultural change initiative provided me an opportunity to apply theories of both learning and change to my individual practice and to observe the application of these theories in the collective practices of the staff at Careville Health System. My observations and reflections of what I learned fall into five main categories:

1. The use of the three types of teaching and learning and their elements (especially Type III);
2. The use of Schein's model and the three types of teaching and learning to facilitate change;
3. The facilitator's experience,
4. My personal experience; and,
5. The leader's experience.

### The Use of the Three Types of Teaching and Learning

Early in this culture change initiative, I discovered some research conducted at Dartmouth by a multidisciplinary group of health care professionals relative to collaboration in health care that was very comparable to the experience at Careville. In this research (Bataldin, 1998), the group asked front-line health care leaders a very important question: "What have you not been able to figure out?" To paraphrase Bataldin (1998), their responses were grouped in seven common categories:

- Listening to and appreciating others;
- Thinking across disciplines and roles;
- Sharing ideas and linking those shared ideas to execution and deployment of change;
- Appreciating systems and interdependencies;
- Using research (including local research) to inform our practices;
- Using methods, skills, and techniques as facilitators of collaboration; and,
- Working across organizational boundaries.

Many of these same issues were present as I worked to facilitate a greater understanding of the Three Types of teaching and learning. Inherent in successfully facilitating Type II teaching and learning and Type III teaching and learning is the ability to listen carefully and completely to another person. As Isaacs points out, "Listening requires we not only hear the words, but also embrace, accept, and gradually let go of our own inner clamoring" (1999, p. 83). As Bataldin and others found in their projects, that type of listening is hard work. Careville staff had never before discussed suspending assumptions about the way things should or should not be done in customer service in order to reach the goal of co-constructing a common language. The staff's collaborative work revealed both traditional worldviews of "how we've always done it" and "fear of the unknown."

John Peters, a scholar I greatly admire, once described discussion as being like "popcorn", meaning people that pop up, waiting for their turn to talk. Jockeying and vying for position in a conversation seems to be the mode of discourse at Careville. Through my efforts, a different model of discourse has been attempted through sharing

and demonstrating Isaacs' principles of dialogue. I also observed discussions that turned from dialogue to debate, and I have respectfully stopped conversations, when possible, to point out barriers to dialogue. The old habits of debate and talking over others were very hard to break, for me as well as for others.

In the introduction of a Type III teaching and learning approach into a predominantly Type I teaching and learning culture such as Careville's, there were many barriers to overcome. Careville was not unique in its tradition of Type I teaching and learning with an emphasis on control. In fact, the majority of health care institutions have traditionally been less participative and more directive (Healthcare Advisory Board, 1999). Isaacs (1999) describes typical programmatic change efforts using this directive style in this way:

> It is a contradiction in terms to use a top-down, control-oriented approach to try to manufacture learning and empowerment instead of creating conditions where they naturally emerge. A second contradiction is embodied in our habit of taking terms like empowerment or learning organizations and making idols out of them. In such a case, empowerment becomes a 'thing' to achieve, not a path to follow . . A dialogic approach to change in organizations must take problems such as these into account. . . .The work then becomes finding, enhancing, and strengthening the organization's central voice or story" (p. 337-338).

Careville's culture was rife with many of these contradictions in its historical approach, such as using a top-down, control-oriented approach to culture change. In this customer

service initiative, I have seen Careville staff struggling with finding its central voice or story.

In my experience with Careville staff members, collaborative learning typically created initial frustration and confusion when the responsibility for learning was turned over to them. The process of collaborative learning for staff required both time and the ability of participants and facilitators to adjust to the initially unfamiliar demands of the collaborative learning experience.

The Use of the Three Types of Teaching and Learning to Facilitate Change

I believe Schein's model of culture change was the best model to use in order to understand the steps a culture needed to take in order to realize a new way of being. As Schein's model indicates, unfreezing the culture would occur more quickly if staff were allowed to participate in articulating the desired behavior changes. The co-constructing of the Interaction Standards helped the movement toward a different culture of service at Careville come about more quickly. However, I found that the use of Type I teaching and learning techniques to share best practice information and customer value research did not allow for dialogue between staff members that could have been very valuable to the unfreezing process. Unfortunately, time was a factor due to the brief nature of the training program. Had there been more time, the use of Type II teaching and learning methods would possibly have been more effective as a way to engage the staff in conversations concerning their views and interpretations of the presented facts. My hope is that because leaders at Careville were coached in the use of Type II and Type III teaching and learning approaches, they will continue the conversations initiated in training sessions and will continue the unfreezing process in their individual departments.

