UTILIZING TRANSFORMATIONAL LEADERSHIP IN

HOSPITAL STRATEGIC PLANNING: THE CASE OF

MEDICAL CITY DALLAS HOSPITAL

by

Britt Richard Berrett

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This work is dedicated to

my faith, my family, and my friends.

I recognize that it is easier to say I wish than I did.

For that reason, each and every

grumpy morning,

long day, and

late night

has been worth it and has led me closer to something

I was promised I would do.

And to my mother . . .

that set the example as she returned late in life to earn her college degree

with kids in school, a busy family,

and a love for education . . .

thanks mom.

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DISSERTATION

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Nothing is more important to me than my faith and my family. My faith has driven me to do more and be more – line upon line, precept upon precept. So the thought of completing a PhD wasn't so formidable. In fact, it was foreordained. And throughout it all my family was by my side. A very special group of people that inspire, encourage, chastise, critique, and love. I thank them all for being such an important part of my life.

My work-family has also played an important part in my pursuit. These four years have been almost insufferable but they have given me strength and encouragement. You know who you are and I am grateful for all your support.

This work was completed only through the support and love of my 2005 cohort. An odd and unlikely group of intellectuals bound together in the crucible of academia. Doric, Deanie, Coby, Karen, Kathy, Sue, Tom, Brian, Dave, Nancy, Raoul, Kelly, and all the rest.

But most importantly, Dr. Doug Watson. A man that inspires me by word and action. His life's story should be told and someday I am sure someone will. But for me, he was the catalyst that fanned my expectations and has left an indelible mark on my life.

Early in my academic career, I had an instructor write on one of my more thoughtful papers, "You need to be more scholarly in your writing." I reject the notion. Much like a tree that falls in the forest, the unread and misunderstood writings of the brilliant are of little affect. While this may be a harsh criticism, it is this thought that has pushed me through the most difficult of times. I have hoped that my contribution to the field of hospital administration will not be overlooked but rather, considered. And not by the academic world

but by those that are in the hospitals, walking the floors, dealing with the challenges and trying to figure it all out.

Our profession is most certainly a life calling. The hours are long and the stress substantial but at the end of the day, we know that in some small way we have allowed our talents unlock the potential in those that have the clinical expertise to bless so many lives. We are behind the scenes doing those things that support our fellow health care workers in such a way that allows them to focus on the needs of the patient and their families. Nothing gives me greater joy than to know that others don't worry about the administrative minutia so they can focus their thoughts and prayers on caring for their patients.

I envision a profession of health care administrators that not only administrate but they lead. They lead by learning from the best and the brightest and using this new found knowledge to bless the lives of others. This has been the fuel that has driven my passion. If we could do something incredible. If we could change the basic fundamentals of a health care organization in such a way that is undeniable then perhaps others will take notice and learn.

Early in my career I was hoping to just survive. Midway through my career I wanted to change the face of health care. Frustrated with the blinding egotism of little fish in little ponds, I hoped to enter the end of my career on the national stage of HCA – the largest private hospital system in the world. And so we have taken a journey, although somewhat circuitous and unpredictable, we have demonstrated that health care organizations that take a balanced approach can not only succeed but demonstrate brilliance.

Medical City has done that. We have done that together and so hopefully others have noticed. They have noticed that by focusing our efforts, zealously so, on the patient's

experience, the employee's passion, the physician's expectations, and the needs of the community that the financial returns will be spectacular.

I fear, however, that our results are noticed but quickly dismissed. Perhaps, and perhaps not. Nonetheless, my dissertation is an attempt to document just a small portion of our work and in so doing inspire others to join in our passion.

Most sincerely

Britt Berrett

February, 2009

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The researcher is the president and chief executive officer of Medical City Dallas Hospital, a 705-bed acute care hospital located in the Dallas/Fort Worth metroplex. The transformation of this organization from mediocrity to excellence is the subject of this research. The hypothesis is that hospital performance improves when transformational leadership is utilized in strategic planning. The research chronicles the organization's transformational journey over the past eight years, including the creation of the Medical City Dallas Leadership System (MCDLS) placed within a strategic planning framework. In defining transformational leadership, the researcher categorized the results into seven attributes which were identified by an internal HCA study on high performing facilities. These attributes are defined as visionary leadership, consistent and effective communication, selection for fit and on-going staff development, agile and open culture, service is job one, constant recognition and community outreach, and hospital-physician leadership. The strategic planning was

categorized into seven phases which included: plan, input, analyze, prioritize, establish, deploy, and review. The comprehensive multi-year strategic planning process incorporated the elements of transformational leadership. The creation of mission, vision, and value statements was foundational to this work and provided clarity of organizational purpose and direction. Medical City Dallas Hospital developed five key indicators of success or the Five Keys to measure organizational performance against strategic planning structures and efforts. The creation and establishment of these elements is explained. The five key indicators are as follows: employee pride, physician engagement, patient loyalty, fiscal performance, and community involvement. The research confirmed a progressive improvement in results from 2000 through 2008 and demonstrated superior performance in comparison to other HCA facilities, HCA high performing facilities, and HCA North Texas hospitals. The research described and confirmed the presence of leadership behaviors as defined by transformational leadership theory. The incorporation of these behaviors in the strategic planning process was documented and the resulting achievements demonstrated superior organizational performance. This case study of Medical City Dallas Hospital confirmed the hypothesis that hospital performance does improve when transformational leadership behaviors are utilized in strategic planning.

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CHAPTER 1

INTRODUCTION

The delivery of health care in the United States is in a constant state of change as new technology, treatment protocols, demographic shifts, and societal expectations influence the manner in which health care is delivered (Atchison and Bujak 2001, 5; Seymour 2007, 2). Hospital care is the most significant and critical component of the almost $2 trillion health care industry, representing over 30 percent of all health care expenses (May 2006, 1). In response to this dynamic and complex environment, hospital leaders are required to develop plans and initiate change in new and innovative ways. This dissertation will explore the use of transformational leadership theory in executing a strategic plan in a hospital setting. Utilizing action research and case study methodology, the researcher, also the President and Chief Executive Officer of Medical City Dallas Hospital, will provide a unique evaluation and insight into the transformation of the performance of Medical City Dallas Hospital in the changing world of health care.

Medical City Dallas Hospital is a large and complex organization with 705 licensed pediatric and adult beds, 2,400 employees, 1,100 physicians, 355 volunteers, gross revenues in excess of $2.0 billion, two million square feet of office and hospital space, 23,000 annual hospital admissions, 59,000 annual emergency department visits, 8.4 million tests and procedures annually, the largest heart transplant program in the State of Texas (10th largest nationwide), and one of the largest cranio-facial programs in the world. It is a privately-owned member of the Hospital Corporation of America (HCA) and one of ten HCA hospitals

located throughout northern Texas. HCA operates 189 hospitals[1] and 92 freestanding surgery centers in 23 states, England, and Switzerland (HCA 2007). Recognized as a leader in hospital management, HCA is the largest privately-owned hospital system in the United States (Luke, Walston and Plummer 2004, 230), employing 200,000 health care professionals, and is the 84th largest company in the United States (Fortune 2007).

As the President and Chief Executive Officer of Medical City Dallas Hospital for the past eight years and with a total of 20 years of executive leadership responsibility in for-profit and nonprofit hospitals, numerous health care and community organizations, and federal, state and local health care initiatives, the researcher has a unique perspective for this dissertation. In light of these experiences and academic study, the researcher believes that a hospital executive has the opportunity to lead strategic planning and introduce leadership theory that will allow an organization to respond effectively in a dynamic and changing health care environment (Atchison 1990). The theory of transformational leadership provides the framework for moving an organization to a higher level of performance and a strategic plan establishes both the targets and the measurements to determine the levels of success.

In general, the action researcher will discuss the complexity of hospitals and will identify the key stakeholders within hospitals. These include patients, board of trustees, medical executive committees, medical staff department chairs, medical staff members, executive team members, leadership team members, supervisors, employees, volunteers, and corporate personnel. External stakeholders will be discussed only briefly due to the complexity of the health care industry. These include community agencies, third party

[1] Through the course of this study from 2000 through 2008, HCA acquired and divested no more than 20 different hospitals.

insurers, government agencies, and, regulatory agencies at both the state and federal levels. The identification of both internal and external stakeholders is important to establish the influences on leadership on the road to transformation.

