

THE INFLUENCE OF TOP MANAGEMENT TEAM REPLACEMENT ON
TRANSFORMATIONAL CHANGE INITIATIVES IN HEALTH CARE

by

Steven J. Brown

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Management in Organizational Leadership

UNIVERSITY OF PHOENIX

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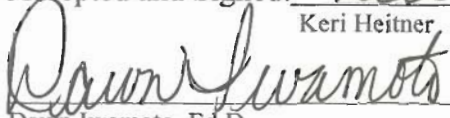
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ABSTRACT

Although the health care industry is in need of dramatic transformation, the industry has performed poorly relating to effectiveness of culture transformation initiatives. The overall success or failure of transformational change initiatives in hospitals is unclear as evidenced by the number of organizations engaged in or that continue to seek—2.6 initiatives on average over the past decade by this study group—a successful transformation formula. The current study focused on 32 of 46 hospitals across the United States that participated in a Voluntary Hospitals of America collaborative transformational change initiative. The purpose of the quantitative correlational research design was to examine the influence of top management replacement on the effectiveness of organizational culture transformation as measured by improved employee and patient satisfaction. Quantitative statistical methods assisted in an assessment of the strength and direction of the relationship between the percentage of top management team leaders replaced and employee and patient satisfaction measured through annual survey data of the organizations examined. The most significant new findings of the study were a moderately strong negative correlation between leadership tenure and employee satisfaction, which is significant because the finding has no previous literature support. Also important is the finding of no correlation between tenure and patient satisfaction, which is a notable outcome because the finding is counter to the literature. A further discovery was the apparent lack of understanding of transformational theory and transformational practice by the study participants. It may be that executives may be engaging in transformation without entirely understanding what it involves and, in some cases, demonstrating a weak, fleeting commitment to transformation.

DEDICATION

This work is dedicated to the two most important women in my life: my mother, Rosemarie Dorothea Brown, who always believed I would make a difference; and my wife, partner, and best friend for the past 29 years, Carole Jane Brown. Carole's selfless sacrifice and strong active support of this difficult journey made attainment of this wonderful goal a reality. This doctoral degree belongs as much to her as to me.

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CHAPTER 1: INTRODUCTION

Health care organizations are not meeting the needs of U.S. consumers, as evidenced by the escalating dissatisfaction with high cost, lack of access, and concerns about quality (Institute of Medicine, 2001; Scotti, Driscoll, Harmon, & Behson, 2007; Spear, 2005). The U.S. health care system is underperforming at the organizational level, and the responsibility of organizational performance falls to the top management teams of health care organizations. Experts question why the industry is in a state of disarray (Satcher & Higginbotham, 2008; Thomas, 2006; Tilson & Berkowitz, 2006). Health care leaders have responded with several theories regarding why their industry is under siege and where the real causes or problems lie (Dracup & Bryan-Brown, 2003; D. Smith, 2004; M. E. Smith, 2003; Thielst & Gardner, 2008).

Health care organizational leaders have received serious criticism about structure, quality, and cost of health care services in the United States. In its landmark second and final report, titled *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Committee on the Quality of Health Care in America called for a redesign of the entire health care system, with a focus on the organizations and professionals that currently comprise the system (Institute of Medicine, 2001). Based on the activities of countless health care consultants and various forms of transformational change initiatives undertaken by U.S. health care organizations, the industry is, in differing approaches, attempting to respond to the call to action. Although some transformational change initiatives focused on improving quality and safety were successful (Kim, Force, Rasmussen, Dodd, & Whildin, 2007; Reeves, 2007), the need for major reform of the system continues (Lurie et al., 2008; Rashford, 2007).

Examining the outcomes of quality- and safety-focused improvement initiatives may help in understanding and incrementally improving the effectiveness of future initiatives. Absent from the literature are studies of successful or failed transformational initiatives focused on the role of the health care leader. The gap in literature related to examining what some consider the cause of a health care system in crisis—the lack of leadership capable of providing needed transformational change—creates a potentially important void in the understanding of why transformational change efforts fail (Alimo-Metcalfe & Alban-Metcalfe, 2004; Ralston & Larson, 2005).

Although many change initiatives are underway in hospitals in the United States (Bujak, 2005; Kim et al., 2007; Reeves, 2007; Schockey, 2006), few data exist as to which approaches are working and which approaches are not working. The goal of the current study was to add to the scant body of knowledge through examination of an organizational transformation collaborative undertaken by a group of hospitals across the United States over a 4-year period. The examination focused specifically on the influence of the top management team on the success of transformational change initiatives.

Chapter 1 includes a detailed background of the problem and outlines a conceptual or theoretical framework addressing the connection between leadership and transformational change. The framework led to the central research questions and hypotheses examined, as well as an examination of the scope, assumptions, and limitations and delimitations of the study. The conclusion of chapter 1 includes a brief summary. Chapter 2 includes a review of present and past literature relating to the variables and theories examined. Chapter 3 includes an overview of the study methods

and support for the chosen methodology. Chapter 4 includes an analysis and presentation of the data, and chapter 5 concludes with implications and recommendations.

Background of the Problem

Based on the literature and daily anecdotal experiences from the late 1990s through early 2007, there seems to be a widespread belief that health care in the United States is in crisis (Chassin, 1998; Fromberg, 2007; D. Smith, 2004; M. E. Smith, 2003). Specific evidence of the disarray of the health care system comes from Dracup and Bryan-Brown (2003), who noted, “We have developed amazing silver bullets to treat disease. Unfortunately, we are delivering these miracle bullets in the weapons-equivalent of a wheelbarrow (i.e., our dysfunctional healthcare delivery system” (p. 306). Dracup and Bryan-Brown posited the U.S. health care system is faltering and that it has become complex and inefficient. Continuing the theme, Thomas (2006) reported the health care system is close to “hitting the wall” (p. 138), and Simpson and Bolton (2007) described the crisis in health care as the brewing of a perfect storm.

The Institute of Medicine (2001) and the Institute for Healthcare Improvement outlined a vision for an improved health care system (Beyea, 2007). To achieve the vision, health care leaders must become adept at transforming the industry at the organizational level. Sufficient evidence exists through research by the Institute of Medicine, the Institute of Healthcare Improvement, and others suggesting reaching the goal requires new solutions and guidance for health care leaders. The new solutions and guidance include closely monitoring outcomes and improved understanding of episodes of harm (Beyea).

Placing the Crisis in Context

Possible causes for the health care industry's state of disarray include numerous challenges facing the industry, such as shrinking reimbursement, increased regulation, and serious labor shortages. In an article in *American Nurse* ("Nursing Council Takes Aim," 2003), a report by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) highlighted the severity of the labor crisis in nursing:

The JCAHO report warns that the growing nursing shortage needs immediate attention because it is putting patients' lives in danger. More than 126,000 nursing positions are unfilled today, and that number is expected to skyrocket as 78 million aging baby boomers begin placing unprecedented demands on America's health system later in the decade. (p. 8)

Although researchers have attempted to explain what has precipitated the dramatic shortage, including an examination of the relationship between the shortage of nurses and patient satisfaction conducted with 827,430 patients, 733 hospitals, and 25 states (Clark, Leddy, Drain, & Kaldenberg, 2007), organizational leaders are only beginning to appreciate the true impact on the health of our communities. To place the seriousness of the issue in perspective, Korcok (2002) noted,

An acute and growing shortage of nurses in US hospitals has been a factor in almost one-quarter of all adverse events resulting in death, injury or permanent loss of function over the past 5 years, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports. (p. 1159)

According to Herman, Olivo, and Gioia (2003), health care organizational leaders must refocus on their constituents. Constituents include all stakeholders, from patients to

employees to medical staffs. Relationships among the groups are at an all-time low. Stakeholders must begin to talk with each other about solutions that may seem unfamiliar and uncomfortable (Fromberg, 2007).

Leadership's Role in Crisis Intervention

Top management teams are responsible for creating a working environment that attracts and, more importantly, retains high-quality staff (Wagner, 2006). The central question in this current study relates to the effectiveness of top management teams in leading and executing organizational transformation initiatives. Health care organizations are transforming themselves into more employee-focused organizations by attempting to fully engage employees in transformational change initiatives (Herman et al., 2003), yet little is known about how leadership and changes in leadership play a role in the process.

Health care organizations came to the realization that changes in internal environments are needed to attract workers into the field (Herman et al., 2003; Kerfoot, 2005). Numerous change efforts designed to improve organizational environments are occurring across the United States. Some organizational leaders hire consultants to lead their organizations through the required cultural transformations necessary for achieving organizational excellence (Bigelow & Arndt, 2005; Bolman & Deal, 2003). Others, such as those participating in the Voluntary Hospitals of America (VHA) Tomorrow's Workforce (TWF) initiative, attempt to transform their organizations on their own by sharing experiences and benefiting from collaborative learning (Herman et al., 2003).

Schein (2004) noted, "Dynamic processes of culture change and management are the essence of leadership" (p. 1). Consistent with the understanding, health care leaders might turn their focus to the role of top management teams to determine why

transformational change is so elusive. In addition to understanding the dynamics of the change process, health care organizational leadership might examine the adequacy of their top management team as change agents because, as articulated by Schein, senior leadership teams are responsible for the culture change initiatives within organizations. Schein purported, “The formally designated senior managers of an organization may not be willing or able to provide such culture change leadership” (p. 410). The underlying problem in the health care industry may be an inadequacy in the ability of top management teams to be effective transformational change agents.

Transforming organizations to a new state requires strong leadership. *Harvard Business Review* reprinted Kotter’s (2007) *Leading Change*, and the journal editor introduced the importance of Kotter’s work by noting, “Guiding change may be the ultimate test of a leader” (p. 96). In the referenced article, Kotter outlined eight steps for transforming organizations:

1. Establishing a sense of urgency;
2. Forming a powerful guiding coalition;
3. Creating a vision;
4. Communicating the vision;
5. Empowering others to act on the vision;
6. Planning for and creating short-term wins;
7. Consolidating improvements and producing still more changes;
8. Institutionalizing new approaches. (p. 99)

Each of the eight steps requires competence in transformational leadership skills.

Competence in transformational leadership requires, along with finding the balance

between liberty and power, the ability for creating alignment around common goals and transforming dormant followers into active ones (Burns, 1978). The guidance of Kotter (2007) and Burns highlights the need for strong transformational leadership skills within top management teams of health care organizations attempting transformational change initiatives. Organizations lacking sufficient leadership capability in creating transformational change risk becoming victim to the unusually high failure rate of transformational change initiatives (Kotter, 2007).

A Potential Leadership Gap

Substantial literature conclusions support the influence of transformational leaders on organizational change, including the decades-long work of Edward Lawler III and other transformational change theorists (Burke & Cooper, 2004; Fletcher, 1990). Despite numerous studies, much work remains in identifying which leadership competencies have the greatest influence on driving change. An understanding of how leadership competencies evolved, for those who must drive transformational change in a business world of growing complexity, is necessary. Successful transformation might require an improved understanding of how the constructs of leadership and transformational change interact within the highly complex and challenging cultural and sociotechnical environments found within health care organizations.

If transformation requires overcoming resistance to change (Kotter, 2007), health care leaders must develop competence in understanding and mitigating why most stakeholders prefer the status quo. Understanding where and why followers resist change falls to organizational leaders. Transforming an organization is a skill that requires

knowledge and practice in assessing potential resistance and designing motivation into the change by addressing not only antecedents, but also consequences (Folaron, 2005).

Bennis and Thomas (2002) described a process in which potential leaders derive meaning by passing through a “crucible” (p. 40) of transforming experience that led them on a journey of transformational leadership. This consideration raises the question of whether it is the charismatic leader, the “got nothing else to try” leader, or an enlightened board of trustees that prompts a change initiative. In a study on leadership of a cultural change process, Brooks (1997) claimed, “Cultural purists argue that things are largely unaffected by the intervention of leaders, and by more recent research which suggests that leadership is a pluralistic phenomenon” (p. 2). Finding answers to the leadership questions might provide help in transforming the ailing industry.

Statement of the Problem

The focus of the general problem for the study was the poor performance of the health care industry relating to culture transformation initiatives (Herman et al., 2003; Medieros, 2006; Morrison, 2000). In a study of over 100 companies differing in size, industry, country, and profitability, Kotter (1995) determined less than 50% of organizations achieve desired culture change goals in the first phase of culture change initiatives. The numbers are even lower in the health care industry. In a collaborative cultural change initiative in which 46 health care organizations participated, fewer than 20% of the participating organizations achieved the stated culture change goals in the first phase of the initiative (Olivo, 2005). The role of leadership in the process is virtually unstudied, particularly when considering replacement of top executive leaders in health organizations.

The specific problem addressed within the quantitative correlational study is the inadequacy of existing evidence on the relationship between top management teams and the outcome of transformational change initiatives. The specific goal of the study was to achieve an understanding of whether replacement of top management teams in hospitals correlates with greater employee satisfaction and patient satisfaction, as measured by annual standardized surveys. The study population consisted of 46 hospitals across the United States that participated in an organizational transformation initiative known as the TWF collaborative of the VHA, a subset of all hospitals in the United States currently undergoing transformational change.

Purpose of the Study

The purpose of the quantitative correlational research design was to examine the influence of top management replacement on the effectiveness of organizational culture transformation as measured by improved employee and patient satisfaction. The data collection supported a quantitative examination using descriptive statistics of the average mean months of service for the top management team leaders (vice president and above) within the participating organizations. Quantitative statistical methods helped to assess the strength and direction of the relationship between the percentage of top management team leaders replaced and employee and patient satisfaction measured through annual survey data of the organizations examined.

To begin the process of addressing the crisis in the health care industry, leaders must address the workforce shortage issue that has been directly related to the undesirable work environment encountered in most health care organizations (Gelinas & Loh, 2004). Studies written since the year 2000 on transformational change initiatives

demonstrate a positive influence on improvements in the quality of health (Landon et al., 2007; Reeves, 2007). Organizational leaders must recognize the importance of continuing the work of transforming organizations to an environment of high employee satisfaction to address the retention and recruitment issues faced by the industry.

The findings from past literature support a strong correlation between improving employee satisfaction as a means for improving patient satisfaction and overall quality of care (Atkins, Marshall, & Javalgi, 1996; Geyer, 2005; Moody, 2003; Shortell & Hull, 1996). Health care organizational leaders can begin to address the problem by creating an improved environment through transformational change initiatives resulting in a culture where high employee satisfaction drives high patient satisfaction with the highest levels of quality as an outcome. The goal of the study was to add to the understanding of how leadership at the top management team level influences the success or failure of transformational change initiatives as measured by employee and patient satisfaction and to improve the success rate of future transformational change initiatives in the health care industry.

Theoretical Framework

The question of leadership adequacy for the challenges in the health care industry requires further examination. The health care industry is struggling to develop a framework for change that is effective within the unique structure and context of the health care industry and its existing leadership paradigm. The problem required examination, specifically in the context of not-for-profit leadership with a focus on organizations that attempted transformational change initiatives. The problem was addressed through an examination of two distinct theoretical constructs: (a) existing

leadership competencies for preparedness and effectiveness defined within the context of industry environmental stresses and demands of the “crucibles of leadership” (Bennis & Thomas, 2002, p. 40) and (b) the need for new leadership competencies in health care to meet the demands of health care’s “second curve” (Morrison, 1996, p. 2).

Bennis and Thomas (2002) identified the crucible of leadership as “a transformative experience through which an individual comes to a new or altered sense of identity” (p. 40). Morrison described the second curve as a phenomenon fueled by uncontrollable massive forces of change driven by new technology, new consumers, and new markets. The new experience and forces of change may require new competencies in managing transformational change at the personal and organizational level—an experience similar to the crucible of leadership described by Bennis and Thomas. Figures 1 and 2 are graphical representations of the theoretical affect of the constructs on transformational change.

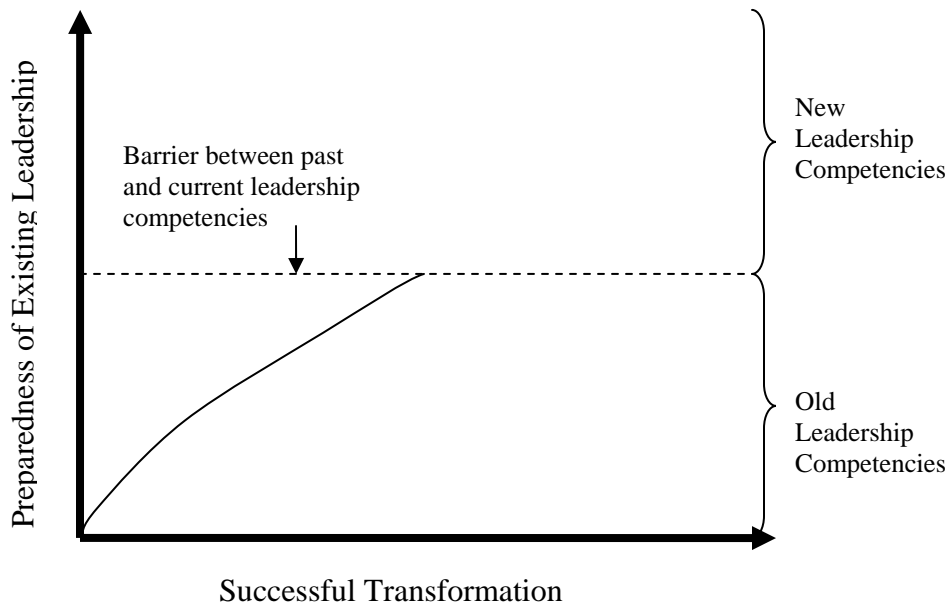


Figure 1. Theoretical organizational adaptability to transformation as a function of existing leadership preparedness and adequacy for managing health care environmental challenges.

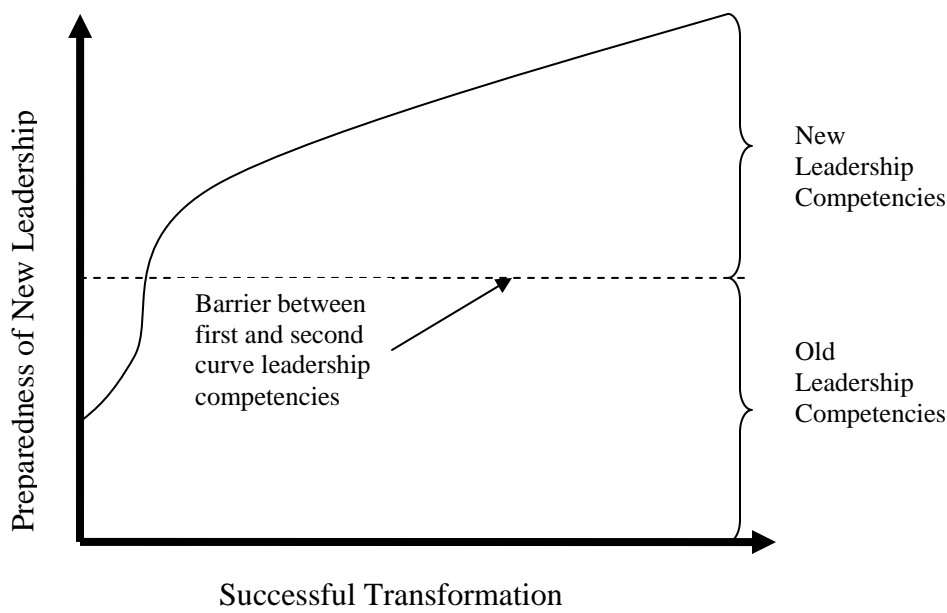


Figure 2. Theoretical organizational adaptability to transformation as a function of new leadership preparedness and adequacy for managing current health care environmental challenges.

A lack of understanding exists between transformational change efforts by top management teams and an understanding of the teams' own role in the success or failure of the initiatives (Kerfoot, 2005; Kotter, 2007; Kotter & Cohen, 2002). Existing literature is limited in the area of diagnosing the success or failure of existing transformational change initiatives in the health care industry. One possible explanation of the phenomenon may relate to unwillingness on the part of health care organizational leaders to learn from their own failures in the area of transformational change. Another consideration may relate to a lack of true understanding of the unexpected outcomes emanating from transformational change efforts.

A new approach to sharing knowledge gained from the efforts should be a focus of the health care industry. McDaniel, Jordan, and Fleeman (2003) discussed “creativity and learning as strategies for capitalizing on the surprises that confront organizations” (p. 266). Organizational leaders must recognize collaborative learning from existing initiatives may reduce the level of complexity surrounding change theory. One example of this learning, central to the current study, was the importance of having leaders who are competent in transformational change at the top management team level of health care organizations. Change at the top is consistent with the insights from complexity science that show “the natural state of things is not a state of equilibrium” (McDaniel et al., p. 269). Yet health care organizations have a tendency to look elsewhere for reasons their transformational efforts fail to meet expectations, rather than to consider themselves and their own limitations as the reason for the failure.

While a lack of sensitivity—or willingness—by organizational leaders to recognize the dynamic as a key predictor of success or failure may exist, the phenomenon

may possibly be more prevalent in the less financially aggressive not-for-profit sector. Linking the natural lack of acceptance by health care leaders in acknowledging their role in leading organizations to a state of inadequate performance provides a framework for understanding transformational change theory: a lack of a sense of organizational urgency amid a state of leadership denial (Beyea, 2007). The difference in the not-for-profit health care sector relates to the reasons people are attracted to working in the industry—to help people (Herman et al., 2003).

The rigor required to overcome the margin versus mission issue is more of a challenge for the not-for-profit health care industry. The phenomena may be underlying causes for the sluggishness found in health care change initiatives. Table 1 contains a theoretical comparison of responsibility acknowledgment between organizations with new versus old paradigm thinking.

Table 1

Responsibility Acknowledgment Gap

| Reasons for failure | Responsible party | |
|---|--|----------------------|
| | Old paradigm leaders | New paradigm leaders |
| Stakeholder rejection | Stakeholders | Leadership |
| Lack of resources | Continuing shifts in cost from third-party payers | Leadership |
| Lack of focus | Growing complexity of regulatory and reimbursement systems | Leadership |
| Pressures for improved quality and control of costs | Unreasonable expectations | Leadership |
| Lack of commitment | Employees | Leadership |

The evidence in Table 1 demonstrates organizations with new paradigm leaders are consistent with new theory on leadership responsibility for transformational change failure (Bigelow & Arndt, 2005). Leaders stuck in the old paradigm are unlikely to successfully lead their organizations to Morrison's (1996) second curve.

The challenge facing organizations is whether top management team members have the prerequisite skills and behaviors necessary for new paradigm leadership. A long-standing debate exists regarding whether leaders can effectively change ingrained or innate characteristics of leadership style as identified by the groundbreaking work related to leader-match considerations of contingency theorist Fiedler and others (Hosking & Schriesheim, 1978). Fiedler argued "changing leadership style is not open to the leader since it is a feature of his 'personality' and is 'an ingrained pattern of behavior' which cannot be changed" (as cited in Hosking & Schriesheim, p. 479). A question for health care organizations is whether the context for leadership has changed so dramatically the inherent characteristics of existing leaders are no longer applicable. If so, perhaps turnover with the intent of acquiring necessary matching competencies will enhance the potential for achieving the desired transformation.

Research Questions

Research questions serve to narrow purpose statements into interrogative statements that provide the specific questions researchers seek to answer (Creswell, 2002). The following research questions formed the basis for the investigation:

Research Question 1: What is the relationship between top management team turnover and employee satisfaction among hospitals actively engaged in transformation efforts?

Research Question 2: What is the relationship between top management team turnover and patient satisfaction among hospitals actively engaged in transformation efforts?

Hypotheses

The literature supports a connection among leaders who are competent in transformational change practices, employee satisfaction, and process improvement (Potthoff, 2004). By evaluating the leadership role and controlling for the top drivers—other than leadership—of employee satisfaction, new knowledge will emerge related to transformational change initiatives in the health care setting. Hypotheses are logical suppositions that provide tentative explanations for phenomena under investigation (Leedy & Ormrod, 2005). The following hypotheses were the logical suppositions for investigation:

H1_a: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of employee satisfaction.

H1₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of employee satisfaction.

H2_a: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of patient satisfaction.

H2₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of patient satisfaction.

Nature of the Study

The current quantitative correlational study involved a custom-designed survey instrument to measure the relationship between the independent variable of top management leader replacement and the dependent variables of patient and employee satisfaction within the studied organizations. The sample consisted of 46 health care organizations across the United States participating in the TWF initiative. Data collected from the surveys were standard interval and nominal scale data.

The quantitative approach is appropriate for examining cause-and-effect relationships (Creswell, 2003) and for providing objective and unbiased results of an examination of the relationship among variables (Creswell, 2002). A correlational research design provided statistical techniques for describing and measuring the degree of association (Creswell, 2002) between the independent variable of top management replacement and the dependent variables. The correlational research design allowed testing whether two variables occur in a predictable pattern.