I also discovered an apparent correlation between the time it took to create movement in culture and how well the work group embraced the change. Facilitating the use of dialogue as a mode of discourse served as the catalyst for unfreezing the culture at Careville. I observed the same kinds of conversational fields that Isaacs (1999) describes in his observations of organizational behavior. Isaacs described these fields in organizations as being powerful, as they are full of memories that are emotionally charged. I saw the staff struggle a great deal to be open to the ideas and experiences of others as they wrote Interaction Standards. In some cases, I encountered individuals that would shut teams down with closed attitudes and agendas of their own. In those instances, I noticed that the other group members would withdraw from the uncooperative person and would quit engaging in co-construction and dialogue with others. Often, the product of their work proved not to be of the same quality as the other groups. I watched the staff engage in very emotional conversations in which they identified what had always worked for them as well as what they believed was or was not "broken" about their behaviors. Isaacs says "these fields are so powerful that they tend to work quickly, seamlessly, and automatically" (1999, p. 235). Again, I was reminded that it might be difficult in the future to change these conversational fields, and continue to believe that it will take time to break down these types of barriers between staff.

I agree with Isaacs when he says that if people wish to innovate or develop new knowledge (as Careville staff wish to do in creating a different service culture), one "must see one's work as the quality of these conversational fields rather than the product of individual action or willpower alone"(1999, p. 238). My experience with observing the quality of conversational fields began when I joined the design team and we reflected

on our own attitudes, beliefs, and different opinions about service excellence. This process has continued with the rest of the staff at Careville. I also observed how dialogue created an unfreezing of ideas and an awakening of new possibilities at Careville. This unfreezing began with the design team and has occurred, or is in the process of occurring, with every staff member at Careville.

This experience also demonstrated to me the importance of providing psychological safety to the staff while they experienced the change. Psychological safety appeared to be a major catalyst in moving people through change quickly. In the experience of "Customer Value: Mission Possible" and its myriad of activities, the positive attitudes about the initiative seemed to be directly related to the staff's active participation, from the writing of the Standards to their participation in the Mystery Observer Assessment.

Cognitive Restructuring was supported by staff participation in the customization of the Interaction Standards according to job responsibilities. The leaders at Careville facilitated this customization using a Type II teaching and learning approach. The cognitive restructuring of service behaviors is still occurring with all staff trying to grapple with their old habits of service in a new environment. The Mystery Observer assessment performed by staff has helped to identify those old habits.

I believe there has been refreezing of new behaviors already at Careville in some very simple ways. These new behaviors have mostly been in the form of adhering to Interaction Standards. Many staff members at Careville now consistently answer their telephones by stating their name, department, and then asking, "How can I help you?" This did not previously occur at Careville with consistency. This is just one of many

occurrences that have led me to believe that some change has occurred and is showing a sense of permanence. However, major refreezing of the culture will take time; it will also take a joint effort on the part of staff to lead what they have clearly seen are improved service behaviors.

The Facilitator's Experience

One of my observations while facilitating the three types of teaching and learning was the periodic frustration felt by the facilitators of the training. Because the facilitators had more experience with Type I teaching and learning and less experience using Type II and Type III teaching and learning typologies, their frustration tended to be focused in those areas. In the case of Type II, many facilitators were unfamiliar with facilitating discussions so that they would occur learner to learner and not strictly between facilitators and learners. In terms of Type III teaching and learning, the greatest challenge for the facilitators was to become co-learners. The group did not easily permit that to happen, nor did the facilitators relinquish their teaching roles easily. I found that Peters's (2000) questions in the "Art of Questioning," when introduced in facilitator training helped the facilitators to think through and feel responsible for being a part of knowledge construction. When I co-facilitated with the others, it was helpful to suggest these types of questions to bring the group back to collaborative learning. Questions such as, "What stood out for you in what you just heard discussed?" seemed very helpful to facilitators to show them a new direction of facilitation.