The journey of transformation from mediocrity to excellence began for Medical City Dallas Hospital in 2000. Five areas were experiencing poor performance: patient loyalty, employee pride, physician engagement, fiscal performance, and community involvement. Performance standards in these areas are determined by external evaluations and by comparisons to the other 188 hospitals in the HCA chain.

For example, the results from the quarterly Gallup survey of patient satisfaction within the organization were poor. The Gallup Organization survey revealed fourth quartile patient satisfaction with significant complaints in the areas of employee responsiveness, cycle times, and billing processes (Gallup 2000). Limited resources were committed to addressing customer service issues and those provided were ineffectively utilized. With the exception of a brief guest service training program for new employees, the organization failed to invest in an organized plan of guest service education. Despite the depth of educational programs made available through the Gallup Organization, Medical City Dallas Hospital did not utilize these resources. Perhaps most disturbing was the obvious ambivalence both internally and externally to the status of patient satisfaction (Everly 2001).

At the same time in 2000, the Gallup Organization conducted an employee satisfaction survey that revealed that Medical City was in the bottom quartile in employee satisfaction among the 189 HCA hospitals (Gallup 2001). Gallup estimated that 38 percent of the employees were "actively disengaged." Gallup defines actively disengaged as employees that are "consistently against everything" (Coffman 2002, 1). Based on a study of

three million employees over a ten year period, Gallup concluded that employees falling within this category are not only unhappy at work but act out in ways that are counter-productive and destructive. The manifestation of a toxic work environment was reflected in excessive staffing shortages, utilization of significant contract or temporary personnel, and poor work results (Coffman 2002, 1). In 2000, all three were present at Medical City Dallas Hospital, as evidenced by the Gallup survey and performance measures.

Physician satisfaction was also extremely low, according to Healthstream Research and Data Management and Research, Inc. (Lagrone 2007). The external evaluation revealed that an aging medical staff was unwilling to welcome new physicians to the campus and resented any effort to recruit new specialists (Smith 2007). In addition, rumors circulated that physicians were resigning from the medical staff to pursue opportunities in the growing suburbs of the Dallas/Fort Worth metroplex (Smith 2007). The relocation of physicians to the growing suburbs caused a declining market share in key medical service lines at Medical City (Lagrone 2007). Where Medical City once stood as the second largest obstetrical service in Dallas, by 2000 deliveries had declined from 4,000 annually to 2,800. Total hospital patient admissions had declined from 24,966 in 1996 to 21,778 in 2000 (Calvert 2007). Most troubling was the eroding trust by the medical staff in the executive leadership of the hospital (Lagrone 2007; Rutherford 2007; Vernon 2007). This lack of trust apparently resulted from the excessive executive turnover since, in 2000, the fourth CEO was taking office within four years.

Declines in volume eroded financial performance as defined by operating margin and return on investment. HCA, which owned and operated nine other hospitals within the Dallas-Fort Worth region, observed declining performance at Medical City Dallas Hospital in

comparison to the other nine facilities. Capital investment in construction and equipment for Medical City Dallas was placed on hold because the organization was unable to develop an appropriate and acceptable strategic plan (Poteet 2000; S. Smith 2007).

Lonestar Research conducted a study that revealed that community awareness of Medical City was eighth among all area hospitals and that the hospital had no community service programs or activities in place. Despite being one of the major employers in the community, the hospital leadership participated in relatively few philanthropic and community service-oriented organizations.

In response to these challenging issues and trends, HCA executives appointed the researcher as the President/ Chief Executive Officer of Medical City Dallas Hospital with a specific mandate to improve the poor standing of the hospital, both internally and externally. This transition in leadership provided an opportunity to establish an organizational vision and implement measurement tools that would transform a marginally functioning organization into an organization of excellence.

The first step in the strategic planning journey was an assessment of the internal and external environment and the establishment of a new organizational vision and supporting goals and objectives identified as the "Five Key Indicators of Success." Through extensive meetings with staff, physicians, and corporate executives, the management team concluded that the indicators of performance success should be employee pride, physician engagement, patient loyalty, fiscal performance, and community involvement. The establishment of the mission, vision, and values and the creation of the Five Key Indicators of Success propelled the management and staff of Medical City Dallas Hospital in a direction with clarity and purpose by focusing on five specific measurements of organizational success and ignoring

the multitude of minor initiatives. This dissertation provides insight into the creation and development of a new vision and strategic planning initiatives for Medical City Dallas Hospital.

Throughout this journey, the researcher explored and embraced numerous theories on organizational change and leadership. An internal HCA study identified seven drivers or principles of success that were consistent with transformational leadership theory: visionary leadership; consistent and effective communication; select for fit and on-going development of staff; agile and open culture; service is job one; constant recognition and community support; and solid physician relationships (Wolf 2006, 1). The researcher explored the use of these transformational behaviors at Medical City Dallas Hospital in assessing the use of transformational leadership theory.

The creation of a strategic plan and planning process combined with transformational leadership behaviors was essential in the transition of the organization's culture from a toxic environment (Atchison 2006) to a positive and high achieving one. In 2004, HCA recognized the significant and demonstrable improvement in the performance of Medical City Dallas Hospital and classified the organization as a high performance facility (HPF) along with ten other hospitals in the HCA network of 189 hospitals. HPFs were recognized for high employee engagement; consistently high and improving patient satisfaction; superior performance as measured by the internally generated HCA Chief Nursing Officer report; low employee turnover; excellence in operating expense per adjusted patient days and adjusted admissions; and, superior overall financial performance (Wolf 2006,1).

In the same year, the *Dallas Business Journal* in its annual "Best Places to Work" competition acknowledged exceptional employee engagement at Medical City Dallas

Hospital when it selected Medical City as the best place to work in organizations with greater than 1,000 employees (Tanner 2004, 11B). The judges recognized the completion of a new on-site childcare center, family-friendly benefits, and a commitment by senior leadership to invest in employees.

One employee commented, "This leadership team is by far the most responsive, visionary, and forward-thinking group we've ever had. They fully walk and talk the mission/vision statement" (Tanner 2004, 11B).

In 2005, the American Nurses Association's Credentialing Center (ANCC) deemed Medical City a Magnet Nursing Hospital, the first in the North Texas region to receive this award and the 94th nationwide. The ANCC was the leading nursing credentialing center in the United States (American Nurses Credentialing Center 2007) and Magnet hospitals were considered as premier health care organizations. The designation as a Magnet Nursing Hospital was the culmination of organizational and operational preparation that concluded with a five-day on-site evaluation by accredited surveyors.

In 2006, Medical City Dallas Hospital received the prestigious Texas Award for Performance Excellence which recognized organizations throughout Texas for superior operational structure and performance (Texas Quality 2007). Of the 453 licensed hospitals in the state of Texas, only one other had achieved this recognition. The Texas Award for Performance Excellence was recognized as the state-level equivalent of the esteemed Malcolm Baldrige National Quality Award. As of 2008, Medical City Dallas Hospital had applied twice for the Baldrige Award and anticipates joining only seven other hospitals nationwide as recipients of this award.

In conclusion, in the dynamic world of health care, hospitals were challenged to respond to external and internal changes that influenced the delivery of care. The experiences of Medical City Dallas Hospital served as a source of new insight and perspective as this urban quaternary hospital transitioned from a toxic work environment to an organization recognized for operational excellence. The uniqueness of this research conducted by the president and chief executive officer, utilizing action research and case study methodology, provides new knowledge to the profession of hospital administration in the fields of strategic planning and transformational leadership theory.

Background

Health care in the United States is unique and distinct from other health care systems throughout the world. Based on a market system in an affluent, industrialized economy, it stands alone with South Africa as the only industrialized nations lacking universal access and coverage (Barton 2007, 3). Cultural, political, and economic values shape a health service system (Starr 1982, 8). The market-based nature of the U.S. health care system thus embraces business structures and theories to respond to a changing and dynamic environment (Starr 1982, 428; Barton 2007, 3). The transformation of the health care industry is well-documented (Starr 1982, 428) as health care systems and organizations consolidate ownership and control. Much like other industries, health care has evolved into "an industry dominated by huge health care conglomerates" (Starr 1982, 428).