A variety of qualitative approaches were rejected because the data collection would have required coding of responses and would have been subjected to the vagaries associated with data coding (Neuman, 2003). In addition to the vagaries associated with coding data, the study outcome goals involved searching for a more quantifiable indicator of relationships between leadership and transformational change within the context of a narrower approach and time frame for a first study. The study involved an examination of the association among variables in the context of an explanatory research design (Creswell, 2002) as a basis for guiding future health care leaders as they continue to develop a framework for organizational change within the health care industry.

The broad population for the study consisted of all not-for-profit hospitals undergoing transformational change initiatives across the United States, whereas the sampling frame consisted of hospitals that participated in the TWF initiative of the VHA. The hospital leaders in the sample demonstrated a belief in the need and value of transformation as evidenced by their commitment of financial and human resources to the TWF initiative. The sampling frame was an appropriate group based on the demonstrated desire for and active implementation of organizational transformation initiatives with stated goals of employee and patient satisfaction and organizational performance improvement. The primary data collection instrument for the study was a custom survey questionnaire. An expert panel participated in the validation and reliability assessment of the instrument through a pretest process. In addition to the primary data collection from the survey, original intent was to include secondary data from a database of over 200,000 employee survey responses from over 500 hospitals across the United States, compiled by Success Profiles, Inc.

The research questions for the study contributed to an exploration into the relationship between the independent variable of turnover (measured by mean months of top management team service or tenure) and the dependent variable of transformation (measured by employee satisfaction and patient satisfaction). Chapter 3 contains more detail on variables and measures. Creswell's (2002) suggested criteria for choosing a statistic (p. 238) resulted in the selection of multiple regression as the statistical tool of choice for "examining the combined relationship of multiple independent variables [to include the control variables] with a single dependent variable" (p. 376). Presentation of results takes place in chapter 4 with matrix and data tables.

Significance of the Problem

American consumers are demanding dramatic change in the health care system, and health care leaders are struggling to meet the needs of an underfunded and overused system ("Nation's Emergency Care," 2006). The study adds to the body of knowledge related to leadership in the health care industry through examination of the influence of top management team replacement on success or failure of transformational change initiatives. Substantial research investigated the role of leaders in culture change initiatives as well as a framework for driving the necessary change (Bass, 1990; Kotter, 1995; Schein, 2004). The literature related to culture change initiatives in the health care sector and the role of leadership is not as well developed. The frameworks should be similar but health care leaders have not used or become comfortable with the methodology of change as evidenced by the health care industry's lack of success in change initiatives.

The crisis in health care requires health care organizations to undergo substantial cultural and structural changes (Clancy & Scully, 2003; Feazell & Marren, 2003). Transformational change in health care organizations focused on establishing organizational cultures with high employee and patient satisfaction as drivers of improved performance. The research adds to the body of knowledge related to understanding the role of leader as opposed to the role of systems changes in the overall impact on organizational change.

The focus of the literature available on the connection between leadership and transformational change success is primarily on leadership characteristics necessary for driving desired change. Examining the effect of replacing top management team

members with leaders more competent in transformational change theory or leaders with new paradigm or second curve (Morrison, 1996) thinking provides needed new knowledge to an industry struggling with organizational change efforts. By examining one key interaction of variables—the effectiveness of top management teams in their approach to increasing employee (and patient) satisfaction—an improved understanding of the relationship emerges and may assist organizational leaders with change initiatives. The search for an answer to these and other leadership questions provides the foundation for making a small mark in the needed improvements to health care systems.

The issue studied is central to the success of health care organizations. The creation of an improved roadmap for cultural transformation has the potential to affect the health of millions of citizens across the United States. Despite some evidence of improvements in health care organizations (Reeves, 2007; Scotti et al., 2007), the health care profession must continue efforts to stem and reverse the tide of the “death spiral of workforce instability” (Gelinis & Loh, 2004, p. 268).

Effective organizational change comes about through strong and charismatic leadership (Schein, 2004). Success in transforming an ailing system requires leadership with a passion for healing the health care system in America. The goal of the research effort was to find an answer to the influence of top management leader turnover of an organization’s leadership to ensure successful and healthy cultural transformation. The research indicated because health care organizations have just begun to respond to the impending crisis through culture change efforts to achieve environmental improvement for the workforce, understanding of the most effective measures and methodologies is in its infancy (Ryan, 2006). Transformation initiatives provide a valuable learning

opportunity to assist the industry in understanding what constitutes the most effective methodology for organizational culture change.

Definition of Terms

The following definitions help to bring clarity to specific terms used in the study.

Employee satisfaction: Most studies of work satisfaction classify the needs of employees as either contextual or content needs (Atkins et al., 1996). Included as content factors are physical environment and job-related tasks: pay, security, supervision, role conflict, role ambiguity, organizational structure, and job climate are contextual.

Leadership: According to Burns (1978), leadership is the process of mobilizing individuals with specific motives, values, and economic, political, and other resources to attain the mutual or independent goals of leaders and followers in a context of competition and conflict.

Nonroutine top management team replacement: For purposes of the study, the term nonroutine replacement refers to the replacement of top management team members through governance action (trustees or chief executive officers [CEOs]) because of transformational change needs.

Patient satisfaction: Atkins et al. (1996) claimed, "Patient satisfaction is an important measure of how effective the provider has been in meeting the patient's needs and expectations and a strong predictor of a patient's intent to return" (p. 17).

Routine top management team replacement: According to Wiersema (1995), routine events occur when an existing executive leaves the firm at normal retirement age. For purposes of the study, routine replacement referred to the replacement of top

management team members resulting from retirement or another normal transition out of the organization through personal decision.

Top management team: Consistent with prior research, the top management team consists of the executives in the highest two levels of management within a firm (Wiersema, 1995). The top tier of top management is the chairperson, CEO, and president, and the second tier is the next highest level, typically executive vice presidents. For the purposes of the study, top management team referred to all positions from vice president through CEO.

Transformational change: For purposes of the study, transformational change at the organizational level is viewed through the lens of Goes, Friedman, Siefert, and Buffa (2000), “Transformations are seen as *frame-breaking* changes initiated by visionary executives who lead the organization to a strategic and spiritual rebirth” (p. 138), and by Bigelow and Arndt (2005)’s statement, “Transformational change is radical and discontinuous” (p. 20).

Transformational leadership: Burns (1978), in defining transformational or transforming leadership, noted, “Such leadership occurs when one or more persons *engage* with others in such a way that leaders and followers raise one another to higher levels of motivation and morality” (p. 20).

Assumptions

The following assumptions formed the basis of the research. Organizations willing to commit resources to a culture change initiative such as TWF demonstrate an organizational desire and commitment for transformational change and the chosen sample is representative of the larger population of not-for-profit hospitals. The

standardized survey data results are accurate proxies for employee and patient satisfaction and conducting a pilot study through survey pretest ensured the survey addressed the research questions thoroughly. Employee and patient satisfaction are common outcomes, and therefore valid indicators, of successful transformation in health care organizations. The 4-year period framed by the TWF initiative was appropriate for determining significant changes in employee and patient satisfaction. Participants responded honestly to the survey questions and supplied accurate demographic and organizational background data based on assurances of anonymity, confidentiality, and ability to withdraw from the study.

Limitations

The study was limited to a small sample from the not-for-profit segment of the health care industry. Although the proposed sample size was small in the context of the total number of organizations involved in transformational change initiatives, an examination of the literature revealed a void in understanding the outcomes specifically for collaborative initiatives such as TWF. Although a strong linkage exists in the literature relating leadership as the strongest factor influencing employee satisfaction, other uncontrolled factors could cumulatively skew the results. The design of the survey instrument attempted to control the other variables by collecting data on other satisfiers implemented from a list of the top five employee satisfaction increasers identified in the literature.

The study had the following additional limitations. The study was limited to two potential measures of successful transformational change: employee and patient satisfaction. The individuals selected to respond to the survey, as well as the researcher's

experience in the topic, may have introduced personal biases in the form of subjective opinions on the state and success of transformational change. The results section of the study relied primarily on numerical data from satisfaction surveys as a measure of transformation success and on human resource department data on tenure of top management team. Subjective data collection helped establish opinions or organizational theories from transformational change experiences.

The time frame for expected results was limited from a longitudinal perspective and the participation by organizations across four waves provided differing periods for transformational change to occur. Because of the limitation, the longitudinal data could have presented bias based on the pooling of data from differing points in time. The nature of purposive sampling may have limited the study (Leedy & Ormrod, 2005), although the intent was to examine organizations that demonstrated commitment to a formal transformational change initiative. The choice of leadership turnover at the top management team level and transformational change as the examined variables measured by employee and patient satisfaction further bounded the study.

The small sample size and the need to collect a minimum of 30 limited the statistical power (Leedy & Ormrod, 2005) responses from the sample of 46 hospitals to achieve statistical validity. The potential measurement error introduced from a custom survey instrument may have limited the study (Creswell, 2002). The correlational design limited the conclusions drawn because correlation alone does not indicate causality (Leedy & Ormrod).

Delimitations

The research was confined to surveying the 46 hospitals from Waves I through IV of the TWF transformational change initiative of the VHA. This decision limited the scope of the study to the not-for-profit hospital sector. Surveying organizations that identified and committed to the need for transformational change provided a rich dataset of organizations in varying states of change initiatives but the small sample size and homogeneity limited the generalizability of the results to broader populations beyond those participating in common transformational initiatives. By designing the study to use self-report data, the results were limited by bias introduced from memory or perception limitations (Leedy & Ormrod, 2005).

The examination excluded the effects of other variable measures of transformational change, such as enhanced organizational performance and general turnover. Consistent with most literature that examines top management teams, the study also excluded leadership positions below the level of vice president. The years included from a data collection perspective of 2001 through 2007 further bound the study.

Summary

Hospital leaders across the United States are involved in transformational change efforts as they attempt to improve their internal environments through initiatives to increase employee satisfaction as a means to increase the satisfaction of patients. The limited literature in the area of study identified a problem with the success rate for transformational change initiatives in the health care industry consistent with this as a general problem throughout all industries (Kotter, 1995). In addition to identifying the problem, purpose, nature, and significance of the study on leadership and culture change

in health care organizations, chapter 1 included an overview of the research methodology, a conceptual framework for the examination, and the assumptions and limitations of the study.

The purpose of the study was to address the specific problem through a quantitative correlational research design that examined the influence of top management team replacement on the effectiveness of organizational culture transformation as measured by employee and patient satisfaction. Using a quantitative method of correlational statistics to examine the relationship between the percentages of top management team members replaced and employee and patient satisfaction measured by annual survey data offered potential new insight into the question of the leadership role in transformational change efforts. Additional conclusions emerged addressing the relationship between employee and patient satisfaction.

The crisis in health care requires health care organizations to undergo substantial cultural and structural changes. Transformational change in health care organizations focused on establishing an organizational culture with high employee and patient satisfaction as drivers of improved organizational performance. The study added to the body of knowledge related to understanding the role of the leader as opposed to the role of systems changes in the overall impact on organizational change. Chapter 2 provides historic background on leadership and transformational change as a backdrop to the problem of failed transformational efforts.

CHAPTER 2: REVIEW OF THE LITERATURE

Chapter 2 contains an outline of the available literature related to organizational leadership in the context of the influence of top management teams on transformational change in the health care industry. The review included germinal and current books on the topics, as well as peer-reviewed journal articles from major databases including EBSCOhost, ProQuest, Questia Media America, Business Source Complete, and MEDLINE. Broad database search heuristics on top management teams, leadership, transformational change, organizational change, and the health care delivery system provided the general backdrop. The focus of the literature review was on top management teams, leadership, and transformational change specific to the health care industry.

Chapter 2 begins with a historical perspective on the evolution of leadership theory in response to demands of evolving organizations and required leadership skills for transforming complex organizations. The historical perspective leads to a discussion of past and present theory relating to the general and specific problem and purpose of the study. The historical perspective creates a framework for the in-depth literature review of past and present literature relating the influence of the independent variable of top management team replacement to specific performance measurements of the dependent variable of transformational change.

The second section provides an overview of the literature related to current and desired states of the health care industry. The section includes background regarding the need to transform health care organizations to close the gap between existing and expected organizational and industry performance. The section includes a discussion of

historic changes within the health care industry leading to the identification of an industry in crisis.

The dependent variable section includes an overview of the literature addressing measures of success in transformational change efforts. The section focuses on the dependent variable of transformational change in general industry and specifically in health care organizations. The purpose for the section is to present any differences discovered in an attempt to explain why the success rate of organizational culture change efforts in the health care industry lag behind that of general industry.

The independent variable section includes an overview of the literature addressing the influence of top management teams on transformational change efforts in general industry and specifically in health care organizations. The section focuses on the role of the top management team in organizational transformation efforts. The purpose for the section is to frame the state of leadership and address the question of leadership adequacy for driving transformational change in health care organizations.

A section describing the relevance of the study method follows the independent variable section. The section contains an explanation of methods considered and why the chosen method was most appropriate for the study and precedes the conclusion. The conclusion ties together the earlier sections and addresses how the variables relate to each other, as well as including references to literature on the appropriateness of the variables, study population, and limits of the study. The analysis of the relationship between the identified conclusions and remaining questions or gaps will aid future studies. From the gap analysis, future studies can continue to examine methods for improving transformational change efforts in the health care sector. The current study adds to the

existing literature and the understanding of the influence of top management team replacement on transformational change efforts in the health care industry.

Historical Perspective on Leadership and Transformational Change

An examination of past leadership and transformational change theories revealed a wide and diverse body of literature. The findings from the literature indicated a strong relationship exists between the two constructs, with leadership driving transformational change (Bass, 1990; Bass & Avolio, 1993). An in-depth understanding of both constructs must occur prior to attempting to demonstrate the connection. With an understanding of historic and current leadership and transformational change theories, organizational leaders can begin to relate leadership and transformational change to the work of organizations and organizational effectiveness. Leaders manage organizations and an examination of organizational performance measures the success of leadership effectiveness on organizational change (Forbes, 1999).

Effectiveness of organizations, often examined within the context of leadership effectiveness, has been of interest to society since Frederick Taylor's scientific management era (W. R. Scott, 2003). Many theories followed Taylor's, including trait, situational, contingency, transactional, and transformational, as the work and science of leadership evolved in response to the evolution of society (Northouse, 2004). The evolution can be tracked from a focus on the inner workings of machinery and then humans to a combination of both as society works to understand the modern corporation and leadership workings within the context of a sociotechnical framework (W. R. Scott, 2003; Wren, 1994).

Understanding the modern organization and underlying leadership theory presents several challenges. As with any theories, definitive proof or absolute answers are not always available in concrete form, but are immutable only within the context of a certain space, time, and defined set of parameters. The ability to change leadership style within a changing environment defines a true leader (Avolio, 2005). Organizations are unique and can be examined within the context of many metaphorical frameworks including machine, organism, brain, culture, political system, and psychic prison (Morgan, 1996). The same metaphors may apply to the similarly multidimensional and complex phenomenon of leadership as described by Burns (1978).

Existing literature provides a view of leadership as both art and science. The art and science of leadership are broad and ambiguous topics evidenced by the 12,173 books on leadership listed on Amazon.com on October 23, 2002 (Dobson & Mark, 2003). Despite the plethora of thought and theory on the topic of leadership, questions remain regarding the role and influence of leaders on organizational transformation and success. The following, from the forward of the Dobson and Mark text, supports the suggested gap in literature:

If the current crop of books [on leadership] is anything to go by then we still will not be in a position to implement ‘the’ answer because leadership studies do not appear to be edging incrementally closer to an agreed formula. (p. ix)

Within a broad framework, researchers continue to develop new theories relating to the interaction between leaders and followers as the quest for understanding organizational dynamics continues. The quest becomes even more important for organizations encountering turbulent times and struggling with carrying out the

organizational transformation necessary to adapt to emerging technologies or societal change (Rogers, 1995). The continued growth in complexity of organizations makes the study of leadership effectiveness, from a perspective of transformational change, of increased importance.

Crisis, rapid growth, shorter organizational life spans, and constant change are the dynamics enveloping the modern organization (Jones, 2004; W. R. Scott, 2003). The environments within which organizations exist are uncertain and ever-changing and require constant organizational change in response to the new problems and challenges presented (Jones, 2004). The dynamics drove changes in general leadership theory from the early 1980s to the current state in 2007 as leaders worked to cope with the increasingly complex environment through use of integrative strategies and situational roles (Avolio, 2007; Vroom & Jago, 2007).

Reacting to external and internal environmental changes was always within the domain of the top management teams of organizations (Jones, 2004). Organizational survival is dependent upon leaders with highly developed competencies. Leaders who demonstrate the vision and transformational ability to adapt an organization's structure and culture to address the needs of consumers within a changing societal set of expectations provide strategic direction. The challenge requires a leadership able to develop new vision, mobilizing organizations to transform to meet the demands of a changing environment (Bennis & Nanus, 2003).

The relationship between having the right leaders and having strong and effective organizations is the problem examined in the study. The focus of the general problem was the poor performance by top management team leaders in leading successful

transformational change initiatives. The specific problem related to the poor performance of top management teams in the health care sector. Health care organizations are under heavy pressure to increase consumer satisfaction, performance, and quality outcomes. Nowhere is the need to respond to changing environments more dramatic or challenging than in the health care field (Anson, 2000).

The purpose of the study was to examine the influence of top management team replacement on transformational change efforts. By examining the possible relationship of top management replacement through evaluation and turnover practices, health care organizational leaders will have an improved understanding of the role of leadership change on overall transformational change. Understanding the role of leadership change could provide an answer to why health care change initiatives have a lower success rate than change initiatives of other industries and poorer performance as a result. The next section includes an examination of the current and desired states of the health care delivery system.

Health Care in Crisis

Health care was a much simpler concept in the early years of homes for the infirm and insane (Starr, 1982). Starr described an environment where hostels of safety provided shelter, comfort, and the simplest of medicine's offerings for the neediest and most vulnerable members of society and where the main concerns for leaders of that era were sustaining charitable funding to fuel the mission and the advancement of the art and science of medicine. The basic mission has not changed, as cost and best practice are arguably among the top concerns for the modern health care leader, but the challenge to

meet the mission grew exponentially in complexity as the simple clinic morphed into complex organizational networks and systems of care (Merry, 2003; Morrison, 2000).

According to several studies (Dracup & Bryan-Brown, 2003; Institute of Medicine, 2001; D. Smith, 2004), the complex infrastructure of care is in crisis. The system is an overburdened system that can no longer adequately support the health care needs of communities in the 21st century. Although the literature contained numerous challenges including low reimbursement rates, high regulation, competition, and complexity, the greatest challenge may be in the area of human resources because of shortages of skilled workers (Gelinas & Loh, 2004).

Herman et al. (2003) illustrated an impending crisis for employers and noted “a dangerous worker shortage, more severe than most people expect, is compounded by deep systems problems in the way companies operate today” (p. 1). Herman et al. pointed to a sobering U.S. Bureau of Labor Statistics report that projected a shortfall of 10,033,000 workers by 2010. As bleak as the forecast is, the health care industry has felt the effects of a tight labor market for several years. Workforce conditions in the health care industry are where most employers will be focusing change efforts through 2010 (Herman et al.).

Although many researchers have tried to explain what precipitated the dramatic shortage (Clark et al., 2007; Gelinas & Loh, 2004; Heller & Lichtenberg, 2003; Korcok, 2002), leaders are only beginning to appreciate the effect the shortage has on communities' health. Korcok highlighted the danger yet to manifest as fewer and fewer nurses enter the health care profession. Cleary (2003) described a sobering journey of

medical missteps during a hospitalization experience, claiming most health care systems are providing similar risk prone experiences.

Health care organizations must transform the health care workplace into a less stressful and physically demanding environment (Edelman, 2006; Gelinas & Loh, 2004). Leaders of many health care organizations understand change must occur, but are also learning that creating transformational change is not an easy task (Loup & Koller, 2005; Potthoff, 2004). D. Smith (2004) described several interventions necessary to transform the cultures within health care organizations. The interventions include having organizational leaders assess and address structural factors that can serve to create problems around communication, cultural change acceptance, and implementation of new policies; developing methods for transfer of tacit-to-explicit knowledge; and actively addressing resistance to change with not only front-line staff but also top management members. A key question for the study was whether leaders possess the skills necessary for applying the required interventions.

Understanding the Dependent Variable: Transformational Change

The dependent variable for the study is transformational change as measured along two dimensions of organizational performance: patient satisfaction and employee satisfaction. As highlighted throughout the study, there exists substantial evidence identifying the need for transformational change as the agent or driver for improving performance within the two identified organizational performance dimensions within the health care industry. The evidence also demonstrates transformational change in health care organizations was slow to evolve, slow to implement, and of questionable effectiveness in organizations that undertook change initiatives (Olivo, 2005).

Scholarly Research on Transformational Change

The examination of the dependent variable included retrieval of peer-reviewed articles and books. The focus of the literature review on transformational change was on the general field of organizational transformation with a specific examination of organizational transformation in the health care industry. A substantial field of literature exists relating to organizational transformation in general, but is lacking with regard to the health care industry.

The Transformational Change of Organizations

The evolution of society from the industrial age to an age of instant global connectivity and a global economy caused a dramatic transformation in approach to work and expectations of the organizations where the work occurs (Bolman & Deal, 2003). The changing expectations resulted in a reactive change from industries as organizations attempt to keep pace with the demands of the consumer. The changes come in the form of transformational change of the industry at the organizational level (Institute of Medicine, 2001).

Transformational change refers to the process in which organizations change culture and structure in reaction to the changing environment (Northouse, 2004). Organizations had to transform as the available technology, workforce, or needs of society changed. How well organizations react to the needed change within their industry typically defined the organization's place within the industry on a micro level and the industry's overall state as viewed by society from a macro perspective (Morrison, 2000).

Because of the competitive nature of organizations, interest in becoming good at reacting and transforming at the organizational level created a new movement in the late

1980s known as organizational transformation. Fletcher (1990) described organizational transformation using the Kilmann and Covin definition of the movement as “an outgrowth of a new global economic perspective” (p. 2). Interest in the new movement caught on quickly as the economy and society continued to grow in complexity and become more turbulent. In 1984, Owen noted, “Currently emerging turbulent environmental conditions are forcing transformation upon all organizations” (as cited in Fletcher, p. 2) and Owen further identified the criticality of the change by claiming, “Organization leaders must either transform their institutions in ways responsive to the emergent environment or cease to exist” (as cited in Fletcher, p. 2).

Turbulent environmental conditions continue the pressure for responsive organizational transformation but the turbulence is such that past views on organizational change may no longer be adequate to guide transformation. The environment in which organizations exist underwent such dramatic change that mainstream organizational theory and practice were left behind (McMillan, 2004). McMillan noted traditional organizational change theories may have been adequate during more stable times, but the uncertainties of the modern world require new solutions and “truly radical thinking” (p. 2).

Different approaches to transformational change are under way in the health care industry, but not many studies included a focus on results in the health care sector. Dixon (1997) examined the relationship between chief executive leadership (transactional and transformational) and hospital effectiveness. Hill (2003) investigated the role of the interim executive as transformational leader in health care organizations in transition. Gabbert (2005) conducted an examination of the relationship between CEO

transformational leadership and hospital performance, and Bannan (2004) examined leadership development as a transformational process. The examinations related to the effectiveness of theory and performance, rather than to individuals and performance.

A lack of currently applicable organizational transformation theory might provide a partial explanation for the lack of success in organizational change initiatives. Applying McMillan's logic of organizational complexity outpacing change theory to the arena of organizational leadership may reveal an additional area of concern in which practitioner theory did not keep pace with a rapidly changing environment. If such an area exists, the interconnectivity of leadership and organizational change can only serve to compound the difficulties encountered in successfully transforming an organization (McMillan, 2004).

Theories exist relating to the role of the leader on transformational change, including the theory that "leaders are so central to transformational change that all successes and all failure are laid unambiguously at their feet" (Bigelow & Arndt, 2005, p. 21). Theories also exist relating to structure and form, such as change the context of the organization before the content (Wentz, 2000), as well as culture's role in transformational change and how transformational change should evolve (Kotter, 1995; Moody, 2003).

Despite the creation of several theories and an ongoing application to change initiatives, the transformational change of organizations is difficult and elusive (Kotter, 2007; Latham & Vinyard, 2006; Roberto & Levesque, 2005). This finding is more prevalent in the health care industry, where little evidence exists of the successful transformation of organizations (Bigelow & Arndt, 2005; Goes et al., 2000; Wentz, 2000; Wischnevsky & Damanpour, 2006). Improved understanding of the barriers to success is

necessary for health care leaders to shift the perception or reality that the risk of entering an American hospital is comparable to “parachuting off a bridge or building” (Spear, 2005, p. 80). This suggestion leads to an examination of why a struggle occurred within the health care industry regarding successful transformational change initiatives designed for organizational performance improvement.