Also, this development was designed to help facilitators learn the basis of meaning as related to the social construction of knowledge. As Shotter (2002) says:

> Instead of taking it for granted that we understand another person's speech simply by grasping the inner ideas they have supposedly put into their words, that picture of how we understand each other is coming to be seen as the exception rather than the rule. For in practice, shared understandings are developed or negotiated between participants over a period of time, in the course of an ongoing conversation. (p. 1)

As the facilitators observed the construction of the Interaction Standards in each staff group and watched each group struggle with the meaning of terms like *nice* and *excellent service*, they understood the usefulness of the Type III approach. In order to create a behavior-specific Interaction Standard, the groups had to "peel back the onion" and reflect openly on what those terms meant to them.

The training of a diverse group of facilitators proved challenging in some cases due to lack of experience with the different types of teaching and learning. One facilitator who had only Type I teaching and learning experience came to me one day and said, "I don't know what to do when I ask a question and they just stare at me. I feel like I ought to be giving them answers instead of questions." Possibly, this facilitator's experience with teaching roles had reinforced the idea that the teacher should always be an expert with all the answers. It was also possible that the group could sense the facilitator's uneasiness and perhaps even heard it in the way the facilitator asked the questions. In our subsequent discussions, I believe this facilitator finally experienced Type II teaching and learning, but I am not sure the facilitator ever completely became one of the collaborators in the group.

I also observed that some facilitators, more so than others, seemed to have a natural ability to work with the Type II and Type III teaching and learning methods. Typically, these facilitators also possessed the ability to be *other-centered* in their practice. For example, the leader of the Celebration/Recognition Committee, who was also a facilitator of the training, had the natural ability to become a co-member of a group and engaged with others easily. She was always interested in being a member and hearing what others had to say. As a result, co-constructing with the groups she facilitated seemed to be a joy for her. I saw, in effect, both ends of the spectrum: those who demonstrated ease with facilitating using Type II and Type III teaching and learning in some facilitators, as well as those who experienced extreme discomfort when asked to become co-members of a group and be co-constructors of knowledge. Nevertheless, I believe that all facilitators benefited from the training and subsequent experience of using Type II and III teaching and learning approaches and that the skills they developed can be used in their future facilitation experiences. Some facilitators just grew in their practice more than others.

My Personal Experience

Facilitating Type III teaching and learning with 2500 staff in a short period of time was extremely challenging. My experience with Type III had primarily been in academic settings where groups of 10-12 participants engaged in Type III teaching and learning, to co-construct knowledge. Applying the types of teaching and learning in a large health system in a prescribed period of time required the collaboration of two distinct groups: leadership and staff. While the leadership of Careville was very interested in having staff jointly construct the behaviors for use in the eight generic

standards, it was also important to create the change to service excellence as quickly as possible given the current climate in health care and the deadlines set by the Strategic Plan.

The critical lesson for me was the fact that collaborative learning takes time. This initiative around Type III teaching and learning required the majority of time to be spent in having leaders collaboratively decide the direction the plan would take, and having staff collaboratively decide the necessary actions to be taken. For the translation of direction from the leadership to the staff, Type I teaching and learning and Type II teaching and learning worked best. The design team and the leadership of Careville tried to encourage a change in the "world-view" of staff, and these approaches carried a prescribed direction to service excellence that differed from how patients had been traditionally served at Careville. In order to be able to achieve this change, it was important that the facilitators in the training experience assume the roles of Type II teachers in certain parts of the training so that the learning of new ideas could be mediated. In this way, the facilitators became more prescriptive about the end-result expected from the participants and thus accelerated the process.

In some cases, this mediation was not necessary. All of the facilitators experienced some training classes in which staff took ownership and became the *teachers* around a new service style or behavior. There were numerous instances of group members asking back as the staff explored a higher standard of service excellence. According to Shotter (1994),

> It is in our use of words that we arouse (in others and in ourselves) certain feelings of anticipation and expectation, a <u>sense</u> as to the

> possible nature of our future conduct—how we will relate what we do both to the others around us, and to the rest of our circumstances. It is this sense that shapes how it is felt appropriate to respond. (p. 2)

In the experience of asking back, the staff of Careville learned to anticipate the importance of the response in the delivery of service.