The health care sector influences all other segments of the U.S. economy. Boris and Steuerle (2006, 72) estimate that in the nonprofit sector 60 percent of all expenses of reporting charities are related to health care organizations. Current estimates place government sector spending on Medicare in excess of $420 billion and total public funding at

$914 billion (May 2006, 1). The entire health care sector exceeds $2 trillion and is 16.5% of the Gross Domestic Product. Clearly, the health care sector is large and intertwined with all other sectors of society.

The large and influential health care sector affects all other segments of the economy and, therefore, the management of healthcare organizations demands fiscal discipline and operational excellence. More specifically, health care organizations function in a constantly evolving environment and must respond to dynamic change purposefully and strategically. Traditional planning in health care is not a new concept and continues to receive attention and participation by health care professionals (Martin and Kettner 1996, 3). However, well-intentioned theorists that challenge the wisdom of blending business practices, specifically strategic planning, with social services, have subverted the discipline of moving traditional health care planning to the next level of strategic planning. The literature suggests that the reluctance to embrace business principles is diminishing (Arndt and Bigelow 2000, 339; Begun, Hamilton and Kaissi 2005, 265; Hambrick 1981, 275; Judge and Zeithaml 1992, 48; Perlin 1972, 62; Thompson 1998).

Hospitals have emerged from the nonprofit sector as a network of charitable homes for the destitute and infirm to multi-billion dollar complex organizations that are strongly linked with the nonprofit, business, and government sectors (Tipping 1914, 98; Tuckman and Chang 2006, 630; Walsh 1915, 19). The emergence of for-profit hospitals began in the 1980's as entrepreneurs recognized the economic advantage of improved efficiency in hospital care (Luke, Walston and Plummer 2004, 227). Three major for-profit companies, HCA, Humana, and Columbia, represented the bulk of proprietary hospitals and comprised only ten percent of total hospitals nationwide (Bays 1983, 850). By 2006, of the 4,927 acute

care hospitals in the United States, the number of for-profit hospitals rose to 899 or 18 percent of total hospitals (May 2007, 18).

The suggested discrepancy in quality of care between for-profit and nonprofit health care is driven by prevailing public attitudes and beliefs that are in sharp variance with the evidence "about the relative performance of nonprofit and for-profit health-care providers" (Schlesinger and Gray 2006, 378). The professional and academic literature on profit versus nonprofit performance in healthcare is extensive (Schlesinger and Gray 2006, 378). Despite public atttitudes, the performance of hospitals is comparable enough in the for-profit and nonprofit sectors to draw conclusions that are applicable (Sloan, et al. 2001, 1).

Clearly, all hospitals function in a rapidly changing economic landscape that continues to influence the delivery of health care services. A review of the historical context confirms that the health services system changed as "the economic and political systems of the country evolved" (Barton 2007, 5). Spiraling health care costs, local government involvement, federal government intervention, and the emergence of managed competition have transformed hospital care into a dynamic, market-driven industry, according to Luke, Walston and Plummer (2004, 6).

Hospitals operate with varying degrees of effectiveness and success (Cleverly, Cleverly and LaFortune 2006, 10) dependent to a large degree on the quality of management, staff, and physician care. Current literature recognizes the need to engage in more disciplined and structured planning that will allow hospitals to move purposefully and strategically in an ever-changing health care environment. Understanding and implementing strategic planning will allow hospital administrators to respond more effectively to the cultural, economical, and political values of the market driven health care system of the United States of America

(Atchison and Bujak 2001, vii; Luke, Walston and Plummer 2004, 6; Spath 2005, 2; Zuckerman 2005, 1).

Strategic Planning

Strategic planning in the business sector is clear and concise, "to win the customer's preference and create a sustainable competitive advantage, while leaving sufficient money on the table for shareholders" (Bossidy and Charan 2002, 178). While other definitions exist (Bourgeois, Duhaime and Stimpert 1999, 11; Mintzberg 1994, 23-29; Schendel and Schendel 1979), core to a strategic plan is a set of goals, tactics, objectives, and strategies that move the organization from one state of being to the next in the midst of change. Michael Porter (1980, xiii), one of the preeminent and early authors on strategic planning, states "there are significant benefits to gain through an explicit process of formulating strategy, to insure that at least the policies (if not the actions) of functional departments are coordinated and directed at some common set of goals."

To that end, strategic planning at Medical City Dallas Hospital combined normative and empirical assessment tools and theories in combination with the previously identified Five Key Indicators of Success. The planning process deployed was comprised of seven identifiable steps. The first six of which were the following: plan, input, analyze, prioritize, establish and deploy. The seventh and perhaps most important step was the evaluative or review process that occurred throughout the execution of the plan. This evaluative process allowed the organization to examine itself through the previously identified steps, creating a dynamic planning process.

Utilizing subject matter experts and an extensive organizational structure, the 10-week planning process produced a comprehensive plan that embraced the Five Key

Indicators of Success. In alignment with the mission, vision, and values of the organization, this process allowed Medical City Dallas Hospital to create a strategic plan that measured operational performance. More importantly, the Medical City Dallas Hospital strategic plan provided the framework and measurements to assess the effectiveness of the introduction of transformational leadership theories in achieving organizational success.

Transformational Leadership

Leadership theory plays an important role in strategic planning as leaders direct and guide organizational and human resources toward the objectives of the organization and ensure that the organizational functions are aligned (Antonakis, Cianciolo and Sternberg 2004, 5). Since the turn of the century, the study of leadership theory included five major schools of thought based on chronology (a specific time period) and scholarly inquiry (the degree of research interest during a period of time). These included: trait; behavioral; contingency, contextual or situational; transactional, and new leadership or transformational (Antonakis, Cianciolo and Sternberg 2004, 6).

Emerging from these numerous schools of theory was the uniqueness of transformational leadership theory. In contrast to transactional leadership theory that posits that leaders and followers enter into transactional relationships to effect change, transformational leadership theorists suggest that leaders inspire and motivate followers to pursue outcomes centered on a sense of purpose and an idealized mission (Sashkin 2004, 173). According to Kouzes and Posner (2002, 153), this type of leadership is commonly referred to as visionary, charismatic, and inspirational. Interest in this school of theory is intense as researchers attempt to understand why some organizations create high-performing

work environments and experiences and others exist in organizations that can only be described as toxic (Atchison 2006, 2).

While numerous theorists comment on the nature of transformational leadership (Bass 1985; Bennis 1984, 14; Kouzes and Posner 2002; Kotter 1996), James MacGregor Burns (1978) is recognized for his early work that led to the study of what is referred to as transformational leadership (Antonakis, Cianciolo and Sternberg 2004, 1973). Transforming leaders empower individuals and organizations to embrace the mission and vision. By so doing, leaders champion and inspire their followers (Burns, 2003, 26). The nature of this change is important as transformational leaders engage in activities that not merely change the performance but, in fact, change the very essence of the organization.

According to Burns (2003, 2), although there may be no grand or unifying theory to provide common direction for researchers on transformational leadership, most scholars agree that central to the practice of transformational leadership is the creation of a "vision" (Antonakis, Cianciolo and Sternberg 2004, 194). A vision is an organizational goal or state of being that transcends previously held conceptual frameworks (Kouzes and Posner 2002, 118,130).

In the case of Medical City Dallas Hospital, transformational leadership theory is consistent with the literature that describes a leadership theory that is needed when "a business is adrift . . . and in dire need of a fresh vision" (Goleman, Boyatzis and McKee 2002, 59). HCA, the parent corporation of Medical City Dallas Hospital, recognized the dynamic health care environment and the need to research the effectiveness of hospital leadership (Hatcher 2008). They attempted to identify characteristics of superior performance in their 189 health care facilities. In 2006, an internal report (Wolf 2006) identified eleven

high performing faciliites and their unique characteristics. The researchers listed seven behaviors identified in these high performing facilities (HPFs). These included: visionary leadership, consistent and effective communication, select for fit and ongoing development of staff, agile and open culture, service is job one, constant recognition and community outreach, and solid physician relations. The presence of these characteristics defined an HCA hospital as a high performing facility.