Transformational Change Within the Context of Improved Performance

Health care organizations participate in a range of change initiatives from Total Quality Management (TQM) and Continuous Quality Improvement (CQI) through reengineering, integration, stakeholder approach, institutional theory, transformation, and chaos, complexity, and quantum theories (Bigelow & Arndt, 2005; Bujak, 2005; Goes et al., 2000; Wischnevsky & Damanpour, 2006). Although substantial literature abounds describing the various approaches to transformational change, the health care industry suffers acutely from having no common or unifying framework for guiding the necessary change (Goes et al.). Bigelow and Arndt described a model for change developed by Goes et al. in which change is classified “along three dimensions: (a) level of change, (b) type of change, and (c) mode of change” (p. 20). Health care organizations must develop a structured approach to understanding and creating a model for change addressing all three dimensions described by Goes et al. within the context of the unique and chaotic environment of the health care system.

The environmental and societal demands on health care organizations require development of transformational leadership traits in the front-line management teams, where the ability to transform at the individual staff member level is greatest (Ruchlin, Dubbs, & Callahan, 2004). The required paradigm shift from central command-and-

control to engaged and empowered leadership at all levels ensures the participation of vital transformation agents (middle and front-line managers) as a workforce environment centered on vision, mission, and values is created. According to Reinhardt (2004), “The position of the transformational leader is most effective at upper management. However, unit-level transformational leadership positions can demonstrate positive results” (p. 28).

An organization experiences an almost instantaneous shift of power from centralized to local control through “decision migration” (Ruchlin et al., 2004). According to Ruchlin et al., decision migration allows for “management by exception” (p. 52) to create an environment where the senior-level staff are not making all the decisions and function as checks and balances on less senior staff. The newly created empowerment, which is a loosely defined and little understood term, begins to build trust at the staff level, and trust connects and maintains the workforce or mission alignment, enabling the possibility of transformation.

Health care leaders must begin to create a new paradigm of transformational change by committing to understand the requirements for successful transformational change and creating a revolution by no longer being “the carpenter who blames his tools” (Kuhn, 1962, p. 79). With the available evidence pointing to no single effective means of organizational transformation, new models must be theorized and tested within the collective of progressive health care systems.

According to the theories of organizational transformation, the approach used by collectives for transformational change must be one of “revolutionary fashion” (Wischnevsky & Damanpour, 2006, p. 108) to be effective and “thus, rational models of organization lead to the expectation that organizational transformation must involve

simultaneous and rapid changes in multiple attributes” (Wischnevsky & Damanpour, p. 108). As with any environment in crisis, the health care industry and the consumer are ready for revolutionary change. Revolutionary change, as described by Kuhn in *The Structure of Scientific Revolutions*, requires health care leaders to not merely address one of the levels of change within each dimension outlined by Goes et al. (2000). By example, directly applying industry-wide best practices models of change is not sufficient. Adaptation of any model must consider the uniqueness of the individual organization to avoid the common pitfall of mimetic isomorphism (Bolman & Deal, 2003) that is so tempting to health care organizations as a result of typical organizational problems relating to “fuzzy goals and uncertain technology” (p. 273).

Not only must health care leaders consider their individual organization, but also the examination must occur within the unfriendly framework of political, social, and financial dysfunction. The challenge facing health care leaders is the magnitude of change required. Industry leaders cannot fix the crisis in health care with contemporary organizational structure, strategic planning, or best practice solutions. The leaders must create new organizational and system models through major transformation efforts that will take them into uncharted environments.

Literature Scope and Gaps in Available Literature

Most early studies on organizational change concluded under conditions of constant environmental change that large-scale transformative changes and the creation of new approaches to organizational theory and practice are required (Fletcher, 1990). Various new approaches or theories for ensuring the success of change initiatives are prevalent within the literature. Although abundant literature exists to support

organizational change, and currently transformational change, as a vehicle for improving organizational performance, organizational leaders need an improved understanding to connect the relationship of change variables to the outcome variables (Wischnevsky & Damanpour, 2006).

Health care leaders must become expert at understanding differences between successful and unsuccessful change initiatives. In the health care industry, there exists a lack of definitive research on the effects of the rapidly changing organizational context on clinical outcomes (Aiken, Sochalski, & Lake, 1997). The area of study requires more research to illuminate the differences further.

Dukerich, Golden, and Shortell (2002) pointed to an interesting gap in the literature relating to a component of organizational culture: individual and organizational identity and identification. Dukerich et al. acknowledged, “Although the concepts of identity and identification have generated a great deal of theoretical attention, relatively few empirical studies have been published that examine their effects” (p. 507). The gap in the literature is of concern because an improved understanding of the organizational dynamic may provide insightful knowledge into the “fundamental challenges of managerial life” (p. 507), which may be an important consideration for the examination of transformational change in health care.

Although transformational change is needed within all levels of the health care industry—political, social, and organizational—the industry struggles with embracing and executing the necessary changes. Despite substantial discussion around the obvious need for change, few serious transformational change initiatives are under way in health care and even fewer stories of success exist (Olivo, 2006). An obvious dichotomy exists

between need and action within the health care industry. Perhaps the answer lies in the inability of existing top management teams in health care to make the shift from a primarily transactional leadership paradigm, which is the dominant leadership theory in play during the command-and-control years, and the need for transformational leadership characteristics. The recognition of the more subtle components of culture, such as identity and identification and their influences, requires leadership with a talent for understanding and transforming organizational culture (Dukerich et al., 2002).

Many industries saw serious transformation occur at the organizational level in response to needed change (Gordon, Stewart, Sweo, & Luker, 2000). The most visible stories highlight the visionary and transformational leaders who came from outside the organization and often the industry to create the spark, ignite the flame, and complete transformational change within the needed organizations. The leaders often bring in new top management teams to fill an identified gap.

Conclusions

Evidence is clear within the literature that existing health care policy at the national, state, and local levels is not working. The U.S. health care services are struggling at the system (Morrison, 2000), industry (Goes et al., 2000), and organizational (Dobson & Mark, 2003) levels. There also exists clear evidence that the history of transformational change in the health care industry was not easy, timely, or effective (Aiken et al., 1997; Amelberti, Auroy, Berwick, & Barach, 2005; Olivo, 2005). Past models of organizational change such as TQM/CQI, reengineering, integration, and others did not provide an effective solution for the health care industry.

Organizations must begin their cultural transformation efforts at the top of the organization, with the top management team (Schein, 2004). Health care lags behind most other industries in implementing organizational culture change initiatives successfully (Olivo, 2005). Health care organizations lost their focus on two critical planes: people—their patients, employees, and medical staff—and quality. As a result, organizational performance from a quality of care and financial perspective suffered.

The most successful organizational transformations occurred within health care organizations in which the CEO had a personal epiphany or a personal impatience with the slowness of an outlined culture change initiative (Olivo, 2005; Ryan, 2004). Early data indicated the most successful organizations are those in which the CEO took an aggressive approach, through direct involvement in evaluation and replacement of top management team members when indicated, to ensuring his or her top management team completely accepted the new vision and valued the epiphany produced (Olivo, 2005).

Most organizations did not handle the issue in this manner. The consequences of not doing so are grave: poor morale by other leadership levels and front-line staff and disenchantment by the top leaders who do understand, resulting in frustration and possible exodus from the organization (Wesorick, 2002). Organizational performance lacks maximization, and without the support of a fully unified, engaged, and aligned top management team, initiatives are doomed to failure.

Health care leaders are attracted to the field for altruistic, compassionate reasons (Morrison, 2000; Starr, 1982). Health care leaders may not be the best or strongest business leaders when tough personnel decisions are necessary (Bigelow & Arndt, 2005); perhaps compassion gets in the way of reason. By not handling this shortcoming

adequately, the required transformational change necessary for bringing the health care industry to Morrison's (1996) second curve of change is seriously impeded. Morrison described the need for leaders to lead organizations to a new paradigm, or second curve, by transforming the organizations to align with the demands of an increasingly complex society.

Whether the problem is lack of appropriate change tools or lack of tool execution within the industry or individual organizations, it is inherent upon health care leaders to find a solution that answers the demands for an improved health care system. A meaningful challenge for health care leaders is making sense of the various change initiatives within the industry, which are possibly varied as a result of the theory of scientific revolutions (Kuhn, 1962) and the current environment of chaos and turmoil within the industry, as well as sorting through competing theories to create a new transformational change paradigm. Continued studies of transformational change within the context of differentiating between success and failure must be undertaken.

Understanding the Independent Variable: Leadership for Transformation

The independent variable for the study was top management team replacement within the context of the actions influencing the success of transformational change initiatives in the health care industry. The health care industry is a late entrant to the application of the art and science of effective leadership on creating transformational change (Dobson & Mark, 2003; Morrison, 2000). The lack of meaningful organizational change activity leaves a void in the existing literature and effective application on the role of top management team success or failure in transformational change initiatives.

With the focus on health care's crisis, industry leaders need an improved understanding of leadership's role in transformational change within the social sector and a safety net for the citizens of U.S. society. To improve the state of dissatisfaction with the overall delivery of health care in the United States, dramatic change must occur at all levels of the system (Institute of Medicine, 2001). The focus of the study was on the needed changes at the unit or organizational level and the study contains new information regarding the influence of top management team replacement on the success or failure of change initiatives in the health care industry.

Scholarly Research on Leadership

The examination of the independent variable included retrieval of peer-reviewed articles and books. The focus of this part of the literature review was on the general field of leadership with a specific examination of two components of leadership theory prevalent in the health care industry: transformational and transactional leadership theory. A substantial field of literature exists relating to leadership and the role of the leader in transformational change.

The Role of Top Management Teams

The top management team of an organization is responsible for providing the leadership necessary to sustain and grow the organization (Chandler, 1962). Leadership of organizations is an often-studied but misunderstood concept that exists in many forms (Storey, 2004). Leadership is central to the work of organizations and was the topic of scholarly research for decades in an attempt to understand better the role of leadership in organizational development and advancement. An organization's top management team

provides direction, guidance, and role modeling of desired behaviors as the teams define and build leadership and culture (Schein, 2004).

The role of top management teams in creating and leading the culture of health care evolved in response to the dramatic changes that occurred within the industry (Morrison, 2000). The competencies and characteristics of a health care leader morphed in dramatic ways from the skill set necessary to lead a home for the infirm at the beginning of the 20th century to the complex set of leadership skills necessary to guide large, complex, and integrated health care systems composed of horizontally and vertically integrated organizations. New dynamics emerged as the “potential for conflict within the dominant coalition increases as external forces require internal compromise on outcome preferences” (Thompson, 1967, p. 138). Leaders in the health care industry may not possess the new skills required for fulfilling the changed role.

Politicians, regulators, health care system trustees, and top management teams worked to transform the health care system in response to demands from the media, regulatory agencies, and constituents to overhaul the failing system (Morrison, 2000). Various transformation tools and models exist to accomplish the goal, including CQI and various reengineering efforts that were successful in other industries. The same level of success does not seem so apparent in the health care industry (Bigelow & Arndt, 2005).

Reacting to and correcting disruptive change is within the role and responsibility of organizational leaders as they attempt to incorporate innovative solutions to change initiatives (Rogers, 1995). An underlying concept of the current study relates to whether existing health care top management teams evolved sufficiently to effectively transform health care organizations into a new paradigm that defines the needs of the industry

(Morrison, 2000). To test the concept, examination of change initiatives in health care organizations should focus on the connection between leadership and transformational change.

Leadership Within the Context of Transformational Change

A strong dichotomy exists between the health care organization's noble mission and the satisfaction of stakeholders in the industry as evidenced by national data on employee and patient satisfaction levels (Olivo, 2005), as well as quality-of-care concerns expressed by the Institute of Medicine (2001). The gap continues to exist despite a universal acknowledgment of the gap, as well as efforts by health care leaders to transform their organizations in an attempt to be more responsive to changing needs. A clear understanding of why the industry is unable to close the gap is elusive. Some researchers are beginning to point to leadership as the problem.

Allen (1991) posited, "The real problem [in failed transformational change in health care organizations] has been overlooked or ignored—it is leadership" (p. 46). Don Berwick, in discussing the inability of health care leadership to reform the system, indicated, "The capability that is key to the proper allocation of resources and development of the proper workforce is leadership, and that's where we still lack traction" (Galvin, 2005, p. W5.2). Rona (2005) further evidenced why the industry is viewed as lacking leadership traction and attributed the state of health care in the 21st century to "the lack of vision, determination, and adequate management methods of those who lead America's healthcare organizations" (p. 87).

Health care leaders must discover where the gaps in leadership competency exist (Dobson & Mark, 2003). The tools and skill set of the transformational leader may not be

transferable to the former command-and-control regimes with their inherent high levels of transactional leadership. In-place top management teams may not have the prerequisite skills for the needed transformational change initiatives in the health care industry.

Bennis and Nanus (2003) speculated, “Leadership is the pivotal force behind successful organizations and that to create vital and viable organizations . . . [leadership should] mobilize the organization to change toward the new vision” (p. 3).

One area of transformational competence that may be lacking in the ranks of health care organization top leaders is the ability to articulate the relationship between identity and identification within the health care environment. A key motivator for health care workers is the need to feel they are involved in meaningful work (Studer, 2005). An organization’s health care workers must identify with the mission and identity of the organization where they work. A new interest exists in the study of identity and identification as organizational leaders work to rediscover “the importance of meaning and emotion in organizational life” (Albert, Ashforth, & Dutton, 2000, p. 14). According to Albert et al., the use of identity and identification as “a way of accounting for the agency of human action within an organizational framework” (p. 14) creates a sense of meaningfulness and connection. An improved understanding of individual and collective behaviors of organizational members could assist health care leaders in their quest for knowledge regarding transformational change failure. Transformational concepts such as these may be beyond the competency of existing members of top management teams in health care organizations.

A strong linkage exists between transformational leadership and transformational change (Bass, 1990). Perhaps because of the depth of human interaction in complex

health care organizations, the need for transformational leadership manifests the most when organizations are in a performance crisis. During times of crisis, identifying where the organization is and where the organization is going becomes a basic need for organizational members and is foundational to the ability to align organizational members behind the purpose and need for change. Perhaps top management teams in health care organizations struggle with the effective articulation of the identity.

As the environment in health care continues to change rapidly, the need for articulating the new identity of the organization becomes critical for leaders as they attempt to transform the organization into a new state. According to Bujak (2005), leaders must make a distinction between substance and form. Especially during times of rapid change, “it is imperative that you identify the essence of who you are and what it is you do, and separate that from the form in which it is currently being manifest” (Bujak, p. 38). Identifying the essence of identity appears to be a critical competency for top management teams to cascade the understanding throughout the management ranks of organizations. Leaders at all levels must become transformational in their relationship with subordinates. The cascading transformational effect must begin at the top management team level, highlighting the importance of high levels of transformational rather than transactional competency (Avolio, 2005; Burns, 1978; Ruchlin et al., 2004).

Ruchlin et al. (2004) used Kotter’s six key tasks of leadership to distinguish between leadership and management functions:

1. Establishing direction;
2. Aligning people;
3. Motivating and inspiring people;

4. Planning and budgeting;
5. Organizing and staffing;
6. Controlling and problem solving. (p. 49)

Ruchlin et al. contended Kotter's former three tasks are leadership driven and the latter three are management driven. The transition from the decades-old predominantly transactional leadership style (latter three tasks) to a predominantly transformational style (former three tasks) must be accelerated if the leadership of health care organizations hope to successfully drive their organizations to the second curve (Morrison, 1996) of change.

Scant literature exists regarding why health care industry top leaders are unsuccessful at transformational change efforts despite the fact that the health care industry continues to struggle with change. In other industries, evidence from studies demonstrated a connection between improved organizational performance and turnover of top management (Wiersema, 1995). The health care industry leadership, despite the many forms of and attempts at change initiatives referenced earlier, was not able to get the job of transformational change accomplished in any meaningful way and might need to look outside the industry for answers.

Communicating and persuading others to work toward a vision is the responsibility of effective leaders (Bass, 1990; Froeschle & Donahue, 1998). If communicating and leading an organization to a new organizational state is the task of the transformational leader, top management teams in health care must become adept at accomplishing the task carried out successfully by transformational leadership teams in

other organizations. Froeschle and Donahue pointed to the challenging times for health care requiring new leadership skills and stable leaders.

Many health care organizations attempted to infuse new skills in existing leaders as evidenced by the multitude of leadership development consultants currently working with health care leaders. The work involved 360 evaluations, emotional intelligence development, and other personal leadership transformational tools for developing transformational leaders. Despite the investment, few success stories exist as testimony for successful leadership and, thus, organizational transformations (Bigelow & Arndt, 2005; Melum, 2002; Storey, 2004). One can theorize unless the CEO fully invests in needed personal transition, developmental programs for top management teams will fail (Melum). Denis, Lamothe, and Langley (2001) noted, “The long tenure of a leader with a particular style is likely to create a tradition in which other leadership team members will tend to play symbiotic roles that are adjusted to this style” (p. 816).

Alimo-Metcalfe and Alban-Metcalfe (2004) reinforced the theory that senior leader support is one of the most important considerations in leadership development initiatives. Alimo-Metcalfe and Alban-Metcalfe noted the most formidable barriers were attributable to the attitudes of the most senior managers. The first barrier came from a reluctance by senior leaders to participate, believing they had little need for such support. The second barrier was the result of a greater understanding of the nature of leadership on the part of middle managers coming from their developmental experiences in addition to heightened awareness of a lack of appropriate role modeling by top leaders. The final barrier identified was the lack of general support for the initiatives by top management created cynicism at the lower levels, resulting in a lack of enthusiasm for applying the

developmental learning (Alimo-Metcalfe, Ford, Harding, & Lawler, 2000, as cited in Alimo-Metcalfe & Alban Metcalfe). The factors point to the circularity in failed developmental initiatives, possibly caused by senior leaders who expect results from undertaking a development program but lack the willingness to engage fully, leading to failure, which then leads to loss of faith in the developmental program at the grass roots level. The phenomenon can provide an explanation regarding why organizations try program after program without achieving any measurable success and indicates further support for the need for new leaders in top management teams (Reinhardt, 2004).

Another possible consideration is top management team members cannot shift from managing the historic silo-oriented health care organization. The concept is consistent with the theory posited by Hodgson and colleagues “that the effectiveness of leadership role constellations [top management teams] depends on the degree of *complementarity* among their members” (as cited in Denis et al., 2001). Industry leaders, especially boards of trustees, must acknowledge the existing health care leadership model is still so heavily autocratic and silo-oriented that top management teams cannot move out of the comfort zone of the old management paradigm (Merry, 2003).

In reviewing the state of leadership in academic health care settings, Froeschle and Donahue (1998) reported the health care industry is between two paradigms and in a state of flux that places extraordinary challenges on health care leaders. The description is consistent with earlier discussions relating to health care being caught between the first and second curves of change (Morrison, 1996). If crossing the paradigm gap to a new vision of health care delivery requires effective leadership (Morrison, 1996, 2000), the health care industry must find a solution to closing the existing leadership void or gap.

Two additional dynamics within health care organizations are that change appears to occur in cycles and there exists a fragility of internal leadership alliances (Denis et al., 2001). Alignment for change can occur when top management teams create a coupling of interests rallying against external forces but, according to Denis et al., the couplings are fragile and easily disrupted. Leaders who lost credibility through creating past social or political networks for specific personal change agendas struggle with creating the alignment necessary for the major organizational transformations needed. Many health care organizations struggle with the situation because rifts between top management teams and medical staff occurred over economic competitive pressures, making strategic reorientation difficult (Merry, 2005).

The change of leadership merely for the symbolic benefit of change itself might be the catalyst to starting a fresh new cycle of change. This appears best suited to a change in the CEO position. Results of studies outside the health care industry supported a connection between industry turbulence and CEO turnover as precursors to strategic reorientation, although top management team turnover negatively relates to strategic reorientation (Gordon et al., 2000). The selective replacement, rather than the overall replacement, of the top management team members by a new CEO might be the best method for creating the new cycle of change. Regardless of which management change theory an organization embraces, there appears to be sufficient argument, but not definitive evidence, supporting the need for a fresh set of leaders in the health care industry.

Literature Scope and Gaps in Available Literature

Substantial literature exists regarding top management team replacement in Fortune 500 companies needing dramatic transformational change. Articles and texts describing organizational transformation success stories include IBM (Gerstner, 2002), Walgreens, Circuit City, Gillette, Kimberly Clark (Collins, 2001), and numerous other transformation/leadership relationships in industries other than health care. There is no lack of literature attesting to a connection between bringing in new top management and successful transformational change, as well as some literature indicating no relationship or an overstated level of importance. This is not the case in the health care industry. Despite an overwhelming acknowledgment of the need for change, few studies demonstrating successful transformational efforts exist, with even fewer addressing the leadership question.

Conclusions

The question of why health care transformational efforts lag behind those of other industries and the role of the health care top management team in the inability to achieve transformation needs further examination. Research into the effectiveness of leadership development programs on the transformation of leaders is a good beginning, but data on the application of the skills on transformational efforts are scarce. By examining the independent variable effects of replacing top management teams in health care organizations, organizational leaders may begin to find an answer to the question of transformational change ineffectiveness in health care change initiatives.

Design Methodology and Considerations

In deciding whether a quantitative, qualitative, or mixed design is the most suitable for a study, one should begin by adopting a general framework “to provide guidance about all facets of the study, from assessing the general philosophical ideas behind the inquiry to the detailed data collection and analysis procedures” (Creswell, 2003, p. 3). Creswell further contended using an “extant framework” helps “to lodge our plans in ideas that are well grounded in the literature and recognized by audiences that read and support proposals for research” (p. 3). By completing an exercise of outlining a research study plan—albeit in its infancy—within a contextual framework, a researcher might find the framework leads to a default research method. At the very least, as a person continues to learn more about the various pros and cons of the contemporary methods—and some variant of mixed methods or new approaches—her or she is better positioned, with a framework in mind, to visualize the inherent relationship of the methods to the needs of a particular study.

Although the basis for the chosen methodology for the current study was a quantitative examination of top management team replacement correlated with effectiveness of transformational change, several other approaches had a basis for examination. A grounded theory qualitative approach appeared a reasonable method for providing appropriate background and data for accomplishing the objectives of the study. However, as supported by the *Program Handbook* (University of Phoenix, 2007), the grounded theory qualitative approach is best suited to studying the perceptions people have about a phenomenon. Because the study involved leadership and transformational change, evaluating the perceptions of the study participants would have been important to

developing the study's conclusions, but would not have been as conclusive as a quantitative study.

A second approach examined was a mixed study, which would involve blending the findings of qualitative case study data using a form of naturalistic inquiry (Lincoln & Guba, 1985) combined with a quantitative review of health care industry performance pre- and posttransformational change initiatives. However, the approach would be too broad and too difficult to complete within the time frame available for the study. Based on the literature and past research, a quantitative study correlating leadership replacement practice with transformational change effectiveness would add new knowledge to the available literature and was achievable within the chosen time frame.

A quantitative study is descriptive and explanation-oriented, while being sufficiently specific and narrow and having measurable, observable data (Creswell, 2002). By addressing the specific problem within the context of the larger industry, the current quantitative study provides new knowledge to the existing body of literature relating to leadership and transformational change. The statistical analysis approach initially chosen for examining the relationships in the current study was Pearson's product moment correlation coefficient. The basis for the rationale behind choosing Pearson's method was Creswell's (2002) suggested criteria for choosing a statistic (p. 238) with a single independent variable and the ability for "determining the magnitude of association between two variables and to detect the direction (the sign, '+', or '-') of a relationship" (pp. 370-371). A basic correlational analysis, presented in a matrix table format, provides a sense of the bivariate relationships.

Contextual Framework

The study involved an examination into leadership within the health care industry through the lens of two theoretical leadership constructs: (a) existing leadership preparedness and effectiveness defined within the context of industry environmental stresses and demands as the crucibles of leadership (Bennis & Thomas, 2002) and (b) the need for new leadership in health care to meet the demands of health care's second curve (Morrison, 1996). Bennis and Thomas defined the crucible of leadership as a transformation of personal identity. The transformation is necessary to prepare leaders for the rigors of organizational transformation efforts. The current study includes an outline of the dichotomy between existing leadership preparedness and effectiveness and the leadership skills needed to position health care organizations through the necessary transformational change for meeting the needs of an evolving health care system paradigm.

Organizations Examined Within the Context of the Study

The focus of the current study was a subset ($n = 46$) of the more than 5,000 hospitals across the United States that acknowledged the need for transformation and joined the VHA TWF change program. The VHA is a health care provider alliance of more than 2,400 not-for-profit health care organizations that helps members deliver safe, effective, and cost-effective care through both national and local support (VHA, 2007). The VHA has 18 regional offices as well as offices in Washington, DC.

The group was well suited to the study because of its recognition of the need for change in the health care industry, as well as its commitment to driving serious transformational change, as evidenced by financial and other resource commitments

made by the 46 participants in the TWF initiative. Tomorrow's Workforce is a cultural transformation initiative created by VHA for member hospitals interested in improving patient satisfaction by improving their workforce environment. The initiative provides, for a fee from participating members, a formula and collaborative forum of structured practices for transforming organizations with the goal of improving employee satisfaction and therefore enhancing the healthiness of the overall organizational culture. The conclusions drawn from the participants of the study provide insight into the entire health care industry as organizations continue to realize the need for organizational change and begin major change initiatives.