Another significant learning experience for me was the facilitation of the three types of teaching and learning and the roles these approaches played in creating cultural change. Although Type II teaching and learning dominated the majority of the Customer Value Learning Model, the staff had some brief experiences with Type III teaching and learning techniques. The co-construction of Interaction Standards by large numbers of staff marked a different approach at Careville. There had been attempts in the past to create an *empowered* culture at Careville, but, ironically, these attempts were done by creating a model at the executive level (without staff input) that was then deployed to the staff with the understanding that "this is the way we do business." In this way, "creating a learning organization (became) a standard to impose, not a process to germinate" (Isaacs, 1999, p. 337). Many aspects of this initiative are processes still germinating within staff and their teams. If I, as a member of the design team, can help leadership come to terms with seeing themselves as *not* having all the answers, but as contributors able to collectively create the answers, a shift in thinking through this experience could result. Hopefully, this shift would then be applied to other initiatives at the Careville Health System.

Understanding the importance of dialogue and the cultivation of relational responsibility was another significant learning experience. My deeper understanding of dialogue has grown due to my involvement in this initiative. I observed the importance of relational responsibility in service excellence throughout all stages of the initiative. The attention Careville staff paid to each other as they created Interaction Standards demonstrated the value of seeking out others' views to create common meaning. Through the evaluation of the feedback of patients in customer value research as well as the descriptions of best practice and the actual sessions with staff, understanding and emphasizing relational responsibility in every interaction emerged as the key to creating a culture of service excellence. As Shotter (2001) indicates:

> Only if "you respond to me" in a way sensitive to the relations between your actions and mine can "we" act together as a collective-we and if I sense you as not being sensitive in that way, then I feel immediately offended in an ethical way- I feel you lack respect for 'our' affairs. (p.1)

My reflections upon my own actions through this initiative were varied. I found myself living my own contradiction many times: I would encourage the group to use Type II and III teaching and learning methods while I actively practiced Type I teaching and learning. I experienced a great deal of personal reflection through the writing of this thesis, and I believe that as a result I am now better able to be a co-member of a group and a better listener. I have always had strong opinions I have not hesitated to share in a group. What I have developed over this experience is improved listening skills so I can really hear what others have said. I hope I also demonstrate greater respect for others' ideas.

Despite the enormity of the work ahead, I was encouraged by the collaboration of the staff in finding solutions to problems such as implementing certain Interaction Standards. I believe this work demonstrated the ability of Careville staff to see new ways of coming together. I believe this can be attributed to the different types of teaching and learning the staff have experienced. For example, I witnessed several leaders using a different approach in facilitating groups, including asking more questions of the group to seek to understand others' points of view before continuing a discussion. I also witnessed more instances of collaboration in decision-making about ways of implementing changes in individual departments since the start of this project.

The attitudes of staff suggest that there has been some unfreezing in approaches to interacting with customers. I have already seen a change in how Careville staff give directions, how they meet and greet customers, attention to privacy, and how telephone business is conducted.

The Leaders' Experience

I made several key observations of the leadership's experience during this initiative. First, I observed the various responses of leaders to the types of teaching and learning. Some leaders seemed to have more difficulty with the three types of teaching and learning than others. Leaders that have traditionally managed autocratically without a lot of input from staff seemed to experience some discomfort using Type II and Type III approaches. One leader, after the session in which the Interaction Standards were presented to the Leadership Group, brought the Standards to the staff and said, essentially, "Do this." The leader did not initiate any dialogue on how these Standards could or could not be performed within the context of day-to-day activities in interactions

with customers; plus, the possible barriers to performing these Standards within existing work systems were not discussed. Fortunately, a facilitator was able to intervene with this group and helped this leader learn, simultaneously with the staff, the benefits of Type II and Type III teaching and learning. This facilitator volunteered to conduct the meeting with the staff and asked the leader to participate as a co-member of the group. She also volunteered to facilitate a discussion within the group about the customization of the Interaction Standards. In this discussion, she asked the group to clarify how the Standards would work in their department. She asked the group to discuss any systems or processes that would not allow the work group to implement the Standards. This example represents a kind of *tug of war* between some leaders and staff when faced with decision-making about implementing the Standards.