The literature on transformational leadership aligned with the characterstics identified in the HCA study and thereby was the framework and definition utilized to explore transformational leadership at Medical City Dallas Hospital. Combining these behaviors with the creation and execution of strategic planning provided a contextual framework to study their influence and impact on the strategic planning activities. Lastly, the establishment of the Five Keys provided operational measurements to assess the effectiveness of utilizing transformational leadership behaviors in the execution of a strategic plan.

Research Questions and Hypotheses

This dissertation addresses the following research question and proposes the following hypothesis.

Research Question: Can the use of transformational leadership theory influence the effectiveness of strategic planning in hospitals?

Hypothesis: H1: Hospital performance improves when transformational leadership is utilized in strategic planning.

Methodology

This dissertation will use action research to explore the impact of transformational leadership theory in strategic planning efforts to improve the operations of Medical City

Dallas Hospital. The description of the active involvement of the chief executive officer of Medical City Dallas Hospital in introducing transformational leadership theory in order to develop and execute strategic initiatives will create new insight and knowledge in the field of hospital administration.

In the literature, there are three different approaches to overall research: technical and empirical research, interpretive research, and critical theoretical research, according to McNiff and Whitehead (2006, 40). The first category, technical and empirical research, is characteristically scientific inquiry and the disciplines of physical sciences, medicine, and engineering universally embrace it. Researchers utilizing this methodology maintain objectivity in order to avoid human contamination through researcher contact and pursue aggressively causal relationships and duplication of results. Statistical analysis, empirical evaluation, and replicability are all cornerstones of this school of scientific inquiry (McNiff and Whitehead 2006, 40).

A second area of research methodology is interpretive research. Social sciences researchers often embrace this research methodology due to the unique and qualitative nature of human interaction. Researchers observe people in their natural environments and attempt to describe and explain their behaviors. The qualitative nature of the analysis of the data requires the researcher to tell the story of what is being observed. The researcher continues to retain objectivity by not engaging in the subject of study; nonetheless, the researcher is apt to insert values within the research process. For this reason, disciples of traditional or technical research consider interpretive research as soft and insufficient (McNiff and Whitehead 2006, 40).

Action research fits into the third category, namely critical theoretical research from which it was borne. The emergence of action research in the social sciences of the 21st century reflects the recognition of both academician and practitioner that a chasm exists between objective, analytical research and personal, experiential learning (Coghlan and Brannick 2005, 3; Greenwood and Levin 2007, 5). While impartial and objective, traditional research observes and theorizes on events that one can see but not experience. The intimacy of actual engagement in the events and behaviors presents unique ethical dilemmas but provides distinctive insight into the social sciences (McNiff and Whitehead 2006, 8; O'Brien 1998, 3). Action research attempts to bridge this divide by contributing to the body of intellectual inquiry and knowledge while responding to the immediate practical concerns of practitioners within an acceptable ethical framework (Rapoport 1970, 499). By so doing, action research centers on exploring and creating knowledge that is useful to people in everyday life, which is self-reflective and revealing, and focuses on the dynamics of on-going real life experiences (Reason and Bradbury 2001, 2).

Context plays an important role for action researchers as they draw in both quantitative and qualitative data in order to draw conclusions for the creation of new knowledge (Coghlan and Brannick 2005, 10; McNiff and Whitehead 2006, 42). The pure critical theorist recognizes that interpretive theory accepts the influence of biases and values in the creation of research conclusions. As such, critical theory researchers refuse to become personally involved to influence the results or nature of the research. Action researchers, however, embrace the values and biases of individuals as part of the research process. They actively engage in influencing the results of the research (Coghlan and Brannick 2005, 7).

Action research places a human and personal viewpoint on research that is both organizationally internal and personally insightful. Action research requires the researcher to be situated, reflective, and explicit about the perspective from which knowledge is created (Coghlan 2007, 51). Action research is only possible by persons and communities, ideally actual stakeholders, in questioning and challenging in a manner that leads to research and new knowledge.

Action researchers are a new breed of researchers that seek answers to perplexing, real life challenges of day-to-day life. Practitioner knowledge is central to practical and theoretical sustainability (McNiff and Whitehead 2006, 18). However, the practitioner possesses a curiosity and interest in exploring the answers to vexing questions. Answering work life questions is not enough. The action researcher observes, reflects, conceptualizes, implements, and evaluates in an evolutionary process rooted in every day experiences (Coghlan 2007, 15). Determining what is worthy of attention is a form of inquiry in its own right that reflects the values of the researcher, according to Coghlan (2007, 35).

Practitioners possess unique perspectives and experiential portfolios that make their observations valid and important. Confirming the value of these interpretations and the competency of these professionals is central to action research (Coghlan and Brannick 2005, 60). Practitioners create critical information as they conduct the day-to-day activities that generate invaluable data. These real-life experiences involve the practitioner in problem solving that is not designed, executed, or assessed as part of an integrated research effort. In a word, these activities are chaotic. Clearly, practitioners struggle with the challenges and activities that represent the real-life world of organizational change without defined frameworks or proven theories (Brannick and Coughlan 2007, 59; Coghlan and Brannick

2005, 13, 33; McNiff and Whitehead 2006, 21). The researcher determines personal and organizational values that are worthy of further investigation and consideration. In so doing, the action researcher reveals individual values and places those values in plain sight for further scrutiny, criticism, and evaluation.

Organizations evolve through a series of phases and experiential challenges, victories, and defeats. Through this course of change, good action research emerges in an evolutionary and developmental process (Coghlan 2007, 15). Researchers note changes within the organization and diligently attempt to create understanding and new knowledge by exploring the nature of these changes. Referred to as the "father of organization development," Lewin is recognized as one of the preeminent scholars in the field of action research (McNiff and Whitehead 2006, 19; Clark 2000, 1). Lewin suggests that all members of a workforce are participants and collaborators in planning, implementing, evaluating, and modifying organizational strategies. As such, they possess invaluable perspective, insight, and credibility in discussing the dynamics of organizational change (Lewin 1946, 36).

Lewin (1946) uses as a foundation for his writings the theory and process of organizational development in an effort to better understand organizational dynamics. By inviting practitioners to explore self-reflectively organizational dynamics, Lewin was able to provoke intriguing perspective and insight that was previously unexplored by academic researchers.

Lewin's earlier work on organizational behavior and study of group dynamics is the basis for the emergence of action research as a viable scientific course of study. His research confirms that learning is best facilitated when there is a conflict between real life experiences

and detached analysis within the individual (Clark 2000, 1). Intriguing to note is the realization that action research demands tremendous critical self-assessment and insight.

Lewin's model follows similar process improvement theories that depict an iterative process of experiences, observations, and reflections. Due to the unique first-person experience of action researchers, the observations and reflections are distinctive and heavily laden with personal values. Nonetheless, these observations are the framework and raw data for the formation of abstract concepts of generalization.

The researcher expands the role from spectator to action researcher by contextualizing these observations into current and new situations. By so doing, the researcher is able to add greater knowledge to the field of study and provide insight for future researchers. The researcher repeats this process not only to establish new knowledge but also to create conceptual frameworks for future inquiry.

Some may argue that pure academic research is able subjectively and thoroughly to observe, while others recognize that the chaos of organizational change can only be explained by those involved in the commotion. McNiff and Whitehead (2006, 8) refer to academic researchers as spectator researchers that are not individually involved or distracted by personal involvement. Action researchers are insiders that have a better understanding of the dynamics of an organization and possess context and perspective that may not be apparent to the sideline observer. While much of this insider information may be intuitive or obvious to the action researcher, many times it is unseen, unnoticed, or unappreciated by the spectator researcher (McNiff and Whitehead 2006, 17, 33).

The third aspect of action research demands explicit observations and conclusions. It is not enough to be personally involved in organizational dynamics. The action researcher is

required openly to make observations and draw conclusions. Coghlan (2007) points out that the term "openly" is purposefully presented due to the recognition that action researchers and action research present observations and conclusions that are available for scrutiny and criticism. The academic researcher is able to observe and conclude with detachment. The action researcher is part of the organization and hence, part of the observations and conclusions (Coghlan 2007, 1). The search for new knowledge requires practical knowledge and unique perspectives and information on how to work with individuals and groups in everyday life. Clearly, action research is participative research and participative research must be action research (Coghlan 2007, 9).