The Current Environment and Existing State of Leadership

The disarray of the health care system can be attributed to several changing dynamics, including the dichotomy between consumer demand for increases in technological advances and medical breakthroughs and increased pressures for improved quality and control of costs (Medieros, 2006). An additional consideration is the continuing shift in costs from third-party payers to the consumer as the system becomes one of defined contribution rather than defined benefit (Morrison, 2000). Recent media focus on quality questions such as the Institute of Medicine's (2001) report criticizing the safety and quality performance of health systems coupled with the knowledge that the United States has the highest per capita health care costs in the world heightened overall dissatisfaction, adding pressure to the already heightened public outrage.

The challenges, in an industry where recruitment and retention of talented and qualified workers become more challenging, continue to test the stamina and will of incumbent leaders (Haeberle & Christmas, 2006). Although strong challenges tend to

attract motivated and talented leaders, the confusion and flux in the health care industry may drive future health care leaders to other fields. Morrison (2000) identified the crisis of theory as being part of the leadership problem in health care. The theory crisis comes in the form of a lack of operating theory for health policy or market strategy. There exists a basic clash between the values espoused and values realized in the United States.

Health care access for all is not a social imperative in the United States. The shift of what some societies see as a basic governmental responsibility to the general populace results in the general hospital serving as the societal safety net.

Leading health care organizations has always been a difficult task, but the growing complexity of regulatory and reimbursement structures coupled with a general dissatisfaction with quality and cost made the task more difficult in an industry that many view as being in crisis. Much debate centered on the question of adequacy of leadership for bringing the health care industry out of the state of crisis (Dobson & Mark, 2003; Dracup & Bryan-Brown, 2003; Morrison, 2000). The industry should potentially seek an answer to the leadership adequacy question within the context of the skills necessary for achieving transformational change. A question exists relating to how the leaders at the helm of the troubled industry can possibly complete the much needed transformation.

The inherent resistance to change and the complexity encountered in transformation efforts will challenge even the best transformational leaders. Health care leaders must consider the elements within their organization that cause the resistance and complexity. Organizational leaders often encounter resistance at the top management team and medical staff levels. Dealing with the resistance is a key step in organizational change (Kotter, 2007). Once the administrative and medical staff leadership teams

endorse the need for change and commit to the hard work required to transform an organization, handling the complexity of transformational change can begin.

Complexity alone is not the only differentiator between health care's inability to transform compared with other industries. Health care is one of the most complex sociotechnical structures in existence, but other highly complex industries made successful transformation by recognizing and adapting to increased complexity (Carlisle & McMillan, 2006; Thompson, 1967). Examples are the airline and aerospace industries.

The search for differentiators must probe deeper into the social structures to seek potential subcultural disrupters to continuity. One possible area of consideration is the discontinuity in leadership caused by what Merry (2005) referred to as the bifurcated organizational leadership structure between a hospital's administrative and medical staff functions. The natural dysfunction caused by a poor organizational leadership structure could be a primary impediment to successful transformation and presents an opportunity for change that leaders should address.

Desired State of Leadership for Health Care's New Millennium

Transformation of health care in the United States must occur at many levels including in society, markets, organizations, and individuals (Morrison, 2000). The focus of the current study was the organizational level, but to understand the dynamics within organizations leaders must understand the surrounding influences. The demands of the consumer for the provision of health care services do not match the available supply in either quantity or quality (DoBias, 2007). A reconciliation of the demands and wants of the consumer with the perceived and real needs of society presents a major challenge.

The challenge must be resolved at the national level and, until reconciled, the overall framework for health care delivery will continue to be dysfunctional. An enlightened leadership at the national level is necessary to create a new paradigm for the delivery of medicine that goes beyond the regulatory and financial focus deemed as the demands of the populace. President Clinton and his wife Hillary proposed this type of social and scientific revolution, but leadership at the national level was too focused on political rather than social responsibilities to effectively manage the needs of society (Gray, Gusmano, & Collins, 2003).

Until a new national health care agenda occurs, it is inherent upon leadership at the organizational level to drive the change necessary to bring health care organizations to Morrison's second curve (1996). The state of health care in the second curve is one where the needs of the consumer for high-quality health care at the lowest cost are the focus. Leaders in the health care industry must realign their organizations around the original principles of health care delivery where healing the sick in the safest and quickest way possible is the core mission.

To accomplish the task amid the turmoil and chaos of the existing health care delivery infrastructure, a leadership skill set much different from the transactional leadership skills that have served the industry well for decades is required. A new type of transformational leadership is necessary that can handle not only the external complexities but also the unique internal complexities inherent to health care organizations. Leaders must develop an understanding of what sets the industry apart from others (Medieros, 2006).

One consideration might be that health care leaders have focused transformational efforts within the context of a single organizational group rather than recognizing two distinct groups exist, composed of administrators and medical staff leadership, and the groups require differing transformational approaches. The recognition is consistent with group change theory (Burnes, 2004), but with a two-pronged approach. The concept is also consistent with field theory as outlined by Back (1992), who stated behavior should be understood within the context of totality and complexity of the field where the behavior takes place.

Recognizing and understanding the differences in the leadership roles, concerns, and needs of the distinctly different administrative and medical staff groups is an important starting point for developing an organizational change methodology. Both groups have a common desire to help others and both feel the need for meaningful work. Understanding the differences are perhaps more important (Merry, 2005).

Understanding the commonalities and differences of these two key stakeholder groups may help health care leaders develop the common vision and goals necessary to align all organizational members to a change initiative. In addition to understanding the underlying makeup of key stakeholder groups, understanding complexity theory can also help guide health care leaders as they design and implement transformational change initiatives. Anderson and McDaniel (2000) highlighted the importance of “examining the intersection of professional concerns and complex adaptive systems characteristics” (p. 83) as a means for developing new insights for transforming health care organizations.

The Leadership Gap

The earlier discussion on the difficulty of attracting talented young leaders to the field may be a testimonial to the gap between challenge and reward that exists in the health care industry. For existing health care leaders, the demands for a new kind of transformational leader may be outstripping the supply of leaders who are able to make the transition from what has been a predominantly transactional leadership paradigm. Health care leaders must be skilled in the art of transformation and comfortable with complexity theory (Anderson & McDaniel, 2000).

The challenge facing organizations is whether top management team members have the prerequisite skills and behaviors necessary for new paradigm leadership. A long-standing debate exists around whether leaders can effectively change ingrained or innate characteristics of leadership style based on the groundbreaking work related to leader-match considerations of contingency theorist Fiedler and others (Hosking & Schriesheim, 1978). Hosking and Schriesheim wrote, Fiedler argued “that changing leadership style is not open to the leader since it is a feature of his ‘personality’ and is ‘an ingrained pattern of behavior’ which cannot be changed” (p. 479). The question for health care organizations is whether the context for leadership has changed so dramatically that the inherent characteristics of existing leaders are no longer applicable. If so, turnover with the intent of acquiring necessary matching competencies is a potential alternative for achieving the desired transformation.

Theory on Addressing the Leadership Gap

Health care leaders should consider a new view of organizational change theory. By acknowledging the complexity of change, leaders will begin to design

transformational change initiatives with the appropriate level of complexity necessary for organizations composed of stakeholders with diverging interests as identified in the medical staff–administrative team model. By viewing organizations as complex adaptive systems, health care leaders may become more proactive than reactive. As a result of the view of organizations through a new context, the “focus turns from knowing the world to making sense of the world; from forecasting the future to designing the future; from finding the right structure to keeping the structure fluid” (Anderson & McDaniel, 2000, p. 84). Creating a focus shift as suggested by Anderson and McDaniel may provide a path to solving health care’s transformation dilemma. Designing and implementing a new paradigm for the delivery of health care at the organizational level may require a new brand of leadership by leaders who are free of the biases developed through creating and maintaining the existing outdated health care model. Leaders working within the new open framework may find the answer to the health care crisis.

Conclusion

Substantial literature exists attesting to the need for transformational change in health care organizations. Dissatisfaction with the nation’s health care system, which is an industry in crisis where needless death and injury occurs every day, has reached an all-time high. Support for this statement is clear in the IOM report, *Crossing the Quality Chasm*: “Patients, health care professionals, and policy makers are becoming all too painfully aware of the shortcomings of our current care delivery systems and the importance of finding better approaches to meeting the health care needs of all Americans” (Institute of Medicine, 2001, p. x). The report outlined a vision for the

transformation of the health care system but “does not recommend specific organizational approaches to achieve the aims set forth” (p. ix).

Bold new top management team leadership is necessary to align organizations with the vision. Health care leaders realize the system is broken, but seem helpless in their approach to transforming from the current state to one in which all people have easy access to affordable high-quality health care. Health care access for all will require change at every level of the system and may not occur for decades because of the major social, political, and financial considerations (Morrison, 2000). Health care organizations should focus attention on quality concerns through transformational change at the organizational level, although to date little documentation exists on successful transformation efforts, despite much activity (Bigelow & Arndt, 2005). The next sections will highlight the major literature themes relating to the study topic.

The Organizational Challenge: Transformational Change

Health care organizations have focused on changing culture and structures in an attempt to improve the transformational outcome measures examined in this study: patient and employee satisfaction as drivers of quality outcomes. Experimentation and research in the area was abundant but fractured: “While some industries evolve slowly over decades, the healthcare industry has been on a non-stop roller coaster of innovation, experimentation, reinvention, and revolution over the last 20 years” (Goes et al., 2000, p. 158). Despite the activity, definitive evidence of which input variable has the greatest influence on success remains elusive and more research on the influence of top management teams on transformational change is necessary to find health care’s solution for effective transformational change.

Starr (1982) described modern medicine as “one of those extraordinary works of reason: an elaborate system of specialized knowledge, technical procedures, and rules of behavior” (p. 3). The assessment holds true 25 years later, but the specialized knowledge is more specialized, the technical procedures are more complex, and the rules are more difficult to understand and rationalize. The increase in complexity from what Starr referred to as a somewhat weak profession based on tradition and relatively minor economic significance to a complex bureaucratic system of providers, consumers, and payers dramatically changed the rules and behaviors of the various stakeholders.

The transition from the early days of medicine when physicians managed care to a system where everyone attempts to control management of care affected all the system’s stakeholders. Relationships between physicians and nurses in many hospitals deteriorated (Sirota, 2007). Top management teams must examine and strengthen relationships between administration, nursing structures, and medical staffs. Instability in the triumvirate relationship adds to the complexity of the typical human dynamics in play between providers and users of services.

Starr (1982) wrote of the medical profession’s former position of cultural authority, economic power, and political influence as a sort of “professional sovereignty” (p. 5). The power shift from physicians had a strong influence on the dynamics of internal organizational behavior and the ability to align various stakeholders to a common goal. The divergence in goals provides a serious challenge to health care leaders as they attempt to create the necessary alignment for achieving transformational change.

Denis et al. (2001) examined the dynamic in five case studies in health care organizations in an attempt “to develop a process theory of strategic change in pluralistic

settings characterized by diffuse power and divergent objectives” (p. 809). Denis et al. further argued for the critical need for collective leadership and complementary roles if health care organizations expect to achieve change. Denis et al. noted the environment in the health care industry collective leadership is fragile.

A possible approach for health care top management teams is the creation of an agenda of commonality among stakeholders, perhaps in particular with the medical staff where the alignment gap seems largest, as a means to achieve needed transformational change. Past political positions and treatment of medical staff by existing top management leaders may have a negative influence on the opportunity to create the levels of trust necessary for a spirit of joint leadership. Opportunities exist for improving trust and eliminating past political and emotional memories (Merry, 2005).

The Leadership Challenge: Competency for a New Paradigm

The industry must complete the shift from a predominantly transactional leadership style to a new paradigm of leadership. Top management teams face the challenge of breaking away from the years of competition and the single organization focus to create the type of internal collaboration that allows for organizational change across the industry. Top management teams must look outside the individual organization and align transformed organizations into an effective and seamless health care delivery system. To accomplish the stated goals, researchers must assist by providing data on why transformational efforts have not produced the desired results.

Industry transformation can evolve more quickly as organizations learn best practices for driving change. Although the shift from transactional to transformational leadership has been under way since the 1980s (Storey, 2004), the health care industry

has been behind the curve in leadership transformation through development or replacement. Storey indicated “signs of a new shift” (p. 8) are emerging that suggest the need for a “third era” (p. 8) of management beyond the transactional and transformational models.

Storey (2004) noted the complexities inherent in health care organizations demand a new order of leadership that is evolving, but so slowly that the framework for the leadership model may lack clarity. If this is the case, the supply of leaders with the necessary competencies will be low and until the new leadership framework is understood and replicable, organizational transformation will continue to be slow. How quickly the health care industry embraces a new leadership paradigm will further influence the speed of change. The poor history of successful transition by existing health care leaders from a transactional to transformational mind-set provides continued argument for the need to infuse health care organizations with new leaders at the highest level (Bujak, 2005; Rona, 2005; Storey, 2004).

The Need for a Collaborative Evidence-Based Movement for Change

The format of the TWF is one area where health care organizational leadership attempted a standardized approach to transformational change. Efforts to promote a collaborative environment of learning among health systems, such as demonstrated in VHA’s TWF initiative, might fill the gap in collective leadership that occurred over the 2 decades prior to 2007. A key principle of the collaborative is getting the right leaders in place early in transformational change initiatives as a differentiator for success.

Health care leaders must learn from the experiences of collaborative efforts for change within the industry in the manner of what Shortell (2006) referred to as evidence-

based management practice. Beyond the scant learning available within the industry, health care leaders must look outside the industry and learn from best practices adopted by others, such as the National Aeronautics and Space Administration's return to a culture of quality and safety and the creation of a culture of innovation at Apple Computer. The lessons from other industries might provide the basic starting formula for health care transformation initiatives.

The Challenges of Complexity and Chaos

In addition to learning the successful components of a framework for change, leaders must become more adept at handling the high complexity found in health care organizations. Evolving nursing leadership models further complicate the complexity caused by technology, high regulation, low reimbursement, and a bifurcated leadership structure between administration and medical staff (Merry, 2005). Managing the health of the individual might be "the most complex and complicated problem the species has ever worked on, and one certainly high in importance" (Barlow, 2003, p. 51). Working on complex problems such as health care typically requires the management of a complex hierarchy of actors and interrelated processes: "The nature of the situation is far out on the dimension of simple to contingent to systematic to heuristic to ecological to chaotic" (Barlow, p. 51).

Top management teams need help managing the chaos. Perhaps existing health care top management teams placed too much emphasis on their role as the transactional saviors of health care and not enough focus on the role of transforming middle and front-line managers into organizational change champions. Creating the transformational management champions who have the power and sway to transform at the individual staff

member level might be the most important job facing top management teams in health care (Reinhardt, 2004; Ruchlin, Dubbs, & Callahan, 2004). The literature indicated transformation at other levels of the organization cannot begin until the top management teams personally commit to becoming transformational change champions and create the interactions in which people are raised to higher levels of motivation and morality (Burns, 1978).

The Role of Development at the Top Management Team Level

Health care organizations invest heavily in developmental programs for top management teams. Despite the investment, the transformational change capabilities have not proven sufficient to create the needed evolution of the industry to health care's second curve of change (Morrison, 1996). The industry must find an answer to why the investment has not transformed leaders into successful change agents. To accelerate the transformational curve, researchers must identify the missing link.

Perhaps health care leaders find themselves immersed socially and politically in an old paradigm or cultural complexity yet to be unraveled sufficiently to accept transformational change. Leadership development cannot occur through mandate or osmosis. Leaders must desire a change in personal state. Leaders must believe the transformational state desired is within reach and a change in personal thinking must occur (Avolio, 2005). According to Avolio, a leader can believe in the value of development but unless his or her mental model changes, barriers will exist, hampering the ability to influence how others think. Perhaps the mental model of top management teams is one of collective self-pity where health care leaders convinced themselves the problems are all environmental, such as insufficient reimbursement, overregulation,

unrealistic quality expectations, and competition on all fronts, and they are simply victims of the times. If existing top management teams in health care do not embrace the needed personal change, developmental efforts for existing leaders may not be the answer.

Relevance of the Study to Current Literature

Despite the thousands of books and articles on transformational change and leadership, gaps remain in the understanding of both variables as applied to the health care industry. Specific areas requiring deeper study include (a) successful transformational change initiatives in health care identifying best practice components of change efforts as demonstrated through improved performance; (b) the effectiveness of leadership development programs on creating the new leadership competencies for effectively transforming health care organizations; (c) the shift in organizational identity driven by a more complex and chaotic health care environment and top management's ability to recognize, effectively articulate, and align stakeholders to the new identity; and (d) the theory that top management teams in health care are so embedded in an old paradigm they do not have the leadership skill set for successfully transforming health care organizations.

The last area of inquiry is where the current study adds knowledge. Evaluating the influence of top management team replacement on organizational transformation efforts measured by improvement in employee and patient satisfaction may provide insight into the question of industry leadership adequacy. The industry can view the conclusions from the study in the context of future studies on the effectiveness of leadership developmental programs in transforming existing top management leaders.

Potential limitations of the study were the narrowness of the study group and the lack of longitudinal history of performance data (6 years) of the study population. Despite the limitations, by researching the influence of top management team replacement on transformational change initiatives in health care, health care leaders may move closer to an understanding of the dynamic and perhaps solidify the first step in an evolving transformational change framework for the health care industry. Chapter 3 outlines the methods used for completing the study.

CHAPTER 3: METHOD

The purpose of the quantitative correlational study was to examine the influence of top management team replacement on the effectiveness of transformational change as measured by employee and patient satisfaction and organizational performance improvement. The research questions addressed whether a positive relationship exists between top management team replacement and successful transformational change as measured by an increase in organizational stakeholder satisfaction levels and performance outcomes. Correlational research is a statistical process for exploring the relationship between two or more variables applied at a surface relationship perspective and does not necessarily probe for causal relationships (Leedy & Ormrod, 2005).

A goal of chapter 3 was to outline the methodology and process used for examining a group of 46 hospitals in the context of leadership influence on their transformational change efforts. Other goals included outlining and validating specific processes for conducting a research study using a custom-designed instrument for primary data collection and processes for analyzing secondary data related to the research. Additional objectives included outlining an objective methodology that provides outcome data generalizable to a larger population, thus furthering the industry knowledge base for transformational change initiatives in a manner reproducible by others for future studies.

Research Design

Transformational change in the context of the TWF initiative related to improving organizational culture by increasing employee and patient satisfaction. The research design incorporated standard annual survey data from the participating organizations'

employee and patient satisfaction scores as outcome criteria to indicate performance toward achieving the desired transformational change. Quantitative statistical methods allowed an examination into the relationship between specific organizational performance measures (improvement in employee and patient satisfaction) and the average mean months of service for top management leaders within the participating organizations. As defined by prior research, the definition of top management team includes the executives in the highest two levels of management within a firm (Wiersema, 1995). For health care organizations, the definition fits with the position of vice president and higher.

Understanding complex problems requires a process of inquiry, observation, and conclusion. Developing a design framework requires the consideration of methods for combining elements of inquiry with approaches to research that can be translated into practice, resulting in specific design processes of research (Creswell, 2003). Three main approaches exist for conducting scientific studies: quantitative, qualitative, and a method of combining quantitative and qualitative elements into a mixed-methods approach. Because the intention for the current study was to understand better the predictors of outcomes or identify factors that influence an outcome, a quantitative methodology provided the best match of problem to approach (Creswell, 2003).

When examining the relationship between two or more variables, a descriptive survey instrument can provide data for use with statistical formulas to provide information regarding the direction and strength of relationship between variables (Leedy & Ormrod, 2005). As in the case of the current study, when considering a quantitative correlational approach, analysis of facts and conditions allows observers to validate or

dispel specific hypotheses of a general research question. Data collected from the surveys was standard and nominal scale data.

Correlation allows for the determination of how two variables or two sets of data vary consistently (Creswell, 2002). The statistical procedure known as multiple linear regression was intended to be used on the secondary data to provide a means for predicting the influence of two or more independent variables on the dependent variable (Leedy & Ormrod, 2005). The intent of the secondary data was to provide additional examination and possible support for the validity of leadership replacement as a proxy for transformational change. Tom Olivo, founding partner of Success Profiles, a health care consulting firm, compiled from 2001 to 2007 a database of standardized employee satisfaction surveys from over 500 hospitals across the United States (Olivo, 2007). With over 200,000 responses from more than 500 hospitals, Olivo has possibly the largest database of employee satisfaction surveys in the health care industry.

The use of secondary data requires caution because secondary data are at risk of what has been referred to as a barrier to truth composed of the distortion and insensitivity of human senses, weaknesses inherent in instrumentation, and challenges inherent in communicating thoughts or witnessing and reporting events identically, as well as other concerns regarding validity (Leedy & Ormrod, 2005). During the secondary data collection phase of the study, it became apparent that the data from the Success Profiles, Inc. database of over 200,000 employee survey responses from over 500 hospitals across the United States addressed the relationship between middle (rather than top) management team influence. Because of insufficient investigation of the variables

available in the data set from Success Profiles Inc., planned additional analysis using multiple regression on secondary data could not be conducted.

Appropriateness of Design

A quantitative correlational approach provided a well-established method for investigating potential relationships between the independent variable of average mean months of service and the dependent variables of employee and patient satisfaction and a standardized quality outcomes measure. An effective approach for deciding whether a quantitative, qualitative, or mixed design is the most suitable for a study should begin by adopting a general framework that connects theory to the components of the study to include the philosophy guiding the inquiry to the detailed data collection and analysis procedures (Creswell, 2003). Creswell (2003) further contended by using an “extant framework” (p. 3), the process connects ideas well grounded in the literature and is easily recognizable by other researchers and interested parties.

Several methodological approaches were considered for the study, including a grounded theory design based on a systematic grounded theory (Creswell, 2002) and a mixed study blending the findings of qualitative case study data using a form of naturalistic inquiry (Lincoln & Guba, 1985) combined with a quantitative review of health care industry performance pre- and posttransformational change initiatives. The basis for the rejection of qualitative approaches was that the data collection would have required coding of responses and would have been subjected to the vagaries associated with data coding (Neuman, 2003). In addition to the vagaries associated with coding data, the study outcome goals involved a search for a more quantifiable indicator of

relationships between leadership and transformational change within the context of a narrower approach and time frame for a first study.

The purpose of the research was to provide an improved understanding of the differences between successful and unsuccessful change initiatives in the health care industry. The final choice of a correlational approach provided an effective means of collecting data and applying an explanatory approach to comparing two or more variables and examining their rate of covariation (Creswell, 2002). The approach was well suited to the study's research question examining whether a relationship exists between top management team replacement and responsiveness of cultural transformation as measured by improved satisfaction levels and organizational performance.

By correlating two variables, the relationship or association between them can be shown, although no conclusions that one is the cause of the other can be drawn (Meltzoff, 1998). The descriptive portion of the study involved the collection of demographic and top management team average mean months of tenure data, and the correlational portion of the study involved an examination of the strength and direction of the relationships examined. A quantitative study is descriptive and explanation oriented while being sufficiently specific and narrow and having measurable, observable data (Creswell, 2002). By addressing the specific problem within the context of the larger industry, the quantitative study provides new knowledge to the existing body of literature relating to leadership and transformational change.

Research Questions

Research Question 1: What is the relationship between top management team turnover and employee satisfaction among hospitals actively engaged in transformation efforts?

Research Question 2: What is the relationship between top management team turnover and patient satisfaction among hospitals actively engaged in transformation efforts?

According to Meltzoff (1998), experimental hypotheses “are predictive statements about the expected outcome of the research” (p. 27). Hypotheses define the research design and dictate the method of the research through the connection between test and conclusion (Meltzoff). The study involved examining and testing two hypotheses related to the potential connection between top management team tenure and achievement of desired transformational change.

The basis for the presumed theoretical connection between leadership turnover and transformation was a shift in recognition by some hospital organizations that top management team leaders do not have the necessary leadership competencies, described earlier as new paradigm leadership competencies, for successfully driving organizational transformation. When a lack of the technical or emotional skills necessary for successful organizational transformation exists in top management team leaders, some hospital organizations choose between two strategic approaches to the problem: (a) addressing the issue from a leadership development perspective or (b) actively replacing top management team leaders. The latter approach follows the assessment of an individual’s lack of ability to transform into the required new leadership paradigm.

The measure of transformational change in the first hypothesis (H1) was employee satisfaction as measured by standardized annual employee satisfaction surveys. For the second hypothesis (H2), the measure was patient satisfaction as measured by standardized third-party annual patient satisfaction surveys. The survey instrument provided data on replacement of leaders as a strategy of an organization's transformational efforts versus normal turnover. The hypotheses for the study were as follows:

H1_a: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of employee satisfaction.

H1₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of employee satisfaction.