Secondly, I observed the role that the relationship of leadership and staff played in an individual department's ability to implement the Interaction Standards. When the staff culture had been one that supported a leader as the ultimate authority with an unequal distribution of power and authority in the group as a whole, the group was reluctant to take on construction of knowledge and the leader was not necessarily willing to give up power. In some instances, I saw a need for a shift to occur in the leader's perspective so that the leader would come to view his or her role as *serving* staff. As Lauer (1993) puts it,

> It all starts with humility. By that I mean not taking yourself too seriously. Too many executives think their organizations would fall apart were it not for their talent and dedication. They don't want to share power because they're too insecure about their own

> abilities. Even more important is the desire to treat your colleagues and customers with a gentleness that inspires confidence and loyalty. For some people that's hard to do because they feel vulnerable when they show their emotions. It's all very easy, but it requires the leader to be with his (her) people, not in some office on the top floor where there's no noise and no laughter and where everyone is afraid to say anything for fear of being criticized or ridiculed. (p. 1)

In short, for some leadership at Careville, the use of Type II and Type III teaching and learning techniques also required a shift in perspective of the role of a leader.

Finally, I observed that we included elements of control and coercion in the model for change. I believe that some progress was made when staff designed the Interaction Standards, but many other decisions were made by the leadership for the staff. Whether those decisions made for the staff will lead to the failure of the effort (or at least the slowing down of the effort) is not yet evident, for the change is still early in its process. However, I have already noticed some telltale signs that indicate there may be impending mutiny in areas where staff members feel that they were not allowed to direct their own service improvements.

Conclusion

In conclusion, I believe there is a place for all three types of teaching and learning in cultural change. I am convinced that, in order to introduce cultural change, there must be some new information or set of facts shared (logically in a Type I format) that one would not be able to create collaboratively because the information is not readily

accessible to the culture and the group. With the Type II format, I experienced the importance of offering staff an opportunity to discuss their views of service delivery and the importance of staff's perceptions of the barriers to service such as processes that do not serve the customer well. Also, the staff must work together to visualize a different way to deliver service. Finally, I have no doubt that the Type III teaching and learning approach provided an effective and powerful means for initiating the creation of a culture of service excellence delivery, since the approach meant that every staff member was involved in co-constructing new knowledge to improve service. For the Careville project, the use of Type III teaching and learning was limited to the introduction of dialogue and a focus on construction. The efforts at action and reflection and ways of knowing were limited, possibly due to the large numbers of people involved and the level of understanding of the facilitators, including me. Perhaps most importantly, though, Type III allows the greatest opportunity for growth in the culture of the Careville Health System. This way, Careville can continue to offer experiences with collaborative learning and measure the positive results of the use of this type of learning in the culture. The challenge for the Careville Health System remains, yet the design team members and leadership continue to encourage staff to carry on dialogues about customer service, thus engaging each other in creating a different culture at Careville. The three types of teaching and learning have helped Careville staff begin conversations that will hopefully lead to a different way of being. It is important for Careville staff that, through this process of culture change, they come to recognize some of their own habits of thought in action. When Careville leaders can see that the staff need to create change that is not what the leaders have decided for the staff, but what *staff have formed for themselves*, the

Careville Health System staff may come much closer to creating a sustained culture of service excellence delivery.