One last issue requiring attention and consideration in action research is the ethical dilemmas and resultant boundaries necessary to conduct action research. The far-removed observational research, which occurs in most academic research, is partially shielded from the day-to-day dilemmas of personal involvement. Action research, however, demands attentiveness to the influence of the researcher in gathering new knowledge. The traditional researcher may ask, "How does a hospital improve organizational performance?" Through observation and data-gathering, theories are generated and conclusions drawn. In the case of action research, the participant asks, "How do I improve organizational performance?" and "What have I done and what will I do to influence the outcomes of this research?" Within the personal nature of this inquiry rests a vexing dilemma of influencing behavior and outcomes in the pursuit of creating knowledge (McNiff and Whitehead 2006, 8).

Further, questions of anonymity and confidentiality appear as significant and real deterrents to translating real-life experiences into knowledge. Aspiring and unprepared researchers are susceptible to embarking on action research that may compromise the

anonymity and confidentiality of participants. In addition, action research creates a vehicle for researchers to influence personal and organizational behavior that may be vulnerable to the personal interests of the researcher (McNiff and Whitehead 2006, 207).

Adding new, worthwhile, and pertinent information is possible through the engagement and involvement of participants. While this is most certainly true, action researchers are cautioned that anonymity, transparency, confidentiality, and personal agendas can create ethical dilemmas for individuals exploring real life experiences and seeking to add new knowledge for future researchers to consider (Coghlan and Brannick 2005, 77, 80; McNiff and Whitehead 2006, 86). Rapoport (1970, 499) describes action research as engaging both the practitioner and the academician within a mutually acceptable ethical framework. Further, action research is an emerging process of inquiry that applies behavioral science knowledge within existing organizational frameworks to solve real organizational issues. Lastly, action research allows organizations to develop self-help competencies while adding to the body of scientific knowledge (Shani and Pasmore 1985, 439).

In summary, then, action research is an evolutionary research methodology that embraces practitioners in the pursuit and creation of new knowledge (McNiff and Whitehead 2006, 1). The impersonal nature of technical research is due to an inability to function within organizational chaos. On the other hand, the social sciences readily embrace interpretive research, recognizing that values and biases influenced observations and conclusions. Action research emerges from the field of critical theoretical research that studies social situations created by people with a keen focus on interpersonal and interrelationship dynamics (McNiff and Whitehead 2006, 42).

Combining action research with case study methodology is complementary. The use of case studies continues to be an acceptable and effective means of conducting social science research (Yin 2003, xiii). The use of case studies is preferred when the "how" or "why" is questioned in a complex environment, when the researcher has little control over the events, and when the focus is on contemporary phenomenon within real-life situations (Yin 2003, 1). Medical City Dallas Hospital existed in the complex and dynamic field of health care and was experiencing internal and external influences that affected its organizational performance. As a result, it was an ideal subject for a case study.

The use of a case study provides understanding within this complex social phenomenon and allows the retention of meaning and understanding of real-life events. Case study research allows the researcher to take on specific strategies to gather new knowledge. These strategies include ones that are either exploratory, descriptive, or explanatory (Yin 2003, 3). In this dissertation, by combining an exploratory case study methodology with action research, the knowledge created provides insight for future exploration of transformational leadership theory in executing strategic plans.

In order to ensure the validity of the case study, the author outlined three issues beginning with construct validity. The successful determination of organizational transformation was a difficult and challenging endeavor. How does one conclude that an organization has actually moved from one state of performance to another level? In 2000, the executive leadership at Medical City Dallas Hospital posed the same question and concluded that the creation of Five Key Indicators of Success was essential. To that end, five parameters were outlined which included employee pride, physician engagement, patient

loyalty, financial performance, and community involvement. These success measures determined a framework to quantify organizational success.

A second issue in constructing this case study was ensuring internal validity (Yin 2003, 36). By examining the influence of each of the indicators on overall organizational performance, the researcher in this case study examined the possible influence of these measures on overall performance and their interdependence. The focus on these five indicators was a unique aspect of this research and was the foundation of this dissertation. Nonetheless, internal validity remained a concern as the likelihood of bias and unfounded causal conclusions were possible by the action researcher.

Ensuring external validity posed one of the most important aspects of this research. Medical City Dallas Hospital, part of a 189-hospital system, established itself as a high performing organization within that system and among the broader community of hospitals. High performing hospitals met a predetermined set of criteria and performance standards created by HCA. HCA utilized this classification to determine the characteristics of top performing organizations (Wolf 2006, 1). It established external validity within HCA and assumed it was applicable to the hospital industry as a whole.

Lastly, research reliability was established by trending and confirming specific data points. The unique and qualitative nature of transformational leadership made this aspect of the case study more difficult to ensure. Action research recognized this quandary and insisted upon research discipline to expose behaviors and activities to displace value-laden observations with factual and measurable evidence (Coghlan and Brannick 2005, 29).

Case study methodology, when conducted with discipline and objectivity, provides a unique and insightful glimpse into organizational change. Combining action research with

case study methodology is consistent with similar research in the social sciences. This case study of Medical City Dallas Hospital, conducted by the chief executive officer, presents a unique opportunity to explore the impact of transformational leadership in executing a strategic plan.

Work Plan

The work plan for this study includes an outline of the strategic planning processes utilized by Medical City Dallas Hospital and describes the key elements in comparison to current literature on the subject. In-depth interviews and comparative of other HCA hospitals provides insight into the creation of the plan at Medical City Dallas Hospital. The strategic planning work resulted in the establishment in 2000 of the Five Key Indicators of Success – employee pride, physician engagement, patient loyalty, fiscal performance, and community involvement. While numerous external measurements of success were available throughout the industry, the use of these measurement tools was unique to Medical City Dallas Hospital. Importantly, the use of these Five Key Indicators of Success created measureable performance criteria to evaluate the effectiveness of the strategic planning efforts.

The researcher evaluated the use of transformational leadership theory in implementing the strategic plan. Disagreement still exists in defining specific behaviors of transformational leadership theory. For this reason, the researcher utilized the seven characteristics identified in a study conducted by HCA on high performing hospitals to define transformational leadership behavior. The manifestation of these characteristics at Medical City Dallas Hospital was examined and the researcher provided intimate insight into the introduction and utilization of these behaviors.

The literature review includes challenges to the effectiveness and value of transformational leadership behavior. This study focuses on the influence of these behaviors in realizing the organizational objectives in a hospital setting. The researcher explored and assessed the effectiveness of transformational leadership behavior in strategic planning and how these behaviors influenced the attainment of the organizational objectives as outlined in the hospital strategic plan.

Clearly, the value of action research in this study is the intimate and personal evaluation of the performance of the organization by the chief executive officer. The research recognized the influence of personal values and biases. This research adds to the body of knowledge in the field of hospital administration and provides keen insight for other health care professionals.

In conclusion, this dissertation was a case study of Medical City Dallas Hospital and the use of transformational leadership theory in the development and implementation of a strategic plan. Action research provides the tools to explore the impact of transformational leadership in executing this strategic plan and the case study methodology provides insight into the Medical City Dallas Hospital experience.

Organization of Study

This dissertation is comprised of seven chapters. Chapter One provides a general background and overview of the dynamic health care industry, the challenges facing Medical City, the creation of measurement tools as part of the strategic planning process, and the history of strategic planning in organizations in general and, more specifically, in hospitals. Chapter One also includes a brief presentation of transformational leadership theory and the

definition of the characteristics identified by an internal HCA study. The research question and theoretical hypotheses upon which this study is conducted are stated.

Chapter Two focuses on the literature on transformational leadership theory and strategic planning. Included is the battle between scholars on the actual effectiveness of transformational behavior and the disagreement that exists in the field on this topic. In order to clarify the terminology, an internal HCA study identifies seven characteristics of high performing hospitals. These behaviors are consistent with transformational leadership theory and their manifestation at Medical City Dallas Hospital is identified. The use of strategic planning in the hospital industry is also described as hospital administrators reluctantly accept the responsibility to address organizational objectives in a dynamic health care environment.