H2_a: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of patient satisfaction.

H2₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of patient satisfaction.

The variables examined were chosen because the literature supports the finding that quality (competence) of leadership was correlated as a primary driver of increased employee satisfaction (Bass, 1990; Humphreys & Einstein, 2003; Jawahar, 2006) and increasing employee satisfaction levels leads to increased patient satisfaction, which are common measures of transformational change success in hospitals (Geyer, 2005). This

suggested finding is an important reason why increasing employee satisfaction and patient satisfaction are primary goals of most transformational change efforts undertaken by the hospital industry. This conclusion is further supported by an examination of over 200,000 responses to business practices research conducted by the consulting firm Success Profiles from over 500 hospitals in the United States (Olivo, 2007). It became clear through the large research effort that other variables such as increased pay and improved working environment, although having some influence, do not drive increases in employee satisfaction as dramatically as leadership quality or strength.

An assumption that many health care leaders are caught in the old health care leadership paradigm where transactional command-and-control styles dominated further supported the hypotheses. The same leaders find themselves replaced by leaders who successfully made the shift or were trained in a more transformational approach of leadership, fulfilling Allen's (1991) prediction that hospitals need new leaders who bring a new quality of leadership with respect to transformational change initiative competence.

Population

The broad population for the study consisted of all not-for-profit hospitals undergoing transformational change initiatives across the United States, whereas the sampling frame consisted of hospitals that participated in the TWF initiative of the VHA. The VHA is a health care provider alliance of more than 2,400 not-for-profit health care organizations that helps members deliver safe, effective, and cost-effective care through both national and local support (VHA, 2007). The VHA has 18 regional offices as well as offices in Washington, DC.

Tomorrow's Workforce is a cultural transformation initiative created by VHA for member hospitals interested in improving patient satisfaction by improving their workforce environment. The initiative provides, for a fee from participating members, a formula and collaborative forum of structured practices for transforming organizations with the goal of improving employee satisfaction and therefore enhancing the healthiness of the overall organizational culture. The organizations represented a subset of the 2,400 not-for-profit health care organizations distributed through 18 regions across the United States. Appendix A identifies the geographic distribution of the 32 organizations that returned the survey instrument and consent form. Solicitation occurred through direct contact via a personal letter of introduction and a formal request to participate.

The characteristics of the sample frame were highly homogenous, with all members exhibiting the characteristics of not-for-profit hospitals, and membership in VHA demonstrates a willingness to learn best practices through collaboration and networking. The participants in the sample demonstrated a belief in the need and value of transformation as evidenced by their commitment of financial and human resources to the TWF initiative. The sample was an appropriate group based on the demonstrated desire for and active implementation of organizational transformation initiatives with stated goals of employee and patient satisfaction and organizational performance improvement. According to Leedy and Ormrod (2005), a smaller sample size may be considered when working with homogenous groups.

The literature review demonstrated a lack of data on measurement of organizational transformation initiatives in the health care industry. By examining the somewhat cohesive (common basic framework) group of health care organizations, new

knowledge emerged to aid in the understanding of barriers to successful change initiatives in the health care industry. The organizations received a Request to Participate Letter (see Appendix B). The organizations were at various stages of their chosen transformational change initiatives. Although all the organizations chose the TWF initiative as a transformational change framework, preliminary results indicated varying rates of success and differing internal approaches to change (VHA, 2004). Because the sample was the total number of hospitals that participated in the TWF initiative ($N = 46$), a minimum of 30 responses was required for statistical significance of the primary data used in the study, with an ideal goal of 35 respondents to achieve sufficient power and effect size at a 95% confidence interval (Creswell, 2002).

Informed Consent

Persons identified for the sample received a communication via U.S. Postal Service containing two letters (explanation of study purpose and informed consent form) in a single packet, rather than the originally intended distribution via electronic mail. CEOs in the pretest group recommended surface mail as the most effective method. Respondents were directed to sign the informed consent form prior to completing the survey, and to return the consent form in the included postage paid self-addressed envelope. No surveys were included in the data unless an executed informed consent form had been received. The informed consent documents will be stored in a locked container for a period of 3 years and then destroyed by shredding.

Confidentiality

Organizational confidentiality was assured through the specific processes outlined in the confidentiality section of the informed consent agreement (see Appendix B). The confidentiality section addressed the security of the data and limited survey data access to the person conducting the study; data aggregation occurred for the purpose of evaluation and individual organizational identity remained anonymous. No individuals, other than researcher, had access to identifier data. A locked file cabinet housed hard copy survey documents, and electronic materials were stored in a password-protected file directory. Destruction of all data and documents will occur 3 years after completion of the study by shredding hard copy documents and purging electronic files.

Instrumentation

The primary data collection instrument for the study was the survey instrument presented in Appendix C. The instrument provided the necessary data on top management team (vice president and above) mean months of service or tenure and included other organizational demographics such as organization size and number of months (years) of active participation in transformation. The instrument also solicited data on whether top management team replacement was a proactive strategy of the transformation initiative and other pre- and post-transformational change initiative metrics, including employee and patient satisfaction scores as measured by standardized third-party survey. The instrument included questions assessing the opinion of overall effectiveness of the TWF approach to transformational change compared with previous initiatives and with a specific focus on examining leadership's role in transformation.

Validity, according to Cooper and Schindler (2003), refers to the success of an instrument in obtaining the desired measurement. As noted earlier, scant literature exists on the research into the success or failure of transformational change initiatives in the health care industry. The process for developing and constructing the instrument followed the four-step process of planning, construction, quantitative evaluation, and validation (Cooper & Schindler).

Cooper and Schindler (2003) suggested the use of a panel of experts for validating the content of a survey instrument. Consistent with the four-phase process, the current research included a pretest of the survey instrument by a panel of experts in the area of health care transformational change. Cronbach's alpha was used to confirm the instrument's reliability ($\alpha = .69$). A Cronbach's alpha of .69 for standardized items is close to the expected 0.7 or higher for tool validation (Peterson, 1994), indicating likely agreement in the interpretation of the questions. Cronbach's alpha has the most utility for multi-item scales at the interval level of measurement.

The pretest group consisted of five hospital CEOs whose organizations did not participate in the TWF initiative but had a history of transformational change initiatives. The president and CEO of Mohawk Valley Network and Faxton-St. Luke's Healthcare selected the CEOs. This individual has served as president and CEO of hospitals for over 30 years, is a recognized leader in the area of transformational change in hospitals, and selected the pretest panel from his network of peer CEOs based on his experiences and history of active transformational change initiatives undertaken by the chosen organizations.

Feedback from the pretest group resulted in modifications to the instrument prior to its submittal to the 46 study participants, completing the process of content and construct validity. The expert panel also evaluated the reliability of the instrument from a perspective of stability, equivalence, and internal consistency. The three factors of reliability ensured the time and conditional longevity of the measurements (Cooper & Schindler, 2003).

Data Collection

The current study involved an examination of the influence of top management team replacement on the effectiveness of transformational change as measured by employee and patient satisfaction. No suitable preexisting instruments to measure these variables were identified in the literature review; therefore, a custom survey instrument was developed. In addition to items pertaining to the desired variable data, the instrument design included questions addressing organizational specific demographic and outcomes data related to the TWF initiative and other transformational experiences of the participants. The 21-question instrument included a mix of Likert-type 5-point scale, ranking, and open response questions.

The instrument contained four sections. The first section (thirteen questions) was designed to collect general data on the perceived relationship between leadership role and transformational change effort success for an individual organization, perceived success of the TWF approach to transformational change, and overall length of active transformational efforts resulting from TWF and other transformational initiatives. A section on leadership collected independent variable data on top management team tenure and the aggressiveness of the organizational approach to replacement of individual

team members as a part of the overall transformation strategy. The third section addressed the dependent variable data collection for annual standardized employee and patient satisfaction scores; the final section (eight questions) addressed demographics identifying organizational characteristics such as size, urban versus rural, mission (e.g., small community, Level 1 trauma).

Because of the small sample size and importance of a high rate of return, the CEO of Faxton-St. Luke's Healthcare, who was one of the TWF participants, agreed to provide a CEO-to-CEO letter of encouragement for participation to each of the 46 participating organizations prior to the data collection phase (see Appendix D). The letter included a commitment to share the knowledge gained from the study through an exclusive executive summary provided 4 weeks after acceptance of the study results by the University of Phoenix. Given the demonstrated interest in transformation among the organizations participating in the TWF program, the promise of exclusive access to early results from the study provided a strong incentive for hospitals to participate. The data collection process was conducted through a four-step process (Creswell, 2003). The first phase consisted of advance letters (CEO-to-CEO) sent to participants by U.S. Postal Service on October 1, 2007 and October 19, 2007. The second distribution included the survey purpose letter, informed consent letter, and survey instrument sent by U.S. Postal Service, distributed approximately 1 week after the second advance notice.

The third contact occurred 5 to 7 days later via electronic mail to verify receipt of the survey packet and confirm the identified organizational lead representative for the TWF initiative or a senior member of the human resources department as the party responsible for survey completion. The fourth phase consisted of a personal telephone

call to nonresponding participants 1 week after the survey return due date (October 30, 2007). Based on participant preference, surveys were returned via U.S. Postal Service, electronic facsimile, or electronic mail. The duration of the data collection phase was 126 days. Upon receipt of completed survey data, a blinded organizational identifier represented each set of data prior to addition to the database.

An additional review of data entry integrity provided secondary validation of the accuracy and integrity of response entry into the database. Data security occurred through the maintenance of a secure database with password protection accessible only by the researcher. All survey data and documents, hard copy or electronic, were secured in a password-protected file directory or locked file cabinet. Destruction of all documents and electronic files related to the data collection will occur 3 years after completion of the study.

Data Analysis

Data analysis provided the basis for examining the relationship between the independent variable of turnover (measured by mean months of top management team service or tenure) and the dependent variable of transformation (measured by employee satisfaction and patient satisfaction). Collected data elements included demographics defining organization scope, organization bed size and number of full-time equivalent employees, voluntary turnover rate, average age of plant, and total payroll and benefits as a percentage of total net revenue to control for the influence of the variables on the dependent variable measure of satisfaction. The statistical test was applied individually to each of the two dependent variable measures at a significance level of 95% ($\alpha =$

0.05). The data for the study were represented in matrix form as typically prescribed for correlation studies (Creswell, 2002).

The statistical program Statistical Package for the Social Sciences (SPSS) was used for data evaluation and generation of outcome tables and graphs. Types of analysis included descriptive statistics and interpretive statistical analysis through bivariate comparisons using Pearson's correlation coefficient to examine possible relationships between the independent and dependent variables. Because the final data set from the 32 returned surveys contained less than 30 usable data elements for the measures of the dependent variable ($n = 18$ and $n = 20$), nonparametric testing, specifically Spearman's rank correlation coefficient, was used to examine correlation.

Data were manually entered into SPSS tables and double-checked for data accuracy and integrity. Nonparametric testing was necessary because incomplete data on leadership tenure in some returned surveys and a lack of at least 3 years of patient and employee satisfaction data resulted in a sample too small to meet the requirements for parametric analyses. The extent to which the reliance on the statistical correlation between variables was used was dependent upon how well the characteristics were measured (Leedy & Ormrod, 2005). Validity and reliability of the study components were crucial considerations.

Validity and Reliability

Cooper and Schindler (2003) described validity as referring "to the extent to which a test measures what we actually wish to measure" and reliability as having "to do with the accuracy and precision of a measurement procedure" (p. 231). Consistent results are an indicator of reliability. When searching for relationships between characteristics,

as in correlational studies, the extent to which the correlations are valid and reliable is dependent on how well the measurement of characteristics was conducted (Leedy & Ormrod, 2005).

Use of secondary data presents another risk to overall validity because of the additional level of interpretation between the data and the researcher (Cooper & Schindler, 2003). Review of the secondary data collection methodology and results occurred through a personal interview with Thomas Olivo of Success Profiles, Inc., owner of the secondary data source. Success Profiles, Inc. authorized the use of secondary data (see Appendix E). Eventual discovery of a data element incompatibility to the intended focus on top management teams precluded use of the secondary data. The late discovery of data element incompatibility highlighted a weakness in the approach to initial validation, thus rendering further validation irrelevant.

Internal Validity

Internal validity is the verification within a research study that validates the research design's effectiveness at providing confidence that the conclusions drawn about cause-and-effect and other relationships within the data are accurate (Leedy & Ormrod, 2005). Potential threats to internal validity are an area of concern in research efforts. The primary threat to internal validity for the study was the risk of selection. Because the participants were preselected, group characteristics may have formed some bias in the data responses.

The introduction of bias into research places the integrity of the results into question and is a crucial consideration for researchers (Leedy & Ormrod, 2005). Some examples of bias for the study include the possibility that a higher response rate from

organizations with perceived success from the TWF initiative could have skewed results, as well as other factors determining an organization's willingness to respond to the survey. Design of the instrument mitigated the effects by incorporating questions to discern possible causes of bias.

Three key strategies for identifying possible bias in research, adapted from Leedy and Ormrod (2005), are as follows: (a) carefully scrutinize the questionnaire for items that might be influenced by the participant's interest in the topic or other distinguishing factors influencing nonresponse to the survey; (b) compare the responses on questionnaires returned quickly with those returned later or outside the requested deadline, because significant differences between early and late questionnaires suggest potential bias; and (c) randomly contact a small number of nonrespondents and present an abridged version of the survey with the intent to match any responses with those from the original respondents. The suggestions guided the survey design and implementation by including questions that measured the perceived success (Likert-type 5-point scale) of the initiative in improving employee and patient satisfaction levels by the participants and evaluating response differences by timeliness of return.

Turnover at the top, in itself, does not guarantee leadership that is more competent. The focus of organizational change efforts similar to the TWF initiative must incorporate a process for identifying the necessary leadership competencies for improving employee satisfaction through employee survey or other criteria-based method. The question for health care organizations is whether the context for leadership has changed so dramatically that the inherent characteristics of existing leaders are no longer applicable. Confirming that organizations used a process of evaluating leadership

competency for transformational change in the turnover decision process was a necessary validity component of the study.

External Validity

External validity refers to “the extent to which the conclusions drawn can be *generalized* to other contexts” (Leedy & Ormrod, 2005, p. 99). The primary threat of external validity relates to the risk of the conclusions formed from the selected group not being applicable to the wider health care industry. Because of the homogeneity of the sample participants relating to nonprofit status as well as a demonstrated desire to achieve transformation as evidenced by organizational commitment to a national transformation collaborative (TWF), the study results will likely generalize to the larger population of not-for-profit hospitals seriously attempting transformation efforts. The homogeneity of the sample most likely precludes generalizability to for-profit, governmental, or other hospitals outside the sample frame’s characteristics.

Reliability

Reliability requires scoring of individual questions to be stable across instrument administrations, free from measurement error, and consistent (Creswell, 2002). Creswell suggested avoiding questions on instruments that are ambiguous and unclear and avoiding nonstandardized procedures of test administration. Enhancing reliability of the study occurred through a pretest of the instrument by a panel of experts, standardization of the survey process as outlined in the data collection and analysis sections, and validation of the instrument and methods through interview and description of the secondary data collection researcher’s instrument and methodology. Cronbach’s alpha was the tool used for measuring the reliability of the instrument in the examination.

Cronbach's alpha is the appropriate tool for determining the "degree to which instrument items are homogenous and reflect the same underlying construct(s)" (Cooper & Schindler, 2003).

Summary

Chapter 3 provided an overview of the quantitative correlational research design method chosen for the study. Health care organizations need more research into the causes differentiating success or failure of transformational change efforts. The study involved an examination into the influence of top management replacement on the effectiveness of transformational change as measured by employee and patient satisfaction and organizational performance improvement. Using a quantitative correlational design approach provided the examination of relationships or associations necessary for validating the study's research questions and hypotheses (Creswell, 2003).

The selective nature of the group examined in the study produced advantages and disadvantages to the data and conclusions available. Because all the included organizations predetermined their desire for transformational change, state of organizational readiness was not a variable requiring consideration. The magnitude of desire was sufficient for the organizations to commit substantial financial and human resources toward the objective of improved performance through transformational change. The disadvantage is the lack of randomness that typically improves a study's reliability (Creswell, 2003).

The efforts within the study were intended to examine the relationship of leadership readiness (having the right leaders in place for organizational change) to drive the change necessary to achieve the stated goals. The outcome adds to the available

literature on transformational change initiatives in the health care industry. Chapter 4 presents an analysis of the data, including an evaluation of reliability, the data collection process, and results relating to the research question and hypotheses studied.

CHAPTER 4: ANALYSIS AND PRESENTATION OF DATA

The purpose of the current quantitative correlational study was to examine the influence of top management replacement on the effectiveness of organizational culture transformation as measured by employee and patient satisfaction scores. Identification of a relationship between replacement and satisfaction offers a possible answer to the problem examined, which was poor performance in the health care industry with successful transformational efforts. The data collection supported a quantitative examination using descriptive statistics of responses to transformational change questions and the average mean months of service for the top management team leaders (vice president and above) within the participating organizations. Quantitative statistical methods including correlation and cluster analysis helped to determine the strength and direction of the relationship between the average tenure in current position of top management team leaders and employee and patient satisfaction measured through annual survey data of the organizations examined.

Chapter 4 presents the detailed analysis of data received from 32 participating organizations across the United States. A pretest with 5 hospital CEOs experienced in transformational change within their organizations served as a pilot study for evaluating the survey instrument from clarity and validity perspectives. Upon completion of the pretest, the survey was mailed to the 46 organizations in the sampling frame.

Following the data collection phase, data analyses examined possible relationships between top management team turnover and employee and patient satisfaction. The presentation and analysis in chapter 4 includes an explanation of the

method of data analysis used to examine possible relationships and to provide the descriptive statistics relating and comparing the participating organizations.

The intent of the research questions in the study was to determine relationships between the independent variable of top management team replacement and the dependent variable of transformational change within the organizations studied. The independent variable was measured using submitted data on average in-position tenure of the top management team. Examining the change in employee and patient satisfaction scores over a 6-year period (2001 through 2006) provided a measure of the dependent variable of transformational change.

Survey Pretest

Through a process known as pretesting, a researcher “may rely on colleagues, respondent surrogates, or actual respondents to refine a measuring instrument” (Cooper & Schindler, 2003, p. 86) prior to actual in-field use. A survey pretest with an expert panel of 5 hospital or health care system CEOs assessed instrument validity from an experiential perspective. Broad experience in organizational transformation was the basis for selection of the 5 CEOs. Feedback from the pretest group resulted in modifications to the instrument layout and revisions to question framing and language clarity prior to submittal to the 46 study participants, improving the quality of the questions and completing the process of content and construct validity. The expert panel confirmed the reliability of the instrument from a perspective of stability, equivalence, internal consistency, and content validity.

Population and Sample Selection

The general population targeted for the research consisted of hospitals across the United States undergoing transformational change. The sampling frame was the 46 hospitals that chose to participate in the VHA TWF initiative. The frame provided a set of organizations demonstrating a desire for organizational transformation.

Participation in the TWF initiative varied from full participation (28 hospitals) to a decision not to participate and pursue alternate change methods (4 hospitals) after one or two collaboration meetings or sessions. Full participation meant engagement in the TWF process through networking with other participants from the organization's initial collaborative session through the end of the initiative in 2006. The participant organizations ranged in location across 19 states (see Appendix A).

Data Collection

Data collection commenced with a mailing on October 1, 2007, through the U.S. Postal Service of a CEO-to-CEO introduction and solicitation letter requesting participation in the research effort. The mailing included a self-addressed stamped envelope for return of the signed participation agreement statement. Mail distribution was the chosen methodology based on CEO feedback during the pretest process rather than the originally intended use of electronic mail. A follow-up mailing of a second CEO-to-CEO letter, sent on October 19, 2007, reinforced the importance of participation. A full survey packet was mailed with an acknowledged consent form and self-addressed stamped return envelope upon receipt of the participation agreement statement.

The advance-notice mailings resulted in return of only six participation agreements. A follow-up telephone call was the method chosen to verify receipt of the

request-to-participate letters as well as to encourage and verify participation. Those organizations unable to confirm receipt of the original letters received a second packet containing the full survey and advance-notice letters via fax or electronic mail. Achieving the targeted survey return rate (>30) required numerous follow-up phone calls and in most cases required direct contact and a personal plea to the CEO. Several returned surveys had missing responses to individual questions because of a lack of continued TWF participation beyond one or two initial meetings or because the organization had not consistently conducted employee or patient satisfaction surveys.

Receipt of 32 surveys during the 18 weeks of data collection reflected a 69.6% rate of return. However, considerable data were missing in some of the surveys. Eighteen surveys contained sufficient data to allow examination of the independent and dependent variables using employee satisfaction as the measure for the dependent variable. Twenty surveys contained sufficient data to allow examination of the independent and dependent variables using patient satisfaction as the measure for the dependent variable. The criteria for inclusion was a minimum of 3 years of employee and patient satisfaction score reporting and complete response to the leadership tenure section.

The data were stored in tables using Microsoft Excel. The data were broken into five tables containing responses to the demographic questions, employee survey data, patient satisfaction data, leadership tenure data, and responses to the questions on transformational change experiences. Each survey had a numeric code attached upon receipt, with the documents stored in a locked cabinet after transfer of data to the Excel data tables.

Instrument Reliability

To assess instrument reliability beyond the feedback from the pretest group, Cronbach's alpha was computed for questions with a 5-level Likert-type scale. Tables 2 and 3 contain the results. A Cronbach's alpha of .693 for standardized items is close to the expected 0.7 or higher for tool validation (Peterson, 1994), indicating likely agreement in the interpretation of the questions.

Table 2

Survey Processing Summary Scale Questions for Cronbach's Alpha Analysis

| Surveys | N | % |
|----------|----|-------|
| Valid | 29 | 90.6 |
| Excluded | 3 | 9.4 |
| Total | 32 | 100.0 |

Table 3

Reliability Statistics for Cronbach's Alpha Analysis

| Cronbach's alpha | Based on standardized items | N of items |
|------------------|-----------------------------|------------|
| .606 | .693 | 10 |

Data Analyses and Findings

The data tables contained data from the five sections of the survey instrument. Two SPSS version 16 software databases stored the data prior to conducting statistical analysis. Secondary review for data entry accuracy and validity occurred at each phase of data entry. Data from the background sections of the instrument provide descriptive

supplementary analyses of the demographic information highlighting the differences or similarities between sample organizations. Seven demographic questions allowed comparisons between hospital size and complexity through data provided on licensed versus staffed bed size, full-time equivalent employees, number of hospitals within primary market, total members of medical staff, average age of plant, and number of employed physicians. Thirty hospitals (97%) are part of a larger multifacility health care system. Table 4 provides demographic data on hospital size, primary market, and average age of plant.

Table 4

Hospital Demographic Data

| Item | N | Min. | Max. | Mean | Std. dev. |
|-----------------------------|----|------|------|--------|-----------|
| Licensed beds | 31 | 210 | 1600 | 617.5 | 347.8 |
| Staffed beds | 27 | 173 | 1431 | 472.4 | 277.8 |
| Full-time equivalents | 30 | 1020 | 9800 | 3775.4 | 2261.0 |
| Hospitals in primary market | 31 | 0 | 20 | 5.3 | 5.3 |
| Average age of plant | 26 | 6.0 | 30 | 11.9 | 5.0 |

As identified in Table 4, the smallest hospital in the sample had 210 licensed beds and 173 staffed beds (same hospital). The largest hospital had 1,600 licensed beds but provided no response to the staffed beds question. The highest number of staffed beds was 1,431 (same number as this hospital's licensed beds). Seven hospitals reported the same number of licensed and staffed beds and six hospitals left one or both questions blank. Question 17 addressed the number of other hospitals within the respondent

hospital's primary market. The data provided a measure of competition in the marketplace of each sample hospital. A range from no competition to a highly competitive market where 20 hospitals exist was apparent from the data. Data on average age of plant provided an indication of the level of capital investment experienced by each hospital. Sample hospitals were generally large, with 472 staffed beds and 3,775 full-time equivalent employees on average. This demographic profile fits with the ability to engage as a participant of VHA and the capacity to undertake a transformational effort.

Table 5 indicates the total number of physicians and allied health professionals (nurse practitioners, physician assistants, or certified nurse anesthetists) on staff and the number of employed physicians within the organizations. The sample included hospitals with no employed physicians (independent model) and a hospital with a fully employed model.

Table 5

Hospital Medical Staff Composition

| Item | <i>N</i> | Min. | Max. | Mean | Std. dev. |
|--|----------|------|------|-------|-----------|
| Physicians and allied health professionals | 30 | 167 | 2600 | 765.4 | 532.2 |
| Employed physicians | 30 | 0 | 960 | 94.6 | 181.5 |

Questions 1 through 13 of the survey instrument collected data on the transformational change experiences of the survey respondents. These questions attempted to determine years pursuing transformational change, number of initiatives attempted in the past 10 years, success of the current initiative (TWF), and information

on individual organizational perspectives on factors relating to or influencing the success of transformational change initiatives.