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# Appendixes

Appendix A- Customer Value: Mission Possible Training Program

| Course Outline | Learning Objectives | Type(s) of Learning Used |
|---|---|---|
| 1. The Reason For Cultural Change<br>❑ Mission, Vision, and Goals<br>❑ Best Practices in Health Care<br>❑ Consumer Preferences<br>❑ Next Steps After Training | 1.1 To state the compelling business case for cultural change in the service setting<br>1.2 To state the goals of the service excellence initiative at Careville Health System and set performance expectations for all staff around this initiative.<br>1.3 To introduce disconfirming data to create discomfort and disequilibrium and produce a desire to change. | Type I Learning:<br>❑ Mission, Vision, Values<br>❑ Customer Groups<br>❑ Business Case<br>❑ Best Practices in Health Care<br>❑ Next Steps<br>*Instructional method included a PowerPoint presentation in a lecture format by Executive Vice-President of the Careville Health System*<br>Type II Learning:<br>❑ Consumer Preferences<br>*Instructional method included a facilitated discussion between Executive Vice-President and members of the group on consumer preference in service.* |
| 2. Service Equals Culture<br>❑ What the Customer Says<br>❑ Customer Value Research<br>❑ Staff Satisfaction Survey Results<br>❑ Identifying Strengths and Barriers in the Culture<br>❑ Powerful Cultural Messages<br>❑ Service Habits | 2.1 To establish and deploy customer requirements to staff<br>2.2 To connect disconfirming data to important goals and ideals to create anxiety and/or guilt<br>2.3 To encourage staff to listen to customers feedback around the Careville culture<br>2.4 To encourage voicing within the culture to reveal what is true for the customer (Isaacs, 1999) | Type I Learning:<br>❑ Customer Value Research<br>❑ Staff Satisfaction Survey Results<br>*Instructional method included a PowerPoint presentation and lecture by group facilitator*<br>Type II Learning:<br>❑ Identifying Strengths and Barriers in the Culture<br>❑ Powerful Cultural Messages – Role Play<br>❑ Service Habits<br>*Instructional method included facilitated discussion between facilitator and group participants, and a role play where participants acted out service roles they have seen within a cultural context* |
| 3. FISH Philosophy, Careville Style (related to significant ladders identified through Customer Value Research) | 3.1 To provide an example of a different culture to motivate cognitive restructuring of service attitudes<br>3.2 To create opportunities for staff to co-construct interaction standards that | Type I Learning:<br>❑ FISH Philosophy<br>*Instructional method included a video presentation*<br>Type II Learning:<br>❑ Play<br>❑ Make Their Day<br>❑ Be There |

| | | |
|---|---|---|
| | would serve as Careville "brand" service behaviors.<br>3.3 To provide mechanisms for staff to give feedback to each other around best practices in service behaviors | ❑ Choose Your Attitude<br>*Instructional method included a facilitated discussion of these principles between facilitator and participants.*<br>Type III Learning:<br>❑ Writing Interaction Standards<br>❑ Feedback to determine best practice – Wow, Wow-Wow, and Bow-Wow<br>*Instructional method included small groups creating interaction standards and reviewing others; facilitator became a co-learner/member of group.* |

Appendix B – Leadership Support Modules

| Module | Scheduled Month |
|---|---|
| Personal/Business Needs | January 2002 |
| Internal Customers | February 2002 |
| The Four Things Customers Need | March 2002 |
| Hooks | April 2002 |
| Empathy/Feel-Felt | May 2002 |
| Words to Use/Words to Avoid | July 2002 |
| Reflective Listening | August 2002 |
| Stress Management | September 2002 |

## Appendix C – Interaction Standards

### Meeting and Greeting Customers

1. Smile and make eye contact with customers.
2. Introduce self and welcome customers to Careville.
3. Ask, “How can I help you?”
4. Call the customer by his/her name. Address the patient formally until invited to do otherwise; that is, use Mr., Mrs., or Ms.
5. Serve immediately whenever possible.
6. Escort the customer to his/her destination whenever possible.
7. Before leaving a customer, make sure he/she is taken care of and ask if he/she needs anything else.
8. Thank the customer for using Careville.

### Addressing a Customer Who is Waiting

1. Smile and make eye contact with the customer.
2. Introduce self, call the customer by name.
3. Apologize and thank the customer for waiting.
4. Explain the reason for the wait.
5. Tell the customer the anticipated wait time.
6. Offer coffee, cold drink, magazines, and alternative activities.
7. Make conversation with the customer.
8. When staff is ready to test/treat the patient, notify the patient that we are ready to serve him/her. Do not call his/her name across a waiting area.

9. Update the customer every 15-20 minutes while he/she waits.
10. Offer free parking or meals, etc., if wait is longer than _____.