Chapter Three describes Medical City's history, issues, challenges, and performance. An internal scan identifies key influencing issues in the creation of the mission, vision, values, and strategic plan and the elements of measureable goals and objectives. The creation of the Five Key Indicators of Success is an important and unique characteristic of Medical City Dallas Hospital. Organizational achievements highlight the journey from a toxic work environment into a high-performing, award-winning hospital.

Chapter Four describes how the alignment of the strategic plan with transformational leadership behaviors enhanced and improved the performance of Medical City Dallas Hospital. Interviews with key stakeholders provide insight into transformational behaviors and how these activities are designed, developed, and executed. The Medical City Dallas Leadership System (MCDLS) is discussed as a framework for the introduction of transformational behavior. The alignment of these behaviors with overall organizational

performance as measured by the Five Indicators of Success provides new knowledge in the field of transformational leadership in hospital administration.

Chapter Five provides a review of the history of strategic planning at Medical City Dallas Hospital and outlines how a more disciplined and theory-driven approach was taken to move the organization to a higher level of performance. The seven steps of the strategic plan are outlined and the uses of behaviors aligned with the theory of transformational leadership were utilized.

Chapter Six concludes with findings that are unique to Medical City Dallas Hospital regarding the presence of transformational leadership behavior as evaluated by the leadership and several external organizations. Outcome performance related to the Five Key Indicators of Success in comparison to other HCA hospital groups highlights the accomplishments of this hospital. These groupings include twelve large level-F hospitals with net revenues in excess of $300 million located throughout the United States, eleven high performing hospitals identified in an internal assessment, and ten hospitals located within the North Texas Region.

Chapter Seven provides concluding comments and observations on the influence of transformational leadership in hospitals and the health care environment. These conclusions align with the precepts of action research that call upon researchers to provide perspective that is intimate and introspective. These conclusions, while unique to the case study of Medical City Dallas Hospital, are insightful and may be applicable to other hospitals and health care organizations.

By combining research on hospital strategic planning and the presence of a new leadership paradigm, specifically transformational leadership, the author provides unique

insight into hospital leadership. The personal nature of this research provides a unique perspective and knowledge to the field of hospital administration and the study of transformational leadership. The National Center for Healthcare Leadership (2007, 5) has asked as much when it states in its publication entitled "Transformational Excellence: The Key to Tomorrow's Healthcare Leaders," "If healthcare is going to successfully confront the challenges of a complex, rapidly changing environment, then it will need forward-thinking, insightful, and highly competent leaders who are prepared to transform the industry."

CHAPTER 2

LITERATURE REVIEW: LEADERSHIP AND STRATEGIC PLANNING

The literature on leadership theory and strategic planning are relatively contemporary constructs that have evolved from more fundamental beginnings in the study of leaders and the study of planning. This literature review outlines the emergence of transformational leadership theory and the acceptance of strategic planning in health care and hospital planning. By tracing their evolution into the 21st century, this researcher is able to outline how their intersection provides theoretical frameworks to describe leadership behaviors and their influence on planning efforts at Medical City Dallas Hospital.

Leadership Theory

Originally, the leader was defined as the "head of state," "king," "magistrate," or "military commander" (Bass 1995, 37). The history of the term "leader" extends as far back as Old and New Testament stories of prophets, priests, chiefs, and kings (Bass 1990, 3). Other greats, such as Shakespeare and Tennyson, Asoka and Confucius, Plato and Aristotle, Pharaohs and Greek heroes, ruminated on the role, characteristics, and nature of the leader (Bass 1995, 50; Burns 2003, 7; Maruik 2001, 4; Northouse 2007, 15). Historically, one thing is clear: the leader's position differentiates the ruler from the other members of society.

The term "leadership," however, is a relatively new addition to the English language. It appears only within the last 200 years (Yukl 1981, 3) and denotes a set of characteristics or behaviors unique to a leader. A survey conducted by Burns (1995, 9) identified over 130 definitions of leadership and the world-famous New York Public Libraries has tens of

thousands of biographies, monographs, and newspaper clippings on leaders (Burns 1995, 10). Warren Bennis (1959, 259) observed about leadership as follows: "Always, it seems, the concept of leadership eludes us or turns up in another form to taunt us again with its slipperiness and complexity. So we have invented an endless proliferation of terms to deal with it . . . and still the concept is not sufficiently defined."

Contemporary leadership theory can be divided into five overlapping periods: the trait period (1920's to 1940's), the behavior period (1940's to 1960's), the contingency/situational period (1960's to current), the transactional period (1970's), and most recently, the establishment of transformational leadership period (Antonakis, Cianciolo and Sternberg 2004, 3; Chemers 1995, 83; Van Maurik 2001, 2).

Trait Theory

Trait theorists of the 1920's defined a leader as one endowed with superior characteristics and traits that differentiate him or her from the followers. The conventional wisdom during this period held that "history is handmaiden to men; great men actually change the shape and direction of history" (VanWart 2005, 5). The common reference to the "great man" perspective (Antonakis, Cianciolo and Sternberg 2004, 6) ascribed the shaping of history by exceptionally gifted individuals with certain dispositional characteristics (Zaccaro, Kemp and Bader 2004, 101).

In their research, trait theorists attempted to identify traits that distinguish leaders from their followers and the extent of those differences. The study of traits most prominent in early literature include physical characteristics (e.g., height, appearance, energy level), personality (e.g. self-esteem, dominance, emotional stability), and ability (verbal fluency, intelligence, originality, social insight) (Yukl 1981, 67). Van Maurik (2001, 4), in one of the

early studies, attempted to identify superior performers in industry and business and concluded that the single unique characteristic is that they are tall.

Critics of this school of theory realized that leadership traits that are effective on the battlefield or in public life generally are not necessarily the same as those of a senior researcher in a laboratory (Chemers 1995, 84). In a review on the literature on the topic, Stogdill (1948, 64) concluded: "a person does not become a leader by virtue of the possession of some combination of traits, . . . the pattern of personal characteristics of the leader must bear some relevant relationshp to characteristics, activities, and goals of the followers."

Nonetheless, in th early decades of the 20th century, research on leadership focused on trait theory and the identification of certain traits that differentiated leaders from nonleaders (Antonakis, Cianciolo and Sternberg 2004, 6). Covey (2004, 353) identified a number of leading scholars who wrote on trait theory in the first three decades of the 20 th century: L.L. Barnard, Chester Bingham, C.E. Kilbourne, Shelley Kirkpatrick, Edwin A. Locke, Samuel Kohs, K.W. Irle, James Page, and Ordway Tead.

Today, theorists continue to consider the question of whether a leader is born rather than made and explore specific traits exhibited by contemporary leaders. Sir Bernard Ingham, president of the British Franchise Association, in a 2001 interview, attributed the success of Margaret Thatcher to five qualities or traits including ideological security, moral courage, constancy, iron will, and a low need for love (Van Maurik 2001, 5). Some have even hinted at the existence of a leadership gene (Van Maurik 2001, 5). While not a commonly accepted contemporary theory on leadership, trait theory continued to emerge as theorists grapple with the question of leadership.

Behavior Theory

By the 1940's, behaviorists looked to characteristics of the individual and presented a range of leadership styles (Van Maurik 2001, 10). The shift from a leader's traits to how a leader behaves marked the beginning of behavioral theory in the study of leadership (VanWart 2005, 313). The "great man" theory's appeal evaporated as theorists listed the range of leadership styles available to a manager. Some were so bold as to list ten to thirty identifiable behaviors that are observable in a leader's activities (VanWart 2005, 22).

Fueled by the sudden entry of the United States of America into the Second World War, the military needed to train officers and non-commissioned officers as quickly and effectively as possible (Van Maurik 2001, 7). As a result, the military presumed that leadership could be taught and engaged theorists to focus on the ideal type of leadership behaviors. Several major teaching universities explored these behaviors and attempted to classify specific leader activities.

Work by researchers from both The Ohio State University and the University of Michigan provided a large-scale, comprehensive analysis of leadership behaviors. The Ohio State researchers broadly defined two categories of behavior: employee-oriented leadership and production-oriented leadership (Antonakis, Cianciolo and Sternberg 2004, 7; Hunt 2004, 33; Schriesheim and Kerr 1976, 19; VanWart 2005, 23; Yukl 1981, 106). Their continuing work in the 1950's analyzed 1,500 tasks and distilled these behaviors into two overarching leadership categories: consideration and initiating structures.