Table 6 provides an indication of organization experience with transformational change initiatives. Of the responding organizations not included in the above data set and analysis, one hospital answered zero for years pursuing transformational change and another hospital answered zero to the question on number of change initiatives attempted; a third respondent left the second part of the question blank. On average, these hospitals had pursued transformational change for a little less than 7 years and had undertaken multiple transformational change efforts.

Table 6

Transformational Change Years and Initiatives Pursued

| Item | <i>N</i> | Min. | Max. | Mean | Std. dev. |
|---|----------|------|------|------|-----------|
| Years pursuing transformational change | 31 | 0 | 20 | 6.7 | 4.9 |
| Change initiatives attempted in past 10 years | 30 | 0 | 10 | 2.6 | 2.0 |

Table 7 provides information on respondents' opinion on the level of influence the TWF initiative had on positive culture change within the organization. None of the responses indicated a negative influence. Three responses were neutral regarding influence. The majority of the reporting hospitals ($n = 26$ or 89.6%) indicated either a slightly positive influence ($n = 17$ or 58.6%) or a strong positive influence ($n = 9$ or 31.0%).

Table 7

TWF Influence on Positive Culture Change

| Level of influence | <i>N</i> | % |
|--------------------|----------|------|
| No influence | 3 | 10.3 |
| Slightly negative | 0 | 0 |
| Strong negative | 0 | 0 |
| Slightly positive | 17 | 58.6 |
| Strong positive | 9 | 31.0 |

Table 8 provides information on respondents' opinion on the effectiveness of the TWF initiative in relation to other culture transformation initiatives undertaken by each responding hospital. The responses were almost evenly distributed. In six organizations (20%), the respondent *did not know* the effectiveness of the TWF initiative relative to other culture transformation initiatives. The results do not support TWF as an overwhelmingly successful transformational change initiative.

Table 8

Effectiveness of TWF in Relation to Other Culture Transformation Initiatives Undertaken

| Effectiveness | <i>N</i> | % |
|-------------------|----------|------|
| Less effective | 7 | 23.3 |
| Equally effective | 5 | 16.7 |
| Slightly more | 6 | 20.0 |
| Much more | 6 | 20.0 |
| Do not know | 6 | 20.0 |

Table 9 provides the breakdown of responses to the question of type of approach taken to evaluate top management team leadership fit to desired culture. Half the organizations (50.0%) used criteria-based tools (360-degree evaluation or other leadership competence evaluation tool) to evaluate fit. In two organizations, the CEO personally conducted the evaluation. Twenty-three (95.8%) organizations acknowledged some form of process and only 1 organization (4.2%) acknowledged no evaluation.

Table 9

Approach Taken to Evaluate Top Management Team Leadership Fit to Desired Culture

| Approach | N | % |
|----------------------------------|----|------|
| Criteria based using tools | 12 | 50.0 |
| Criteria based by CEO | 2 | 8.3 |
| Criteria based using other means | 6 | 25.0 |
| Minimal process conducted | 3 | 12.5 |
| No evaluation conducted | 1 | 4.2 |

The purpose of Question 8 was to identify which factor (employee satisfaction, changing organizational structure, changing leadership, vision, accountability, communication, or management effectiveness) had the most influence on achieving successful transformation. The respondents ranked the factors from 1 through 7, from the most influential (1) to the least influential (7). Table 10 identifies the results.

Table 10

Ranking of Factors Having the Most Influence on Transformation

| Factor | N | Min. | Max. | Mean | Std. dev. |
|-------------------------------|----|------|------|------|-----------|
| Change leadership | 30 | 1 | 7 | 2.93 | 1.95 |
| Enhance employee satisfaction | 30 | 1 | 7 | 3.37 | 2.08 |
| Accountability | 30 | 1 | 6 | 3.57 | 1.52 |
| Communication | 30 | 1 | 6 | 3.60 | 1.30 |
| Management effectiveness | 30 | 1 | 7 | 3.83 | 1.64 |
| Revisit/rearticulate vision | 30 | 1 | 7 | 4.43 | 2.18 |
| Change structure | 30 | 1 | 7 | 6.10 | 1.65 |

Table 10 provides evidence of a strong agreement that change structure is the least important ($M = 6.10$, $SD = 1.65$). The highest average importance was change leadership ($M = 2.93$, $SD = 1.95$). To determine if the rankings were statistically different, Kruskal-Wallis nonparametric testing provided evidence that differences between the factors are significant (Chi-square = 43.76, $p < .001$).

The purpose of Question 9 was to identify which concern (clinical quality, employee satisfaction, patient satisfaction, overall organizational performance, or financial performance) had the most influence on organizational leadership's decision to invest in TWF or other transformational initiatives. The respondents ranked the factors 1 through 5, from the most influential (1) to the least influential (5). Table 11 identifies the results.

Table 11

Rank of Factors Most Influencing Decision to Invest in TWF or Other Transformational Initiative

| Concerns about | <i>N</i> | Min. | Max. | Mean | Std. dev. |
|----------------------------|----------|------|------|------|-----------|
| Employee satisfaction | 29 | 1 | 5 | 2.48 | 1.18 |
| Patient satisfaction | 29 | 1 | 5 | 2.59 | 1.24 |
| Organizational performance | 29 | 1 | 5 | 2.69 | 1.39 |
| Clinical quality | 29 | 1 | 5 | 3.14 | 1.43 |
| Financial performance | 29 | 1 | 5 | 4.10 | 1.26 |

Table 11 provides evidence that financial performance is the least important ($M = 4.10$, $SD = 1.26$) and employee satisfaction has the highest average importance ($M = 2.48$, $SD = 1.18$). Patient satisfaction scored the second highest importance, followed by overall organizational importance and clinical quality. To determine if the rankings were statistically different, Kruskal-Wallis nonparametric testing provided evidence that differences between the factors are significant (Chi-square = 25.51, $p < .001$).

The purpose of Question 10 was to identify the reason the organization chose “this particular transformation initiative (TWF).” The choices provided were opportunity to work in a collaborative transformation initiative, reputation of VHA, past success with VHA initiatives, had VHA credits and this seemed like the best investment at the time, timing was right, addressed needs, and program design. The respondents ranked the factors 1 through 7, from the most influential (1) to the least influential (7). Table 12 identifies the results.

Table 12

Reason Organization Chose The TWF Initiative

| Reason | <i>N</i> | Min. | Max. | Mean | Std. dev. |
|--------------------------|----------|------|------|------|-----------|
| Collaborative initiative | 23 | 1 | 7 | 2.74 | 1.69 |
| Timing was right | 23 | 1 | 7 | 3.04 | 1.82 |
| Addressed needs | 23 | 1 | 6 | 3.35 | 1.67 |
| Reputation of VHA | 23 | 1 | 7 | 4.35 | 2.10 |
| Past success with VHA | 23 | 3 | 7 | 4.78 | 1.31 |
| Had VHA credits | 23 | 1 | 7 | 4.91 | 2.39 |
| Program design | 23 | 2 | 7 | 4.83 | 1.75 |

Table 12 provides evidence that the most influential reason for choosing the TWF initiative was value as a collaborative initiative ($M = 2.74$, $SD = 1.69$) and having VHA credits and program design were the least influential factors ($M = 4.91$, $SD = 2.39$ and $M = 4.83$, $SD = 1.75$). The second and third most influential reasons indicated timing and current need were important factors. To determine if the rankings were statistically different, Kruskal-Wallis nonparametric testing provided evidence that differences between the factors are significant (Chi-square = 29.60, $p < .001$).

The purpose of Question 11 was to determine whether the strategic planning process of the organization addressed specifically the role of organizational transformation as a component of the overall strategic plan. Thirty-one of 32 participants in the sample responded to this question. Table 13 provides the results.

Table 13

Organizations Addressing Transformational Change as a Component of the Strategic Plan

| Response | <i>N</i> | % |
|----------|----------|------|
| Yes | 26 | 81.2 |
| No | 6 | 18.8 |

Greater than 80% of the respondents address transformational change as a component of their strategic plans. The second part of Question 11 inquired whether the governing board measured progress and held the top management team accountable for achieving organizational transformation within an established timeframe. Twenty-six of the 32 organizations responded to this question, with 16 (61.5%) indicating that the board held management accountable for the results and 10 organizations (38.5%) indicating the board did not hold management accountable.

The purpose of Question 12 was to determine the extent to which the board of trustees (directors) was kept regularly informed or updated on the progress of TWF or other transformational initiatives. Thirty of 32 participants in the sample responded to this question. Table 14 provides the results.

Results from Table 14 indicate 18 (60%) of the organizations inform or update the board on a periodic (quarterly) basis. The majority, 29 of 30, reported to the board at some time interval, with only 1 organization (3.3%) never updating the board. On average, most organizations provide updates to the board on a quarterly basis.

Table 14

Extent of Informing or Updating the Board

| Informed | <i>N</i> | % |
|--------------|----------|------|
| Periodically | 18 | 60.0 |
| Regularly | 6 | 20.0 |
| Seldom | 5 | 16.7 |
| Never | 1 | 3.3 |

The purpose of Question 13 was to determine, based on experience with TWF or other efforts at transformation, the primary factor necessary for success in achieving transformational change. The factors ranged from influence of board, CEO, or chief operating officer to *none of the above*, with none of the organizations adding a possible unlisted factor. Table 15 lists the results of the 10 factors.

As seen in Table 15, having the CEO as the visible leader of the transformation initiative was the most popular response (37%) and having an organizational sense of urgency was second (18.5%). Over half of the sample identified these two factors as essential elements. Only 3 respondents (11.1%) chose top management team buy-in as a primary factor.

Table 15

Primary Factor Necessary in Achieving Transformational Change

| Factor | N | % |
|---|----|------|
| CEO as visible leader | 10 | 37.0 |
| Organizational sense of urgency | 5 | 18.5 |
| Holding people accountable | 4 | 14.8 |
| Top management team buy-in | 3 | 11.1 |
| Middle management buy-in | 2 | 7.4 |
| Communication | 2 | 7.4 |
| None of the above | 1 | 3.7 |
| Board of trustees as visible leader | 0 | 0.0 |
| Chief operating officer as visible leader | 0 | 0.0 |
| Dedicated financial resources | 0 | 0.0 |

In addition to the above demographic and experiential data, a question in the leadership section of the survey instrument specifically asked for the number of top management team positions listed and how many left the organization (voluntarily or by request) because of poor fit with the organization's culture. This question was designed to provide an indication of relative organizational engagement in ensuring the right people with the right transformational competencies were in the top leadership positions. Table 16 provides an overview of the data collected on the independent variable:

Table 16

Descriptive Statistics for Leadership Transformation

| Top management team data | <i>N</i> | Min. | Max. | Mean | Std. dev. |
|-----------------------------------|----------|------|-------|------|-----------|
| Number of members | 31 | 4.0 | 17.0 | 9.4 | 3.7 |
| Average tenure current position | 24 | 1.3 | 12.8 | 6.7 | 3.4 |
| Average tenure original hire date | 24 | 5.9 | 20.9 | 12.5 | 4.2 |
| Percentage replaced | 24 | 0 | 50.0 | 15.4 | 14.2 |
| Hired from outside organization | 31 | 0 | 10.0 | 4.6 | 2.8 |
| Number promoted within | 31 | 0 | 11.0 | 4.5 | 3.0 |
| Percentage promoted within | 31 | 0 | 100.0 | 47.9 | 26.8 |

The number of top management team members ranged from a minimum of 4 and maximum of 17. Average tenure in current position, which is a relative measure of the time spent as a unified team, ranged from a low of 1.27 years to a high of 12.79 years. Twenty-four of the 32 organizations provided the data for the question relating to nonvoluntary or routine replacement of top management team members, with 7 indicating zero top management team members were replaced for the reason of poor fit to organizational culture. Of the 17 other responses, the numbers varied from 1 to 6 with the most aggressive change resulting in 50% of top management team members leaving voluntarily or by request because of poor fit with organizational culture. The percentage of top management team members promoted from within the organization ranged from 0 to 100 ($M = 47.9$, $SD = 26.8$).

The data in Table 16 demonstrate broad variability among the top management teams within the sample frame organizations. On average, top management teams are comprised of slightly more than nine leaders with an average tenure in current position of 6.7 years ($SD = 3.4$) and an average tenure within the organization of 12.5 years ($SD = 4.2$), which is almost two times the tenure in current position. Of those members on the top management team, equal numbers were hired from outside the organization ($M = 4.6$, $SD = 2.8$) and promoted within ($M = 4.5$, $SD = 3.0$), resulting in a strong overall internal promotion rate of 47.9%.

Testing of Research Questions

Of the 32 surveys received, several lacked data for the measures of the independent or dependent variables, resulting in the need to modify the original analysis model from parametric to nonparametric testing ($N < 30$). Evaluation of several nonparametric tests, including Chi-square, Kendall's tau, Kruskal-Wallis, and Spearman's rank correlation coefficient, resulted in the selection of Spearman's rank correlation coefficient as the strongest possible nonparametric test for examining the data set. The statistical analysis package SPSS version 16 provided the correlation analysis of the independent and dependent variables.

Research Questions

The purpose of the first research question was to determine whether a relationship exists between turnover of top management team members and employee satisfaction within the organizations surveyed:

Research Question 1: What is the relationship between top management team turnover and employee satisfaction among hospitals actively engaged in transformation efforts?

Hypotheses for Research Question 1

The following hypotheses were the logical suppositions for the conducted investigation of top management team tenure and employee satisfaction:

H1_a: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of employee satisfaction.

H1₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of employee satisfaction.

Analysis of mean months of top management team tenure and the organization's employee satisfaction scores from 2001 through 2007 provided data for an examination of the null hypothesis using Spearman's rank correlation coefficient at a significance level of 0.05.

Although the survey instrument requested data for 2001-2006, in some cases, respondents added 2007 scores to the survey grid. The 2007 scores were included because the intent was to collect the latest satisfaction data and acquisition and reporting periods differ between organizations. The responses to the employee satisfaction section included four organizations with no data, four organizations with 6 years of data, four organizations with 5 years of data, five organizations with 4 years of data, seven organizations with 3 years of data; three organizations with 2 years of data, and five

organizations with 1 year of data. The important consideration was the reporting of satisfaction scores over time, with a minimum of three data points required for average analysis ($n = 20$). Two responses were unusable because of missing leadership section data, resulting in $n = 18$. The slope (moving average) of the reported scores was calculated and used as the measure for employee satisfaction. A scatter plot generated with SPSS provided some graphical evidence of a linear relationship between top management team tenure and employee satisfaction, as demonstrated in Figure 3. A test of correlation was conducted using Spearman's rank correlation coefficient as illustrated in the Table 17.

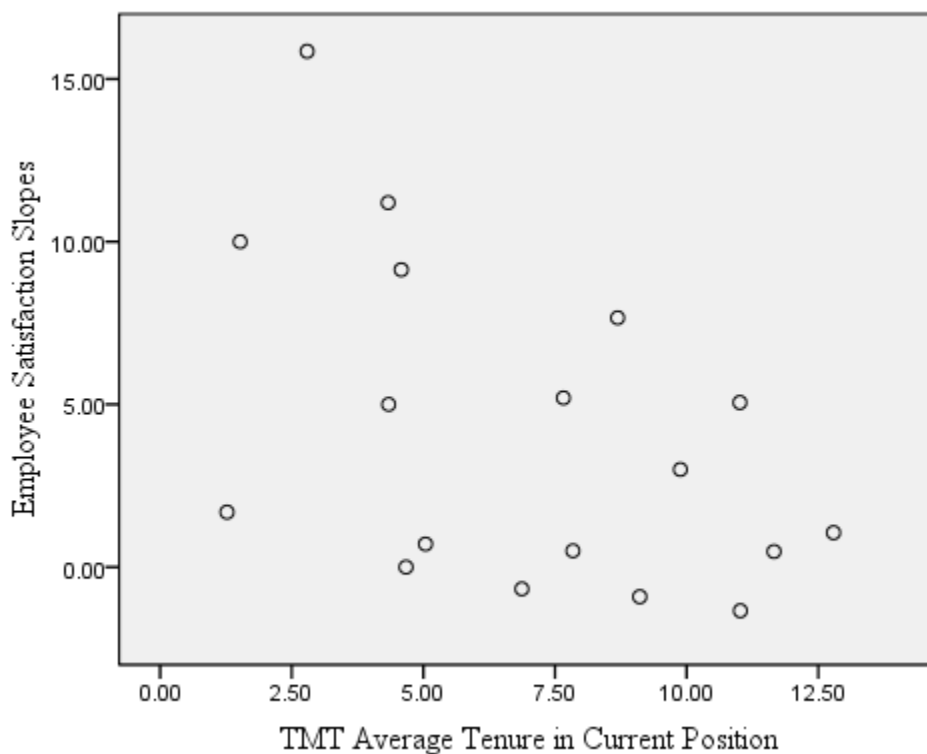


Figure 3. Scatter plot showing linear relationship between top management team tenure and employee satisfaction.

Table 17

Correlation Test of Top Management Team Tenure and Employee Satisfaction

| | Employee slope | Average tenure in current position |
|------------------------------------|----------------|------------------------------------|
| Employee slope | | |
| Correlation coefficient | 1.000 | -.517* |
| Sig. (2-tailed) | | .028 |
| <i>n</i> | 18 | 18 |
| Average tenure in current position | | |
| Correlation coefficient | -.517* | 1.000 |
| Sig. (2-tailed) | .028 | |
| <i>n</i> | 18 | 18 |

* Correlation is significant at the 0.05 level (2-tailed).

The two-tailed p value was .028, leading to rejection of the null hypothesis H_{10} and the conclusion that top management team tenure and employee satisfaction are indeed related. The Spearman rank correlation coefficient indicates a moderate negative correlation ($r(16) = -.517, p < .05$). The longer the tenure of the top management team, the less satisfied were employees.

The purpose of the second research question was to determine whether a relationship exists between turnover of top management team members and patient satisfaction within the organizations surveyed:

Research Question 2: What is the relationship between top management team turnover and patient satisfaction among hospitals actively engaged in transformation efforts?

Hypotheses for Research Question 2

The following hypotheses were the logical suppositions for the conducted investigation of top management team tenure and patient satisfaction:

H_{2a}: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will exhibit a higher level of patient satisfaction.

H₂₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of patient satisfaction.

Analysis of mean months of top management team tenure and the organization's patient satisfaction scores from 2001 through 2007 provided data for examination of the null hypothesis using Spearman's rank correlation coefficient at a significance level of 0.05.

Although the survey instrument requested data for 2001-2006, in some cases respondents added 2007 scores to the survey grid. The 2007 scores were included because the intent was to collect the latest satisfaction data and acquisition and reporting periods differ between organizations. The responses to the patient satisfaction section included 6 organizations with no data, 17 organizations with 6 years of data, 2 organizations with 5 years of data, 2 organizations with 4 years of data, 3 organizations with 3 years of data, 1 organizations with 2 years of data, and 1 organizations with 1 year of data. The important consideration was the reporting of satisfaction scores over time, with a minimum of three data points required for average analysis ($n = 24$). Four responses were unusable because of missing leadership section data resulting in $n = 20$. The slope (moving average) of the reported scores was calculated and used as the measure for patient satisfaction.

In contrast to the relationship between top management team tenure and employee satisfaction, a scatter plot generated with SPSS provided little graphical evidence of a linear relationship between top management team tenure and patient satisfaction, as demonstrated in Figure 4. A test of correlation was conducted using Spearman's rank correlation coefficient as illustrated in Table 18. The two-tailed p value was .719, leading to a failure to reject the null hypothesis H_{20} and a conclusion that top management team tenure and patient satisfaction are unrelated.

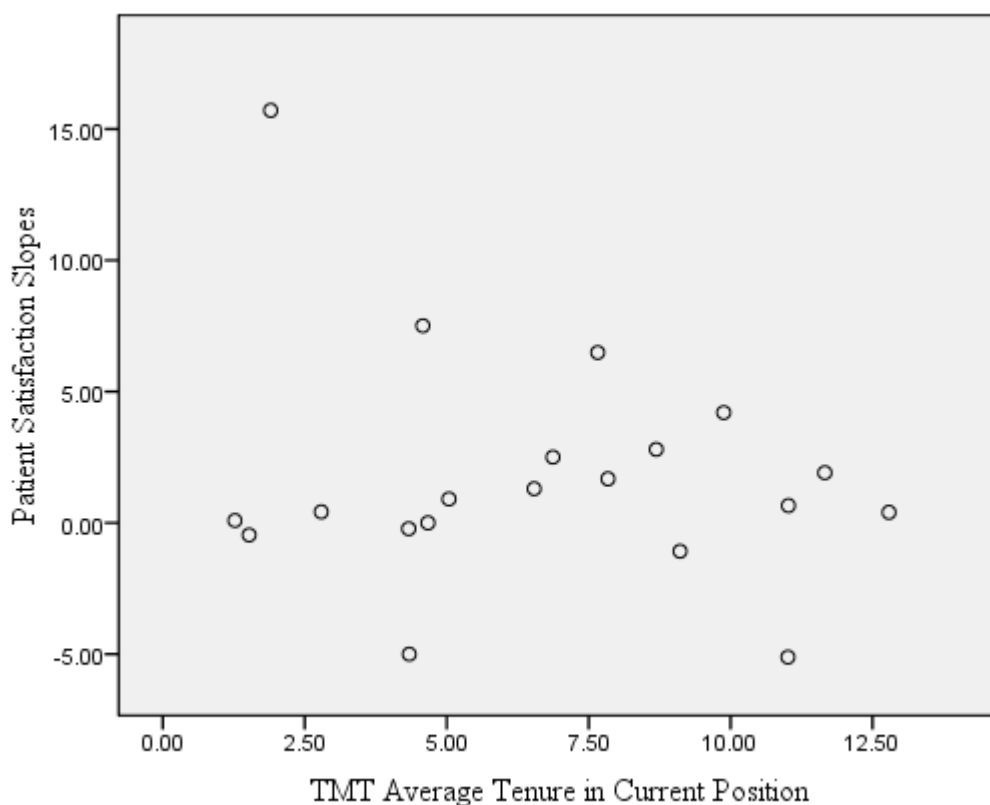


Figure 4. Scatter plot showing linear relationship between top management team tenure and patient satisfaction.

Table 18

Correlation test of top management team tenure and patient satisfaction

| | Patient satisfaction slopes | Top management team average tenure in current position |
|---|--------------------------------|--|
| Patient satisfaction slopes | | |
| Correlation coefficient | 1.000 | .086 |
| Sig. (2-tailed) | | .719 |
| <i>n</i> | 20 | 20 |
| Top management team average tenure in current position | | |
| Correlation coefficient | .086 | 1.000 |
| Sig. (2-tailed) | .719 | |
| <i>n</i> | 20 | 20 |

Summary

Chapter 4 presented data from 32 survey instruments representing 32 hospitals who participated in the VHA TWF transformational change initiative. Chapter 4 provided a review of the pretest, population and sample selection, instrumentation reliability, and data analysis methods and an explanation of the collection and measurement methods. In-depth reporting of results from correlation analysis and descriptive statistics pertaining to the research questions and associated hypotheses provided the analysis for the research findings.

The key findings from the research include the demonstration that top management team tenure and employee satisfaction are indeed related and no relationship exists between top management team tenure and patient satisfaction. The employee satisfaction linkage to tenure is an important finding when considering past literature that supports a strong relationship between employee satisfaction and organizational outcomes. An unexpected finding was the dichotomy between the lack of consistent formal measurement of employee and patient satisfaction levels, evidenced by the gaps in reported data resulting in less than 30 usable data elements, and the documented importance of these measures strongly expressed by the respondents. Further discussion on these and other comparisons to the literature follow in chapter 5. Chapter 5 provides a full summary of the study. Included are an interpretation of the data results presented in chapter 4, conclusions drawn from the data, study limitations, and recommendations for future research.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Although many hospitals in the United States are attempting transformational change initiatives, little evidence exists regarding which approaches are working and which are not working. The primary goal of the current study was to add to the scant body of empirical knowledge about hospital transformation through examination of a transformation collaborative undertaken by a group of hospitals across the United States. The examination focused specifically on the influence of the top management team and turnover on this team in the success of transformational change initiatives. The lack of success of transformational initiatives in the health care industry was the central problem identified for the study.

The findings in the literature indicated a strong relationship exists between the constructs of leadership and transformational change (Bass, 1990; Bass & Avolio, 1993). The effectiveness of top management in understanding necessary competencies for driving change determines how successful an organization will be at transforming a culture to react to external industry changes (Bennis & Nanus, 2003; Jones, 2004; Kane-Urrabazo, 2006). There is growing consensus that achieving improvements in an ailing health care system will require dramatic changes in current health care organizations (Institute of Medicine, 2001). The linkage between top management team influence on employee satisfaction and patient satisfaction is an important dynamic for health care organizations to study.