## Conducting Telephone Business

1. Answer the phone within three rings.
2. Smile. Identify department and self.
3. Use a pleasant, unhurried tone of voice.
4. Listen to the caller state his/her business without interrupting.
5. Ask permission if you must put callers on hold and wait for a verbal response. Let callers know how long they will be on hold and when you will be back on the line.
6. Check in with callers on hold every 2-3 minutes. Offer the caller the option of returning his/her call after 5 minutes on hold.
7. Apologize for "hold."
8. Offer to continue to hold, or ask, "May we call you back?"
9. Check voice mail and return phone calls within 24 hours, if possible.
10. In case of transfer, ask permission to transfer call and give the caller the number in case the call becomes disconnected.

## Giving Directions

1. Greet everyone you pass with “Hello” or “Good morning,” etc.
2. Smile.
3. Make eye contact.
4. If the customer looks lost, ask “Do you need help?”
5. Escort the customer to his/her destination.
6. Walk at the customer’s pace.
7. If needed, offer a wheelchair.
8. Take the customer to a person not an area or department.
9. Ask the customer, “Is there anything else I can do for you?”
10. Make sure the customer has directions back to the parking area.
11. Leave the customer with a map.

## Addressing a Customer Complaint

1. Introduce self and ask how you can help the customer.
2. Listen without resistance to the full complaint in a private place.
3. Maintain eye contact and a neutral posture; that is, arms unfolded, hands out of pockets and off hips, facing patient.
4. Use empathetic responses, such as, “I understand that upset you,” and /or affirmative head nods.
5. Apologize to the customer.
6. Ask the customer how he/she would like you to follow-up.

7. Follow-up within one hour or less whenever possible, but no later than 24 hours, after the complaint.
8. Inform the customer of follow-up time.
9. Send a letter to the customer in follow-up.
10. Give a small gift to the customer in follow-up, when appropriate.

Public/Professional Conversation

1. Use “please” and “thank you,” “sir,” and “ma’am” in all conversations.
2. Never discuss patients, families, or situations in public areas such as hallways, elevators, break areas, or cafeteria.
3. Never discuss negative, sensitive issues regarding staff, hospital, etc., in public areas. If questioned in public, always move to a private area.
4. To protect confidentiality, never use patient names in a public area. Patients should be “learned” (that is, what they are wearing, how to recognize them, etc.) on introduction and approached quietly when notified of the next step in their treatment or testing.
5. Show interest and concern, and give eye contact.
6. Include the patient and family in conversations whenever possible.
7. Use plain language and make sure the patient/family understands.

## Personal Appearance/Dress Code

1. Uniforms/clothing should be clean and in good repair.
2. Include a smile as part of your uniform.
3. No perfumes or cologne can be worn if you have patient contact.
4. Wear minimal jewelry, when appropriate.
5. Hair should be clean and washed, nails should be well groomed.
6. Wear your identification badge at all times.

## Maintaining Privacy

1. Always knock before you enter a room and wait for a response before you enter.
2. Interview customers in private areas.
3. Keep patients covered and provide maximum personal privacy when performing procedures and tests.
4. Always close curtains in semi-private areas, even when interviewing or talking with patients and families.
5. Do not call out patients' names in a public area. "Learn" the patient (that is, clothes they are wearing, etc.) and quietly approach them when calling them.
6. Close doors whenever possible.
7. Provide a robe or second gown when a patient is ambulating or in a wheelchair.
8. Provide sheets or blankets when transporting a patient.
9. Protect private patient information by:

- Clearing computer screens
- Being sensitive to telephone communications
- Keeping charts from public viewing
- Not speaking about patients in public areas

# Vita

I currently serve as the Manager of Leadership Development for the Careville Health System. I have served in various capacities in health care for over 25 years, beginning my career in health care as a Registered Nurse. I have also served in various leadership positions over the last 23 years. I received my Bachelor of Arts in Allied Health from Doane College, Lincoln, Nebraska. I have served as a Tennessee Quality Award Examiner for six years and, more recently, as a Baldrige National Quality Award Examiner in 2002. I am a wife and mother of two girls, ages 14 and 11.