The University of Michigan study also categorized leadership behaviors but emphasized relations–oriented behaviors that included helpfulness, trust, thoughtfulness, delegation, and recognition. The Michigan study added a third category, namely

participative leadership. Participative leadership was described as emphasizing "managing group processes constructively, especially information flow, meetings, and decision-making" (Van Wart 2005, 191). The intent of these two studies was to discover a pattern of leadership behavior that leads to effective group performance (Schriesheim and Kerr 1976, 27; Yukl 1981, 113).

Robert Blake and Jane Mouton (1965) built on these earlier works and presented one of the first theories utilizing a new behavioral orientation to leadership (see Figure 1). The key measure of their managerial grid was that leaders are evaluated on a behavioral continuum utilizing two independent dimensions, which are a concern for people and a concern for production. Further, this evaluative tool demonstrated that some leaders exhibit both types of behaviors at the same time with varying levels of activity while others function with little or no regard for either (Van Maurik 2001, 11).

Henry Mintzberg (1973) added to the study of behavioral leadership theory by defining leadership roles that exist within a team such as figurehead, leader, liaison, monitor, disseminator, spokesperson, entrepreneur, disturbance handler, resource allocator, and negotiator. Mintzburg's work highlighted another emerging aspect in the study of leadership, specifically the differentiation between manager and leader. More contemporary theorists, such as Atchison, Covey, and Kotter, explored this difference in greater detail. Mintzberg suggested that leadership is but one of the many roles of the manager (Hunt 2004, 26).

Other notable theorists contributing to this body of research included George C. Homans, Wallace Kahn, Robert E. Quinn, Steven Kerr, John Jermier, Martin J. Osborn, and James G. Hunt. Despite the diminishing interest in the study of behavioral leadership theory,

many of these components are foundational in the study of transformational leadership theories.

Contingency Theory

By the 1960's, leadership theorists began to focus on the situation and environment in which a leader functions (Antonakis, Cianciolo and Sternberg 2004, 7). Contingency theorists answered the "one best way" approach to leadership by embracing situational parameters in the leadership equation (Chemers 1995, 86). They concluded that different situations require different kinds of leadership (Northouse 2007, 91).

Three features of the situation include leader-member relations, task structure, and position power (Schriesheim and Kerr 1976, 10). Contingency-oriented leadership theories also addressed the relationship of leadership decision-making style as it relates to group performance and morale. Consideration of numerous variables in the development of leadership theory was fundamental to contingency or situational theories (VanWart 2008, 30). But the enormity of variables created a vast body of theory and research which included moderating variables, intervening variables, and performance variables (VanWart 2008, 307); task structure and position power (Ayman 2004, 154); intelligence and experience (Fiedler 1964, 149); and task maturity and psychological maturity (Hersey and Blanchard 1969, 26), to name a few.

Fred Fiedler (1967), considered the first of many (Bennis 1984; House 1973; Hersey and Blanchard 1969) to explore contingency theory models, overlayed these dynamics with leadership development and training and concluded that the most effective style of leadership will depend on the characteristics of the situation (Antonakis, Cianciolo and Sternberg 2004, 7; Chemers 1995, 88; Yukl 1981, 136).

Pop culture leadership literature began to emerge as Blanchard translated earlier work (Hersey and Blanchard 1969) on leadership theory into stylized contingency theory wrapped in popularized literature such as *The One Minute Manager* (1989), *High Five* (2001), and *Whale Done* (2002), among others. Blanchard concluded that the leader's style will be most effective when it meets the demands of the situation confronting the leader (Van Maurik 2001, 21).

Ayman (2004, 163) summarized as follows, "most of the theories and models in the contingency approach consider the situation as the contingent factor that interacts with the leader's characteristics, be they traits or behaviors." Further, effective leadership is contingent on matching a leader's style to the right situation (Northouse 2007, 113).

Transactional Theory

Research extending into the 1960's on leadership embraced a more sophisticated approach to situational and contingency variables. Theorists researched the influence and behaviors of those being led (Wren and Swatez 1995, 246) and their interactions with leaders. Transactional theorists identified the leader-follower relationship as the interaction of persons with different levels of motivation and of power potential, including skill, in pursuit of a common or at least a joint purpose (Burns 1995, 100). The use of rewards and power in transactional exchanges (French and Raven, 1959) is rooted in the principles of contigency theory (Pearce, Yoo and Alavi 2004, 183).

In 1978, James MacGregor Burns presented a unique perspective that the predominant study of literature in this era was focused on transactional interactions. "Leadership, unlike naked power-wielding, is thus inseparable from followers' needs and goals. The essence of the leader-follower relation is the interaction of persons with different

levels of motivation and of power potential, including skill, in pursuit of a common or at least joint purpose," according to Burns (1978, 19). Interaction and social learning theorists, such as H. H. Jennings and C. A. Gibb, agreed and further suggested that the environment and social dynamics create or raise an individual into a leadership position. Bass (1990, 17) summarized this school of thought, indicating that environment does in fact play an important role in the emergence of a leader and organizational leadership. However, the trait and behavior theorists, with their expansive lists, required that recognition be given to the individual leader's role. They reached the conclusion that leaders emerge based on unique and identifiable traits and behaviors despite the evidence of the influence of the environment and of individuals.

The depth and breadth of the study of transactional leadership theory in the 1970's provided value to the field of contemporary leadership theory. In the development of work-related roles, the leader and worker exchanged value through a series of negotiated agreements (Chemers 1995, 91). As the exchanges became more positive, subordinate satisfaction increased, turnover was reduced, and identification with the organization was greater (Graen and Ginsburgh 1977, 1). Autocratic decisions and directive styles in which the leaders told followers what to do were more likely to work when the leaders knew exactly what to tell the subordinates (Chemers 1995, 96).

Transactional leadership theory included specific theory models such as path-goal theory (House 1971), leader-member exchange theory (Graen 1995, 219), and equity theory (Adams 1965, 267). Path goal theory explored how leaders motivated subordinates to accomplish designated goals (Northouse 2007, 127). Different leadership behaviors were overlaid onto subordinate and task characteristics. These motivational theorists' stated goal

was to enhance employee performance and satifaction by focusing on employee motivation.

A unique view of the transactional interchange between leaders and members was part of the leader-member (LMX) theory. Graen and Uhl-Bien (1995, 219) developed a complex relationship-based approach to leadership, making the interaction between leader and member the focal point of the leadership process. Group members made contributions and continued with these interactions because they perceived mutual benefit (Bass 1990, 48).

Equity theory did not try to evaluate the equality of the inputs or outcomes but focused on the fairness as evaluated by the participants (Hughes, Ginnett and Curphy 1995, 332). Tied closely to expectancy theory, both equity theory and expectancy theory attempted to determine the conscious choices and expected rewards by both leader and follower. The study of these transactions in the development of leadership theory provided insight into how leaders interacted and functioned.

Hollander (1987, 16) summarized the dynamics contained in transactional leadership theory: "Fundamentally, there is a psychological contract between the leader and followers, which depends upon a variety of expectations and actions on both sides." The leader gave things of value to those that were led and, in exchange, members provided value to the leaders. The degree and signficance of this social exchange was the foundation of transactional leadership theory; however, theorists believed that there was something that should transcend the satisfaction of self-interests. Transformational leadership was seen as this bridging theory.

Transformational Leadership

The schools of transactional, traits, and behavioral theories collided in James MacGregor Burns' call for the study of a new theory on leadership. He suggested that a more

important area of study was being ignored, namely the study of transformational leadership (VanWart 2005, 8) – a theory that embraces the process of empowerment and that "transforming leaders champion and inspire followers . . . that they might become leaders themselves" (Burns 2005, 26).

Burns contrasted transactional leadership theory with transformational leadership by noting that transformational leaders engaged with others in such a way that leaders and followers raised one another to higher levels of motivation and morality (Burns 1995, 100). This interaction was more than a transaction, it was a transforming relationship. Transformational leaders embraced a dynamic relationship that elevated both leader and subordinate. Bass suggested that transformational leaders transformed their followers (Ayman 2004, 151; Couto 1995, 104).