The specific purpose of the current quantitative correlational study was to examine the influence of top management replacement on the effectiveness of organizational culture transformation as measured by employee and patient satisfaction

scores. Growing pressures from consumers, third-party payers, and regulatory bodies have caused the health care industry to seek transformation. The pressure to change is escalating as the value to cost relationship continues to run out of control (Safavi, 2006). The literature indicates health care executives are seeking to address these concerns through transformational change initiatives focused on improving patient satisfaction levels, and many of these approaches are employee focused based on evidence of a positive relationship between employee and patient satisfaction (Atkins et al., 1996; Geyer, 2005).

The difficulty encountered in convincing the members of the sample to participate, as evidenced by an 18-week process of solicitation, peer pressure, and overall persistence necessary to achieve the minimum dataset necessary, indicates an industry with too many demands placed on executives, including the current pressures for organizational transformation. The multiple demands, coupled with the work of transformational change efforts, make it difficult for the industry to participate in the important added step of knowledge creation. Knowledge creation and sharing should emerge from the failures or successes of transformational change initiatives such as TWF. Whether organizations are embarrassed by failure or simply lack an understanding of the underlying dynamics of individual change efforts, more knowledge is needed to help organizational executives understand what drives transformation and why transformation is so difficult to achieve. To explore this and other concepts further, chapter 5 addresses the comparison of findings to the literature, analysis of data and findings, implications of the research, and recommendations and conclusions within the context of the findings from chapter 4.

Findings and Interpretations

A substantial literature provides evidence that the U.S. health care system is in crisis, as evidenced by dissatisfaction with cost, lack of access, and quality concerns (Institute of Medicine, 2001; Scotti et al., 2007; Spear, 2005). Health care organizations across the United States are attempting some form of transformation or reengineering in response to the dissatisfaction (Bigelow & Arndt, 2005; Runy, 2005). These attempts come either through individual effort or through an attempted collaboration, as experienced by the study sample.

Participants in the research study consisted of 32 of the 46 hospitals participating in the TWF transformational change initiative, or about 70% of the study population. The sample covered a broad spectrum of the industry, with hospital size ranging from 173 to 1,431 staffed beds, and 30 hospitals (97%) indicating they are part of larger multifacility healthcare systems. Although the total number of community hospitals in the U.S. declined from 4,956 in 1999 to 4,919 in 2004, the number of hospitals reporting they were part of a larger health system increased from 2,524 (50.9%) in 1990 to 2,668 (54.2%) in 2008 (VHA, 2006). An interesting finding was the large number of hospitals that chose to participate in the TWF transformational initiative that were also part of multihospital systems (97%), as compared to the industry average of 54.2%. This finding suggests a relationship between system membership (a local grouping of hospitals) and a desire to collaborate on an external basis as evidenced by membership in VHA.

The findings were consistent with the literature regarding an industry in transformational flux, evidenced by the number of years these organizations have been pursuing transformation ($M = 6.7$, $SD = 4.9$) and the number of attempted change

initiatives between 1997 and 2006 ($M = 2.6$, $SD = 2.0$). This history of failed initiatives dates back to the late 1970s and early 1980s when approximately 75% of health care organizations tried to implement multiple change programs with most outcomes “mediocre at best” (G. Scott, 2001, p. 82) and mirrors recent conclusions on the difficulties involved in transformational change (Goes et al., 2000). These and other statistics from the current study support the literature regarding the difficulty in successfully transforming organizations and further suggest a knowledge gap at the organizational leader level in understanding how to convert transformational change theory into practice.

Answering the Research Questions

To test the research questions, Spearman’s rank correlation coefficient was used as a proxy for the originally intended parametric test, Pearson’s correlation coefficient. The change in test was necessary because of a lack of sufficient data ($N < 30$) for the presumption of a normalized sample. Because the available dataset was minimal, follow-up interviews with 4 survey respondents provided a qualitative validation assessment of two key findings.

The purpose of the first research question was to determine whether a relationship exists between turnover of top management team members and employee satisfaction within the organizations surveyed. The null hypothesis ($H1_0$) presumed no relationship:

$H1_0$: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of employee satisfaction.

The research findings led to rejection of the null hypothesis through discovery of a significant moderately strong negative relationship ($r(16) = -.517, p < .05$) between top management team tenure and employee satisfaction. Although the literature search found no studies, in general industry or health care, quantifying leadership tenure as it relates to improved employee satisfaction, the significant finding lends support to the theory that new leadership, and perhaps new competencies, are necessary for achieving second curve leadership in hospitals (Merry, 2003; Morrison, 1996). The findings from the study, consistent with the literature, indicated that transformation drives employee satisfaction through interventions that include leadership turnover. Hospital and system leaders can benefit from examining the possible implications of changing leaders on the effectiveness of transformational efforts.

The important knowledge gained from this finding is that changes at the top level of leadership, for whatever reason, provided some evidence of achieving a goal of transformation, indicated by employee satisfaction. The finding does not provide an answer to whether leadership change in itself was the driver for improving satisfaction or whether the introduction of new leadership competencies caused the improvement. Further research should examine this important distinction. The finding does indicate that leaders too ingrained in the status quo should be required to develop new leadership competencies or leave the organization.

The purpose of the second research question was to determine whether a relationship exists between top management team tenure and patient satisfaction. To test the second research question, the null hypothesis (H_{20}) presumed no relationship:

H2₀: Hospitals actively engaged in transformation efforts that exhibit a higher level of top management team turnover will not exhibit a higher level of patient satisfaction.

The research findings did not support rejection of the null hypothesis. No support for a relationship between top management team tenure and patient satisfaction was found. This finding counters the belief indicated in the literature that a relationship exists between employee and patient satisfaction (Atkins et al., 1996; Kirby, 2005; Moody, 2003). The short duration of longitudinal data available in this study may provide an explanation for the lack of linkage, although other studies have demonstrated a linkage with 5 years or less of longitudinal data (Atkins et al.; Kirby; Sidhu, Berg, Endicott, Santulli, & Salem, 2002; Thies, 1999). Sample size and other factors, including how patient satisfaction is measured, or how patient satisfaction could experience lower performance in the short term in order to build capabilities for the longer term, could influence study outcomes. These factors suggest the need for more detailed longitudinal studies, as discussed below.

The low scores evident from the employee and patient satisfaction data in the study supported the literature claims of substantial dissatisfaction by both groups of stakeholders. Satisfaction levels for the most recent year reported (2006 or 2007) had a wide range, despite the transformational efforts under way, with a variance of 72 percentage points between the highest and lowest employee satisfaction scores and 66% for patient satisfaction. Only slightly greater than 7% of the organizations (2 of 32) had an employee satisfaction score above the 90th percentile and 23% (6 of 26) had patient satisfaction scores above the 90th percentile at the end of the reporting period. These

outcomes highlight the lack of success in achieving high levels of satisfaction by the employee and patient stakeholders through transformational efforts.

An important finding that emerged from the data was the dichotomy between recognition of the importance of increasing employee satisfaction as a necessary component of transformation (greater than 46% of the organizations ranked employee satisfaction as the most or second most important factor), and the number of organizations that had fewer than 3 years of satisfaction data (37.5%). Despite recognizing the importance of measuring satisfaction, the results indicate many organizations do not expend the resources necessary to measure this important metric. The failure to provide satisfaction data could have several causes other than the presumption organizations do not gather the data, including an unwillingness to share.

The most significant new findings of the study were a moderately strong negative correlation between leadership tenure and employee satisfaction, which is significant because this finding has no previous literature support, and no correlation between tenure and patient satisfaction, which is significant because the finding runs counter to the literature. An additional discovery was a general lack of understanding of transformational theory and transformational practice by the study participants. This is explored further later in the chapter.

Follow-up Interviews

Because of the low number of usable data elements for analysis, 4 survey respondents were chosen to provide additional qualitative information to supplement the quantitative findings. The qualitative inquiry focused on two key findings: the discovered relationship between top management team tenure and employee satisfaction and the lack

of understanding of transformational theory and practice, as evidenced by the finding that most participants considered the TWF initiative a positive experience, although no central tendency existed for the question regarding the initiative's effectiveness. Choice of respondents was based on a perception of initial willingness to participate in the study and a mix of organizations that appeared successful in increasing satisfaction levels and acknowledged actively replacing top management team members, and those where neither dramatic increases nor active engagement in replacement were evident.

Relationship Between Leadership Tenure and Employee Satisfaction

All 4 respondents affirmed their belief that a relationship exists between leadership tenure and satisfaction. One respondent used the word “intuitively” and another “instinctively” to indicate the basis for their belief. Three of the respondents were not aware of any specific research on the question. One respondent stated “the experts” support a relationship between employee satisfaction and patient satisfaction. This belief, which is consistent with the literature (Atkins et al., 1996; Kirby, 2005; Moody, 2003), appears to be a driving force for transformational change initiatives as evidenced by the 46 hospitals that joined the TWF program.

Interestingly, all 4 interviewees believed that longevity (stability) of the top management team was a critical element for increasing employee satisfaction. This belief may drive a fear of change at the top, particularly within organizations that have long-tenured CEOs with established “dominant logic” (Prahalad & Bettis, 1986, p. 7). Prahalad and Bettis warned of the influence of dominant logic as a barrier to the unlearning necessary to embrace new mental models and argued that the variation in dominant logics within the organization is dependent upon top management team

composition. These barriers can lead to psychological biases toward concepts such as executive turnover.

All 4 respondents spoke about the need for building trust among top management team members as a prerequisite for building necessary trust within the workforce that leads to high levels of satisfaction. Comments included, “Satisfaction correlates to trust and takes time to build” and “With a cohesive leadership team [built through relationships and tenure] you should have more success building employee satisfaction.” Three respondents commented on the importance of having the right leaders on the senior team. The comments were consistent with actions, as these three organizational leaders acknowledged having actively changed multiple top management team members because of a lack of cultural fit. The leadership action of reshuffling the top management team is consistent with the study theme, although success in increasing satisfaction varied among the three organizations, which suggests a potential gap between theory (and belief) and practice.

Overall Effectiveness of Transformational Change Initiative

Another important finding was the lack of consistency in opinion regarding the effectiveness of TWF compared to other transformational initiatives (see Table 7 and Table 8). Comments from the interview group supported this theme, thus reinforcing a potential theory–practice gap. Three of the interviewees credited TWF as a continuing effort toward organizational transformation; the 4th pointed to TWF as the start or “kick-off” of a transformational change effort.

These and other comments indicated that some executives viewed transformation as a journey rather than a destination. One respondent, while acknowledging the value of

participation, noted that top management team turnover and other variables made it difficult to measure the effectiveness of TWF. This comment suggests factors other than turnover at the top influence organizational culture change through a transformation initiative.

One interview respondent commented that organizations place too high a value on external benchmarking when measuring transformational success and noted organizations are unique to each other and should use improvement goals based primarily on internal metrics. Differing levels of employee or patient satisfaction typically exist at the beginning of transformational change initiatives, indicating different underlying causes of dissatisfaction. By identifying and focusing on organization-specific dissatisfaction, health care leaders can create specific metrics for guiding and measuring transformational efforts.

The transformational change experiences of the survey respondents indicated that transformation takes considerable time ($M = 6.7$ years pursuing transformation, $SD = 4.9$) and multiple initiatives ($M = 2.6$ initiatives, $SD = 2.0$). Of those transformational experiences, addressing the TWF initiative specifically, 26 of 29 respondents (89.6%) indicated TWF had a positive influence on improving the organization's working environment. None of the respondents experienced a negative influence and only 3 hospitals reported no influence.

Although the majority of respondents indicated a positive influence, responses to the question of the effectiveness of TWF compared to the effectiveness of other initiatives were almost evenly mixed between the choices of more effective, less effective, equally effective, and do not know. The lack of central tendency suggests

respondents either did not understand the intent of the question or lacked sufficient methods for effectively measuring success of transformation initiatives. If the latter is correct, the insufficiency of effective measures could be an underlying factor for the lack of meaningful literature on successful transformational change initiatives in health care.

The finding that value as a collaborative initiative was the primary reason for choosing TWF as a transformational change initiative ($M = 2.74$, $SD = 1.69$) indicates the recognition of a need to learn transformation from and with others. This finding indicates health care leaders are beginning to recognize the importance of sharing the knowledge gained from transformational experiences, including failed initiatives. If true, the gap in literature relating to understanding transformational change in health care could begin to close through future guidance, meaningful studies, and more knowledge on how to achieve successful transformation.

Influence of Top Management Teams

Top management team members drive the culture in any organization (Schein, 2004). The empirical data from the current study, supported by the interview feedback, indicated that the majority of respondents considered top management team fit with organizational culture and having the right top management team leadership in place as the most important factors influencing successful transformation. The majority of hospitals acknowledged the need for evaluating top management team fit to the desired culture, with only 4 respondents (16.7%) indicating minimal or no evaluation conducted. The most popular approach, chosen by 12 of 24 respondents (50%), was the use of criteria-based tools (360-degree evaluation or other formal leadership competence tool).

Two respondents (8.3%) reported direct CEO involvement in evaluating the team, and 6 hospitals (25%) reported “other means.”

Although no formal studies or meaningful literature provided evidence to support the connection between direct CEO involvement and transformational change success, performance outcomes evidence indicates a strong connection evidenced by the dramatic transformational change success stories of Parrish Medical Center in Florida and Centegra Health in Illinois. Without collection and documentation of these experiences, the body of knowledge will not advance. Because the lack of understanding is an impediment to propagating successful change strategies, the lack of effective knowledge transfer of underlying causes of success for transformed organizations should be of significant concern to current health care leaders.

As explained in chapter 2, theories abound relating to the role of leaders in transformational change, including “leaders are so central to transformational change that all successes and all failure are laid unambiguously at their feet” (Bigelow & Arndt, 2005, p. 21). Unfortunately, as presented in Table 1 of chapter 1, health care leaders of the old paradigm believe that environmental complexities, rather than leadership, are the cause of poor performance in both transformational abilities and less than desired outcomes. Until the industry accepts the suggested second paradigm thinking outlined in the conceptual framework of the study, which related leadership as the root cause of failure, successful transformation will continue to be elusive.

Evidence of the shift to second paradigm thinking is beginning to emerge, as evidenced by the data in chapter 4. Consistent with the role of leader theory, examining the question of factors having the most influence on transformation (see Table 10),

having the right leadership team ranked highest ($M = 2.93$, $SD = 1.95$) with 30% of respondents choosing changing the leadership team as most important. The second most important influence was “enhancing employee satisfaction,” chosen by 26.7% of respondents ($M = 3.37$, $SD = 2.08$). Kruskal-Wallis testing confirmed a significant difference between these factors. The results indicate support for the perception and underlying theory that leadership is the main driver of successful transformational change and employee satisfaction enhancement is a strong indicator of transformation.

Organizational Commitment to Transformation

During the data collection phase of the study, several organizations acknowledged dropping out of TWF early in the process. Reasons cited include disillusionment (possibly another indicator of the elusiveness of understanding and implementing transformational change); lack of organizational commitment; and in the case of three organizations, change in organizational direction resulting from the replacement of the CEO. The last consideration presents an interesting paradox to the theory presented in this research indicating that effective transformation requires top management team turnover: the possibility a transformational change initiative discontinues or fails because the program was an initiative of the old CEO and not favored by the new leader.

Another consideration counter to the theory espoused in the current research is the possibility that the CEO or top management team is not the primary factor in the success or failure of transformational change initiatives. Storey (2004) noted “the capability for senior positions to ‘galvanize operations’ or to ‘move boundaries and transform industries’ is highly tendentious” (p. 340). For the organizations that followed through with the initiative, the lack of readily articulated outcomes measures or overall

expectation that TWF was intended as a final solution indicates insufficient understanding of the necessary components for transforming organizations, a possible cause of disengagement or failure.

Transformational change is only one of many issues demanding the attention of hospital CEOs and top management teams. The difficulty in soliciting participation for the current study could be an indication that transformational change initiatives may not be the primary concern or focus of these leaders. Evidence from the research indicates a lack of understanding the requirements for successful transformation and a lack of the requisite discipline or commitment from health care leaders to stay the course after choosing a specific initiative, despite a universal desire for change in the health care industry. Perhaps organizations are pursuing transformational change initiatives because of institutional pressures from the board or others, to be part of a national trend, or to be regarded as at the cutting edge of new practices.

Acknowledging the Need for New Leadership

The fact that the majority of health care managers are actively pursuing customer satisfaction initiatives (G. Scott, 2001) highlights an industry focus on transformation and indicates that health care leaders are beginning to acknowledge organizational transformation as a response to the literature claims of an industry in crisis. Evidence from the study indicated that organizations pursue transformational change initiatives primarily to improve employee satisfaction (see Table 11). Evidence from the study also identified changing leadership as the most important influence on the success of transformational change initiatives (see Table 10). This finding is consistent with literature presented by previous researchers (Bigelow & Arndt, 2005; Schein, 2004).

The finding further supported recognition of the need to evaluate leadership fit to culture and the willingness in several organizations to make changes in top management team as necessary. These factors support acknowledgment of the need for new leadership identified in chapter 1 (see Figure 2) to transform health care organizations. Changing leadership may provide the organizational commitment necessary for achieving successful transformation and offers a response to the attribution of the crisis in health care to “the lack of vision, determination, and adequate methods of those who lead America’s health care organizations” (Rona, 2005, p. 87).

Choice of Transformational Approach

Respondents were asked to rank five concerns—clinical quality, employee satisfaction, patient satisfaction, overall organizational performance, or financial performance—that may influence an organization’s decision to pursue TWF or other transformational change initiatives. This question (survey question 9) approached the concept of the most important influence from an outcomes perspective rather than the context or content influence choices of question 10. The responses reinforced employee satisfaction as the most important concern facing leaders ($M = 2.48$, $SD = 1.18$), with patient satisfaction scoring second ($M = 2.59$, $SD = 1.24$). Interesting to note is that clinical quality, the factor least measured and most touted by health care organizations, ranked fourth ($M = 3.14$, $SD = 1.43$) and financial performance concerns ranked fifth ($M = 4.10$, $SD = 1.26$). Kruskal-Wallis testing confirmed a significant difference between factors. The data contradict the old paradigm that top management team leaders in health care are too focused on the financial bottom line (Bodinson, 2005; Feazell & Marren, 2003; Studer, 2004a).

Theories abound relating to structure and form, such as changing the context of the organization before the content (Wentz, 2000), and culture's role in transformational change and how transformational change should evolve (Kotter, 1995; Moody, 2003). Evidence supporting these theories comes in the form of the response that changing organizational structure was the least important influence ($M = 6.10$, $SD = 1.65$). This finding is consistent with Wentz's (2000) argument that "to create organizational transformation, changes in context [business models and mind-sets] must precede changes in content [structure]" (p. 26).

Consistent with theory, the organizations in the current study considered transformational change important enough to address as a component of the organization's strategic plan. Greater than 80% of the respondents addressed transformational change within their strategic plans, highlighting the importance of transformation as a strategic imperative. The importance of connecting critical initiatives to a strategic plan is a premise of successful performance frameworks as evidenced by the Baldrige Performance Excellence Framework (Latham & Vinyard, 2006).

Leadership Accountability as a Function of Transformation

Addressing the question of leadership accountability, 10 of 32 responding organizations, or almost 38% of the study population, indicated the board did not hold management accountable. Having the governing board hold top management teams accountable for the elements of the strategic plan is an important requirement of the Baldrige criteria. The absence of this key component can be a contributing factor for failed transformational change initiatives (Latham & Vinyard, 2006). Most survey respondents were effective in communicating transformational change initiative progress

to the governing board, with only 5 (16.7%) reporting less often than quarterly and 1 (3.3%) reporting updates were never provided.

Contrary to evidence that absence of accountability is a contributing factor for failed transformational efforts, accountability ranked poorly as a primary factor for achieving transformational change. Ten of 27 respondents, or 38% of the study population, identified having the CEO as a visible leader of the change initiative as the primary factor. Five respondents (18.5%) identified an organizational sense of urgency as the primary factor and holding people accountable ranked third (4 respondents, 14.8%). Of the total responses, top management team buy-in ranked fourth. Of the remaining factors, none of the respondents chose having the board of trustees as visible leader, having dedicated financial resources, or having the chief operating officer as visible leader as primary factors; 1 respondent chose “none of the above.” The discovery that top management team ranked low as the primary factor contradicts the underlying premise of top management team influence on transformational change evidenced in the literature and hypothesized in the study.

Understanding Transformation

Responses from the interviewees indicated leaders are recognizing the need for having the right top management team leaders in place—meaning those leaders competent at transformational change—and are supportive of formal transformation initiatives as a means of increasing employee satisfaction. The respondents were not consistent on what makes a transformational initiative successful, indicating a need for consensus in the field about what drives successful transformation and a framework for measuring transformational success. This lack of understanding, evident from the

interviews, data analysis, and literature review, reinforces a key underlying problem with transformational change: a lack of agreement about what transformation really is. Data from the respondents provided conflicting opinions regarding which factors are most important for achieving transformation (see Table 10 and Table 15) and reasons for pursuing transformation (see Table 11). Lack of belief in and commitment to initiatives may also be an underlying factor for failure.

Although literature on executive turnover has had a specific focus on voluntary or involuntary replacement, no clear reasons for replacement were observed, other than poor performance spurs turnover among hospital executives (Potter & Dowd, 2003). Health care leaders are beginning to relate poor performance to poor cultures (Studer, 2004b). Responses to the question regarding amount of involuntary turnover offer insight that health care leaders are beginning to recognize the influence of top management team turnover on the success of transformational change efforts, evidenced by the 53% of survey respondents reporting involuntary changes at the top because of poor culture fit.

Seventy-five percent of the sample provided a response to the question relating to replacement of top management team members because of poor fit to organizational culture, which is a strong indication of awareness of this dynamic. This is a significant finding because the literature does not highlight evidence of poor cultural fit as an indicator of top management team turnover. Most studies focused on CEO turnover related to overall organizational performance (Wiersema, 1995) or external environmental factors (Potter & Dowd, 2003) with minimal data on top management team turnover. Of the survey respondents reporting in this sample, replacement ranged

from one to six top management team members, with the highest equaling a 50% replacement rate ($M = 15.4$, $SD = 14.2$).

In the past, health care leaders accepted a myriad of factors other than leadership as the cause of poor culture, which is a concept consistent with first curve versus second curve thinking (Morrison, 2000). Several reasons, including poor performance as change agents, could explain the recognition of involuntary turnover—beyond cultural fit—as a necessity for successful transformational change. Another potentially significant finding is the emerging recognition for the need for second curve leadership, or leadership that accepts responsibility for existing organizational deficiencies, as described in chapter 1. As T. Scott, Mannion, Davies, and Marshall (2003) noted, “Competing claims exist concerning whether organizational cultures are capable of being shaped by external manipulations to beneficial success” (p. 111) and that a key factor impeding culture change is attributable to “inadequate or inappropriate leadership” (p. 111).

Allen (1991) and Rona (2005) suggest failed leadership as the real problem in health care. The significant finding in the current study that employee satisfaction improvements were negatively related to longer leadership tenure should provide a strong message to hospital boards of trustees. These leaders are caretakers of community health care assets. In this caretaker role, leaders are responsible for establishing vision and guiding mission and have a responsibility for providing an answer to the condemnation by consumers, regulators, and industry watchdogs of a quality gap in the healthcare industry (Institute of Medicine, 2001).

Boards should consider the Institute of Medicine’s (2001) suggestion that a shift in culpability from uncontrollable external environmental factors to health care leadership

is necessary for crossing the quality chasm. Developing a common language and understanding of factors influencing successful transformation might be a starting point for closing the gap. The empirical data from the survey responses and perceptions from the interviews support the need for recognizing a connection between leadership and employee satisfaction as a key relationship for transformational success.

Major turnover at the top, when accomplished to realign purpose, commitment, and competencies, often results in wider organizational adaptation than initially anticipated (Wiersema & Bantel, 1993). The dynamic can cause distraction from current organizational initiatives or effectiveness until the reconfigured top management team coalesces and effectively works together as a team (Wiersema, 1995). The dynamic adds to the difficulty in understanding transformational change. The earlier work of Wiersema et al. provided insight into the phenomenon, but the lack of literature indicates the need for more research.

The difficulties encountered in gathering data and reporting outcomes from the organizations in the study might explain why so few data are available on what works and what does not for successfully transforming organizations. Health care leaders must develop competence in understanding how to transform organizations and be willing to share both good and bad experiences. The evidence in the literature and supporting data from the study indicate a deficiency in this leadership competency so necessary for health care leaders (Storey, 2004). The finding is consistent with the criticism of Rona (2005), who attributed the state of health care in the 21st century to “the lack of vision, determination, and adequate management methods of those who lead America’s healthcare organizations” (p. 87).

This suggested deficiency in leadership competency raises the possibility of a theory–practice gap (Van De Ven & Johnson, 2006) in the health care industry. According to Van De Ven and Johnson, the gap between theory and practice is a knowledge production problem bridged by “creating a mode of inquiry that converts the information provided by both scholars and practitioners into actions that address problems of what to do in a given domain” (p. 803). Existence of a theory–practice gap might explain why transformation is such an elusive concept for health care leaders to understand and implement. Tomorrow’s Workforce should have served as a platform for connecting the proposed theories for transformation with the networking experiences of the participants as they collaborated throughout the 4-year duration of the initiative.

Responsibilities of Leaders

Leaders in health care organizations have a responsibility to the community and third-party payers to provide the highest quality health care with the least costly resources. The inability to provide high levels of employee and patient satisfaction within the health care system at the organizational level is a failure of leadership (Bigelow & Arndt, 2005). Belief in these statements would indicate that the significant finding linking increased employee satisfaction with top management team turnover provides insight into a possible ingredient for successful transformation. This new knowledge for health care leaders should be transferrable to leadership in general, as the phenomenon linking satisfaction and new leadership is likely not limited to the health care industry.

Health care leaders also have a responsibility for sharing knowledge relating to the success or failure of transformational change experiences. Although the literature review highlighted higher failure rates for transformational change initiatives in the

health care industry, all organizational leaders share responsibility for advancing understanding in the areas of transformational theory and the practice of successfully transforming organizations. Efforts by all leaders will help close the theory–practice gap identified in the literature.

Recommendations

The results of the study indicate leaders of health care organizations need an improved understanding of factors influencing the success or failure of transformational change initiatives, including the influence of top management teams, to improve the industry's success rate. To address the crisis in the industry highlighted by the Institute of Medicine and others (Allen, 1991; Feazell & Marren, 2003; Institute of Medicine, 2001; Thomas, 2006), health care leaders need to create working environments where high employee satisfaction improves the retention and recruitment issues faced by the industry. By creating cultures where high employee satisfaction drives high patient satisfaction and overall quality, health care leaders will have transformed an industry in crisis.

The continued pressures from industry watchdogs and the shift to a pay-for-performance system will continue to drive the need for changes to an overloaded and underfunded national health care system. The health care industry needs to continue to address, at the organizational level, the current dissatisfaction with access, service levels, and costs in hospitals. To accomplish this objective, health care leaders need to develop an environment of collaborative learning and new leadership models for transformational change. Specific recommendations for organizational leaders and health care organizations follow.

Recommendations for Organizational Leadership

Leaders in health care organizations need to acknowledge and accept the possible need for new leadership in top management teams. As indicated by the results of the research study, and supported by Storey (2004), there are “signs of a new shift” (p. 8) emerging and the need for a “third era” (p. 8) of management beyond the transactional and transformational models. To affect this shift, boards of trustees must answer the leadership question as part of their responsibility to organizational stakeholders and the communities they serve. Boards must hold CEOs responsible and accountable for ensuring the cultural fit and transformational change competencies of top management teams. Transformational change initiatives must include identified outcomes measures and goals as well as achievement milestones. Boards need to hold top management teams accountable for achieving organizational transformation. Incorporating transformational efforts into strategic plans and creating a system of leadership accountability are proven strategies for creating successful organizational change (Latham & Vinyard, 2006).

The finding from the study relating leadership change to increased employee satisfaction provides a basis for health care leaders to examine the adequacy of current top management teams. The finding related to a general lack of understanding of what transformation is and what is necessary to achieve transformation should encourage leaders to share change experiences. The sharing of experiences will expand the industry-wide understanding of the theory and practice of organizational transformation. To benefit from the findings, the challenge for health care leaders is twofold: (a) accepting that some old paradigm leaders cannot make the necessary shift to new paradigm leadership principles and (b) having the courage and vision to carry out the necessary

changes at the top of the organization. Ensuring the right leaders are in place, and holding top management teams accountable for transforming organizations with identified measurable outcomes and time frames, must become a top priority for governing boards and CEOs of health care organizations.

Recommendations for Health Care Organizations

The responsibility for implementing improvements to the health care system must be recognized and accepted at the organizational level. Improvements within the system require transforming existing underperforming organizations. To transform, an organization must have a top management team able to clearly articulate vision and measurable goals for transformation. Simply seeking transformation because transforming the organization is the expected or right thing to do does not provide an effective environment for change.

The American College of Healthcare Executives, Joint Commission Resources, and other industry support organizations should adopt a more proactive role in helping organizational leaders understand and develop the competencies necessary for transformational change. Certifying competence in leading health care organizations is a central principle of the American College of Healthcare Executives and Joint Commission Resources. Highlighting the role and responsibility of health care leaders in transforming an ailing industry should be a core part of the American College of Healthcare Executives and Joint Commission Resources' future missions. These organizations have the opportunity to set an expectation of leadership competence in organizational transformation as a required component of leadership certification and organizational accreditation programs.

Suggestions for Further Research

The current study focused on whether a relationship exists between top management team tenure and levels of employee and patient satisfaction within 46 hospitals engaged in a collaborative transformational change effort. Additional research on the relationship between leadership tenure and transformational change initiatives in health care could help address several unanswered questions. The study was limited to a small sample size from the not-for-profit sector. Future studies would benefit from a larger, less homogenous sample. Future studies would also benefit from examining other potential measures of successful transformational change beyond employee and patient satisfaction; possible suggestions are clinical quality outcomes or other organizational performance measures.

Addressing the weaknesses in the current study design would be another area for future research. Because the effects of transformation are likely to take time to emerge, future studies would benefit from more longitudinal data on satisfaction levels following transformation efforts rather than during the transformational period measured in the current study. Increasing the number of measures of transformation examined and a lengthier longitudinal view of satisfaction levels would allow deeper analysis using structural equation modeling. Structural equation modeling could provide answers to whether leadership tenure is a causal phenomenon of employee satisfaction or patient satisfaction or whether other measures are more meaningful.

Future research could include an examination into whether the relationship between top management team turnover and employee satisfaction was merely an artifact of change or a result of more effective transformational competencies available through

new leaders. Past research on transformational change in organizations provides several theories relating the roles of culture, organizational structure, and charismatic leader to organizational transformation (Bass, 1990; Jones, 2007; Latham & Vinyard, 2006; Schein, 2004). Beyond the structural dynamics of change theory, future research focusing on managerial cognition—the mind of the leader—could add knowledge about the decision-making processes of top management team members relating to transformational change initiatives. Cognition studies might add to the lack of data on why transformation is such a difficult concept to understand and implement in hospitals.

Conclusion

Contrary to literature, the lack of evidence in the current study supporting employee satisfaction as a driver of patient satisfaction was surprising. The lack of support for a relationship between top management team tenure and patient satisfaction was also an unexpected outcome. These considerations highlight a key learning for the researcher: reinforcement that all researchers bring some experience and expectation (potential bias) to the field of research study.

The most significant new findings of the study were a moderately strong negative correlation between leadership tenure and employee satisfaction, which is significant because the finding has no previous literature support. Also important is the finding of no correlation between tenure and patient satisfaction, which is a notable outcome because the finding is counter to the literature. A further discovery was the apparent lack of understanding of transformational theory and transformational practice by the study participants, indicating that executives may be engaging in transformation without

entirely understanding what it involves and in some cases demonstrating a weak, fleeting commitment to transformation.

Organizational leaders should create standard criteria for measuring the outcome of attempted transformational initiatives and use the data to demonstrate the effectiveness of the chosen approach to transformation. Health care leaders should learn from the experiences of other organizations, and adapt and incorporate proven theories and principles into a custom transformation plan appropriate for the organization. The study supported past literature indicating no general blueprint exists for transformation.

As evidenced in the research, organizations with less tenured top management teams experienced higher employee satisfaction levels. Further research is needed to acquire a deeper understanding of this dynamic, but the results indicate considering the implication of bringing new leaders to top management teams and the possibility the new leaders might bring and apply second curve leadership principles (Merry, 2003; Morrison, 1996) to the transformation of organizations.

The overall success or failure of transformational change initiatives, including TWF, remains unclear, as evidenced by the number of organizations engaged in or continuing to pursue successful transformation formulas. One reason for the problem might be the lack of follow through or commitment to chosen initiatives, despite initially demonstrating a strong desire to transform. Desire to transform is not sufficient—absent other key components—for successfully changing the culture of an organization. If organizational transformation is a responsibility of leadership, hospital leaders must work harder to understand what is required from the leader and the organization if there is to be any hope of transforming this industry in crisis.

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APPENDIX A: PARTICIPATING ORGANIZATIONS BY STATE

| State | Participating Organizations |
|----------------|-----------------------------|
| Alabama | 1 |
| Arkansas | 2 |
| California | 1 |
| Colorado | 2 |
| Florida | 7 |
| Idaho | 1 |
| Illinois | 1 |
| Louisiana | 2 |
| Massachusetts | 1 |
| Michigan | 1 |
| Minnesota | 1 |
| Mississippi | 1 |
| Missouri | 2 |
| Montana | 1 |
| New York | 2 |
| North Carolina | 1 |
| Pennsylvania | 3 |
| Virginia | 1 |
| West Virginia | 1 |

APPENDIX B: REQUEST TO PARTICIPATE AND INFORMED CONSENT

Fellow healthcare leader,

My name is Steven Brown and I currently serve as vice president of operations for Faxton-St. Luke's Healthcare. Faxton-St. Luke's Healthcare (FSLH) was a Wave II participant in VHA's Tomorrow's Workforce Initiative. I am also a student at the University of Phoenix, working to obtain a doctoral degree in organizational development and leadership.

As part of my degree requirements, I am conducting a research study on the influence of leadership on success of organizational transformation initiatives. Healthcare organizations throughout the country are undergoing various forms of cultural transformation without the benefit of experiences gleaned from past initiatives such as TWF. In fact, a lack of literature exists in the healthcare industry on what is necessary for successful transformational change. It is my hope that the insight gained from our collective participation in the TWF initiative will add to the sparse body of knowledge on leadership's role in organizational transformation efforts.

The specific purpose of the research study is to add insight to the body of knowledge on the role of top management team leadership on the effectiveness of transformational change within the 46 participants of the four Waves of TWF. Your participation will involve completion of a survey of organizational demographics, tenure of top management team leaders, and your organizations measures of employee and patient satisfaction as indicators of successful change. All responses are strictly confidential with data reported in a blinded and aggregated manner. Your participation in this exercise is voluntary but crucial to the success of the research project. If you choose

not to participate or to withdraw from the exercise at any time, you can do so without penalty or loss of benefit to yourself.

In this survey, there are no foreseeable risks to you. Although there may be no direct benefit to you, the possible benefit of your participation is to aid in assisting healthcare organization leaders with the success of their transformational efforts as we continue our work to improve the performance outcomes of our industry. Return of the survey will be considered as your consent to participate. Your rights as a participant are outlined in the attached *Research Study Consent Form for Voluntary Participants over the Age of 18*.

If you have any questions concerning the survey, please contact me by phone (315.624.6143) or email (sjbrowniss@email.phoenix.edu or sbrown@mvnhealth.com)

Sincerely,

Steven J. Brown

Research Study Consent Form for Voluntary Participants over the Age of 18

Dear

I am a doctoral student at the University of Phoenix conducting a research study as a requirement of completing a Doctorate in Management degree. The goal of the study is to further our understanding of the influence of leadership replacement on transformational change initiatives in healthcare. The research method involves using quantitative data analyses from a validated survey instrument to examine the relationship of top management team replacement on the success of organizational transformation as measured through employee and patient satisfaction scores.

Participation involves completing a single survey document for collecting background on your organization and specific data on leadership turnover and employee and patient satisfaction scores. Participation in this study is voluntary and a decision to not participate can be made without penalty. The researcher will not report your decision to participate or not participate to any person. The researcher will be the only individual aware of your participation and will use your survey data without attribution.

Academic research studies that involve gathering data from individuals require adherence to certain standards to ensure the protection of participants. The following are additional terms and conditions of your participation in this survey:

1. I may refuse to participate or withdraw my participation at any time without consequence.
2. All records of participation, including survey data, are confidential and presented in anonymous form.
3. All records from this study will be destroyed three years from publication of the blinded survey data.
4. There are no foreseeable risks to your participating in this study.
5. Return of the questionnaire will be considered as your consent to participate.

Please provide your signature below acknowledging willingness to participate in the study:

By signing this form I acknowledge that I understand the nature of the study, the potential risks to me as a participant, and the means by which my identity will be kept confidential. My signature on this form also indicates that I am 18 years old or older and that I give my permission to voluntarily serve as a participant in the study described.

| | |
|--------------------|------|
| Participant's Name | Date |
|--------------------|------|

Please return this informed consent acknowledgement at your earliest convenience via U.S. Postal Service in the self-addressed postage paid envelope provided. Thank you for your assistance in adding experience to the limited body of knowledge available related to transformational change efforts in healthcare organizations. If at any time you have any questions concerning the research study, please call me at (315) 732-0599 or email me at sjbrowniss@email.phoenix.edu.

Sincerely,

Steven J. Brown

Doctoral Student

University of Phoenix

APPENDIX C: SURVEY INSTRUMENT

Fellow healthcare leader:

Through participation in the VHA Tomorrow's Work Force Initiative™, our organizations have worked to improve performance through a focused approach to enhancing our workforce cultures. As part of a doctoral research study, our collective efforts will add to the very limited body of knowledge relating leadership role to success in health care organizational transformation.

Please respond to the questions in the following brief survey regarding data on your organizations leadership and the outcome measures of employee and patient satisfaction. An exclusive executive summary of the study results and conclusions will be provided to you upon completion of the study. A copy of the informed Consent letter outlining your rights as a participant is included in this packet. When completing the survey, please answer all questions.

Please return the survey to my attention in the attached self-addressed postage paid envelope by **XXXX XX**, 2007. Please accept my thanks for taking time to assist in this research study.

Sincerely,

Steven J. Brown

Organizational Change Initiative Survey

Hospital: _____

Person completing the Survey:

Name: _____

Title: _____

Instruction: Please enter the data or fill in the circle that most closely matches your response.

1. In what month/year did your hospital begin the Tomorrow's Workforce (TWF) journey?

_____ _____ Month/Year joined TWF

How many years has your hospital been pursuing transformational change (formal programs with the intent of changing organizational culture through engagement of the entire employee population) through formal initiatives similar to the TWF initiative?

_____ Years formally pursuing transformational change

How many different transformational change initiatives has your hospital attempted in the past 10 years (including TWF)?

_____ Number of initiatives attempted in past 10 years

2. The purpose of the TWF initiative was to improve the working environment within an organization. Please rate, in your opinion, the effectiveness of this initiative in influencing positive culture change (actually changing staff attitude and improving employee satisfaction):

- Initiative had no influence
- Initiative had a slightly negative influence
- Initiative had a strong negative influence
- Initiative had a slightly positive influence
- Initiative had a strong positive influence

3. Please rate the effectiveness of this culture change initiative (Tomorrow's Workforce) in relationship to any other culture transformation initiatives undertaken in your hospital. The TWF initiative was:

- Less effective
- Equally effective
- Slightly more effective
- Much more effective
- Do not know – this was our first formal initiative

Recalling the TWF “Lock of Success” where Leadership effectiveness was the second step in addressing organizational culture change (after organizational Desire), what approach did your hospital take in addressing leadership with respect to the following questions:

4. Evaluation of leadership fit to the desired culture

- Criteria-based evaluation of top management team (VP's and above) using formal tools (360 evaluation, or other formal leadership competence evaluation tool
 - Criteria-based evaluation of top management team by CEO
 - Criteria-based evaluation by other means (please indicate evaluation method):
-
- Minimal evaluation process conducted
 - No evaluation conducted as part of our initiative

5. Leadership development

- Criteria-based development of top management team using external coaching/mentoring
 - Criteria-based development of top management team using internal coaching/mentoring
 - Criteria-based development of top management team by other means (please indicate developmental method):
-
- Minimal development (educating on necessary leadership competencies for transformational change)
 - No leadership development component was conducted as a result of TWF initiative

6. How would you rate the following statements?

- a. “Our organization believes that increasing employee satisfaction results in increased patient satisfaction.”

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

☀ ☀ ☀ ☀ ☀

- b. “Our organization believes that members of the top management team play a major role in employee satisfaction.”

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

☀ ☀ ☀ ☀ ☀

7. Based on past employee satisfaction survey responses, please rate the importance of the following factors (identified through survey questions) on overall employee satisfaction:

| | Important | | | Unimportant | |
|-----------------------------------|-----------|---|---|-------------|---|
| | 5 | 4 | 3 | 2 | 1 |
| a. Employee pay | ☀ | ☀ | ☀ | ☀ | ☀ |
| b. Employee benefits | ☀ | ☀ | ☀ | ☀ | ☀ |
| c. Working environment (physical) | ☀ | ☀ | ☀ | ☀ | ☀ |
| d. Leadership/manager factors | ☀ | ☀ | ☀ | ☀ | ☀ |
| e. Job flexibility | ☀ | ☀ | ☀ | ☀ | ☀ |
| f. Employee recognition | ☀ | ☀ | ☀ | ☀ | ☀ |

8. Based on your organization’s experience with the TWF initiative and other culture change attempts, which of the following factors has the most influence on successfully transforming an organization’s culture? Please rank the following seven factors from most influential (1) to least influential (7):

- _____ Efforts to enhance employee satisfaction
- _____ Changes in organizational structure
- _____ Change the leadership team (get the “right” leaders in place)
- _____ Revisiting and/or rearticulating the vision
- _____ Building greater accountability for positive behaviors
- _____ Efforts to enhance organizational communication
- _____ Efforts to enhance management involvement/effectiveness

9. Which of the following responses had the most influence on the decision for your organization investing in the TWF or other transformation initiatives? Please rank the following five factors from most influential (1) to least influential (5):

- Concerns about clinical quality
 Concerns about employee satisfaction
 Concerns about patient satisfaction
 Concerns about overall organizational performance
 Concerns about financial performance

10. Please rank the following statements from most influential (1) to least influential (7) regarding the reason your organization chose **this** particular transformation initiative (TWF):

- Opportunity to work within a collaborative transformation initiative
 Reputation of VHA
 Past success with VHA initiatives
 Had VHA credits and this seemed like the best investment at the time
 Timing was right
 Addressed needs
 Program design

11. Does your organization's strategic planning process specifically address the role of organizational transformation as a component of the overall plan?

- Yes
 No

If yes, does the governing board measure progress and hold the top management team accountable for achieving organizational transformation within an established timeframe?

- Yes
 No

12. To what extent were the Board of Trustees (directors) kept regularly informed/updated on the progress of the TWF or other transformational initiatives?

- | Informed Regularly
(Monthly or Greater) | Informed Periodically
(Quarterly) | Informed Only
Initially or Seldom | Were Never
Informed |
|--|--------------------------------------|--------------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. Based on the TWF experience and possible other efforts at transformation, what is the primary factor necessary for success in achieving transformational change:

- Board of trustees (directors) as the visible leader of transformational change
- CEO as the visible leader of transformation
- COO as the visible leader of transformation efforts
- Financial resources dedicated to transformation efforts
- Communication
- An organizational sense of urgency about the need for change
- Top management team buy-in or acceptance of the initiative
- Middle management buy-in or acceptance of the initiative
- Holding people accountable
- None of the above. The most important factor is: _____

LEADERSHIP SECTION

This section gathers background data on your top management team members (vice-president and above).

Current Leadership Team Tenure:

| Date | Position | Date appointed this position | Original Hire (if different) |
|------|---------------------------------|---------------------------------|---------------------------------|
| | Chief executive officer (CEO) | _____ | _____ |
| | Chief operating officer (COO) | _____ | _____ |
| | Chief financial officer (CFO) | _____ | _____ |
| | Chief Medical Officer (CMO) | _____ | _____ |
| | Chief Information Officer (CIO) | _____ | _____ |
| | SVP of _____ | _____ | _____ |
| | SVP of _____ | _____ | _____ |
| | SVP of _____ | _____ | _____ |

SVP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

VP of _____

Of the positions listed above, how many left the organization (voluntarily or by request) because of poor fit with the organization's culture: _____ out of _____.

EMPLOYEE SATISFACTION DATA

Organization providing *employee survey* services:

- ☼ Press Ganey
- ☼ Jackson
- ☼ Gallup
- ☼ Other _____

Overall Score 2001 2002 2003 2004 2005 2006

Percentile Ranking _____ _____ _____ _____ _____ _____

PATIENT SATISFACTION DATA

Organization providing *patient survey* services:

- ☼ Press Ganey
- ☼ Jackson
- ☼ Gallup
- ☼ Other _____

Overall Score 2001 2002 2003 2004 2005 2006

Percentile
Ranking _____ _____ _____ _____ _____ _____

BACKGROUND SECTION

This section gathers background data on your organization.

14. How many patient beds are in your hospital?

_____ Total licensed beds

_____ Total staffed beds

15. How many full-time equivalents (FTE's) does your hospital employ (full-time equivalents includes all staff on the organization's payroll)?

_____ Total full-time equivalents (FTE's)

16. What is the average Case Mix Index (CMI) of your hospital over the past 12 months?

_____ 12 month average CMI

17. How many other hospitals are located in your primary market:

_____ Total hospitals in our primary market

18. What is the hospital's Average Age of Plant as reported on financial statements?

_____ Average Age of plant

19. How many physicians and allied health professionals (nurse practitioners, physician assistants, or certified register nurse anesthetists) are credentialed members of the hospital's medical staff?

_____ Total credentialed members of the medical staff

20. How many attending and/or specialist physicians are direct employees of the hospital?

_____ Total employed attending and/or specialist physicians

21. Is your hospital part of a multi-facility healthcare system?

Yes
 No

If yes, how many hospitals in total and how many are actively engaged in formal organizational transformation initiatives similar to the TWF initiative.

_____ Total number of hospitals

_____ Total number currently engaged in an initiative.

Thank-you once again for participating in this survey.

APPENDIX D: CEO TO CEO LETTER

DATE

ADDRESS

Dear (NAME OF PERSON):

I am corresponding with you as a VHA CEO colleague virtually interested in how our leadership impacts organizational transformation. As evidenced by our common participation in VHA's Tomorrow's Workforce Initiative™ (TWF), we desire to transform our organization into an environment more responsive to the needs of our patients and employees. Many healthcare organizations are working with consultants or attempting transformational initiatives on their own with varying degrees of success. Unfortunately, the literature documenting these efforts is sparse and often inconclusive.

Participants in the TWF initiative have a unique opportunity to add to the limited body of knowledge related to organizational transformation in the healthcare industry. One of Faxton-St. Luke's Healthcare executives is conducting a research study—in partial fulfillment for a doctoral degree in management—on the relationship between leadership and successful organizational transformation. The study sample is the 46 hospitals that participated in the TWF initiative. For the study to be statistically meaningful, participation by a minimum of 30 hospitals is required. For this reason, I am making a personal plea, colleague to colleague, to participate in this important study that I truly believe will greatly benefit our industry.

You and I perceived a transformational opportunity in the TWF initiative and perhaps a strategic advantage in our market place. By sharing our experiences, we can play a key role in filling the knowledge gap that defines success in organizational transformation. As a participant, you will receive a CEO executive summary of the TWF research study findings and conclusions. The successes and failures of our leadership abilities to use this transformation vehicle will be detailed. As with all academic research, assurance of confidentiality of your data and organizational identity is through an informed consent and confidentiality agreement.

The survey instrument has been developed in consultation with working hospital/system CEO's in order to obtain maximum value with consideration of your time commitments. It consists of a series of subjective questions and data requests to clarify your organization and workforce demographics.

Continued On Page Two

NAME OF PERSON

DATE

PAGE TWO

If you are willing to engage in this unique opportunity to enhance the healthcare profession's understanding of leadership and its impact on the organization, please sign this letter in the space below, retain a copy for your files, and return it to:

Steven J. Brown, FACHE
Vice President Clinical Operations
Faxton-St. Luke's Healthcare
P.O. Box 479
Utica, NY 13503-0479

If you desire to discuss this doctoral thesis or its research premise, please feel free to contact Steven Brown at sbrown@myhealth.com or telephone (315) 624-6143. You will receive the survey instrument and supporting material approximately 10 days following receipt of your authorization. Thank you for giving this request serious consideration.

Very truly yours,

Keith Fenstermacher
President and CEO
Faxton-St. Luke's Healthcare

KF:cv

Agreed to by:

NAME

DATE

APPENDIX E: LETTER AUTHORIZING ACCESS TO SECONDARY DATA

April 3, 2007

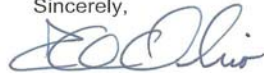
Steven J. Brown
188 Valley View Road
New Hartford, NY 13413

To whom it may concern:

This letter acknowledges our agreement to provide the above named researcher access to the Success Profiles employee survey data collected from our clients over the past several years. The data access and use is provided solely for the purpose of conducting a doctoral research study in satisfaction of the requirements for a doctor of management degree with the University of Phoenix's School of Advanced Studies.

Consistent with the confidentiality requirements of the university, the researcher will not identify specific organizations or individuals by name. The researcher will provide acknowledgment within the study that the data provided is the property of Success Profiles, Inc.

Sincerely,



Tom Olivo, President
Success Profiles, Inc.