Charisma in Transformational Leadership

The study of transformational leadership led to understanding how certain leaders inspired performance beyond expected standards. They did so by developing an emotional attachment between the followers and their leaders (Avolio and Yammarino 2002, xvii). This "new leadership" model suggested by Bass (1985) shifted the field of study of leadership in a new direction (Antonakis and House 2002, 4; Bass 1985, xiii). Orginally conceived by Max Weber (1968, 24) in his work on charismatic leadership, the leader was attributed with the ability to inspire followers to an "attitude that is revolutionary and. . . transcends everything." House (1977, 189, 207) added that charismatic leaders were those "who by force of their personal abilities are capable of having profound and extraordinary effects on followers." He concluded his writings by noting that the study of charismatic leadership was rapidly advancing and that empirical studies would expand the understanding of this phenomenon.

Prior to the 1980's, the study of charismatic leadership was relatively obscure, as evidenced by the limited number of references found from this period. These references consisted of speculative and formative theories (Conger, Kanungo, and Menon 2000, 747). In addition, researchers "have shied away from studying charismatic leadership because of its elusive nature and the mystical connotation of the term" (Conger and Kanungo 1987, 637).

Since the late 1980's, research on charismatic leadership theory expanded to include work by Bass (1985), Conger and Kanungo (1987), Shamir and House (1993). While the empirical research in this area was limited, Shamir et al. (1998) concluded that charismatic leadership was indeed positively correlated with followers' performance and satisfaction. Their research also confirmed the existence of charismatic and transformational leadership in common and ordinary organizations, implying that the charismatic leader was not bound by organizational constraints but possible in any industry.

Charismatic leadership was central to the theory of transformational leadership (Bass 1985, xiv) as leaders commanded strong emotional ties and excited, aroused, and inspired their subordinates. The elements that characterized charismatic leaders were present in transformational leaders. However, transformational leaders were more than inspirational as they played the roles of teacher, mentor, coach, reformer, and revolutionary. The transformational leader sought to engage the full person of the follower and in so doing elevated those influenced to a higher level of performance (Bass 1985, 14). In so doing, transformational leaders were able to attract, retain, and promote others and thereby, creating a succession of transformational leaders.

Succession Planning in Transformational Leadership

In order to associate with better performers, transformational leaders embraced

succession planning as a critical element of their leadership behavior (Atkinson 2008). Effective succession planning was an organization's ability to differentiate between those employees who were most likely to develop and meet the organization's needs from those who would not produce the desired return on the company's investment (Atkinson 2008; Bersin and Associates 2007, 19). The value of succession planning was discussed in a report by Development Dimensions International (DDI), a nationally recognized leader in human resource development. They reported that the workforce recognized the effort to promote from within and develop its own people. By so doing, employee morale improved and staff were encouraged to take on responsibility, assume risk, measure outcomes, and grow through their achievements. Lastly, the DDI report concluded that "growing from within allows an organization to meet both long-term and emergency leadership needs at all levels -- it ensures continuity of management" (Byham 2008, 3).

In a 2003 report by the United States General Accounting Office presented to the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, J. Christopher Mihm, Director of Strategic Issues, stated, "leading organizations identify, develop, and select successors who are the right people, with the right skills, at the right time for leadership and other key positions." The report further stated that in 1997, the National Academy of Public Adminsitration (NAPA) reported that of the 27 agencies responding to its survey, only two agencies had a succession planning program or process in place.

Mihm (2003) identified key practices for effective succesion planning and management in broad categories as demonstrated by leading organizations. These practices

strengthened both current and future organizational capacity. Six of the demonstrated practices identified (Mihm 2003, 2) were as follows:

1. Receive Active Support of Top Leadership. Effective succession planning and management have the support and commitment of top leadership. Not only do top leaders use these programs to develop, place, and promote individuals, they demonstrate support through adequate funding and staff resources to operate effectively over time.

2. Link to Strategic Plan. Succession planning and management is viewed as a strategic tool that focuses on current and future needs and develops high-potential staff to meet the organization's mission over the long term. These efforts are integrated with strategic planning.

3. Identify Talent from Multiple Organizational Levels, Early in Careers, or with Critical Skills – High performing employees are identified from multiple levels in the organization. Succession planning efforts identify and develop knowledge and skills that are critical in the workplace.

4. Emphasize Developmental Assignments in Addition to Formal Training – Succession planning emphasizes development or "stretch" assignments in addition to more formal training components. Assignments place candidates in new roles or unfamiliar job environments in order to strengthen skills and competencies and broaden their experience.

5. Address Specific Human Capital Challenges, such as Diversity, Leadership Capacity, and Retention – Leading organizations are aware of changing organizational needs and demands. Shifting workforce demographics requires agility in responding to diversity needs as well as anticipation of impending retirements. The retention of high-potential staff is important to succession planning.

6. Facilitate Broader Transformation Efforts – Succession planning and management provides resources for organizations to implement change by selecting and developing candidates that embrace a change agenda.

Components of Transformational Leadership

Many scholars (Antonakis and House 2002, 9; Bass 1990, 218; Judge and Piccolo 2004, 755; Podsakoff, et al. 1990, 114) agreed that transformational leadership was comprised of unique charateristics. Bass (1998, 5) defined these factors:

1. *Charistmatic leadership (or Idealized Influence).* Transformational leaders behave in ways that result in their being role models for their followers. The leaders are admired, respected, and trusted. Followers identify with the leaders and want to emulate them; leaders are endowed by their followers as having extraordinary capabilities, persistence, and determination. The leaders are willing to take risks and are consistent rather than arbitrary. They can be counted on to do the right thing, demonstrating high standards of ethical and moral conduct.

2. *Inspirational Motivation*. Transformational leaders behave in ways that motivate and inspire those around them by providing meaning and challenge to their followers' work. Team spirit is aroused. Enthusiasm and optimism are displayed. Leaders get followers involved in envisioning attractive future states; they create clearly communicated expectations that followers want to meet and also demonstrate commitment to goaols and the shared vision.

3. *Intellectual Stimulation.* Transformational leaders stimulate their followers' efforts to be innovative and creative by questioning assumptions, reframing problems, and approaching old situations in new ways. Creativity is encouraged. There is no public criticism of individual members' mistakes. New ideas and creative problem solutions are solicited from followres, who are included in the process of addressing problems and finding solutions. Followers are encouraged to try new approaches, and their ideas are not criticized because they differ from the leaders' ideas.

4. *Individualized Consideration.* Transformational leaders pay special attention to each individual follower's needs for achievement and growth by acting as coach or mentor. Followers and colleagues are developed to successively higher levels of potential. Individualized consideration is practiced when new learning opportunities are created

> along with a supportive climate. Individual differences in terms of needs and desires are recognized. The leader's behavior demonstrates acceptance of individual diffferences (e.g., some employees receive more encourgagment, some more autonomy, others firmer standards, and still others more task structure). A two-way exchange in communication is encouraged, and "management by walking around" work spaces is practied. Interactions with followers are personalized (e.g., the leader remembers previous conversations, is aware of individual concerns, and sees the indvidual as a whole person rather than as just an employee). The individually considerate leader listens effectively. The leader delegates tasks as a means of developing followers. Delgated tasks are monitored to see if the followers need additional direction or support and to assess progress; ideally, followers do not feel they are being checked on.

Transformational leaders were able to motivate subordinates to higher levels of performance by raising the importance of certain goals, demonst*rating the means to achi*eve them, and by enticing subordinates to transcend their self-interests for the achievement of the organizational goals (Conger and Kanungo 1998, 14). Such leaders transformed the needs, values, preferences, and aspirations of the followers from self-interests to organizational interests (Sharim, House and Arthur 1993, 577). They had the ability to "inspire, excite, and persuade their followers to believe that they may be able to accomplish exceptional things with extra work and effort" (Fuller, et al. 1996, 272).

Unfortunately, the field of study of transformational leadership is relatively young with abundant theories and conceptualizations but with little rigorous empirical studies (Conger and Kanungo 1998, xxii). In a meta-analytic study conducted by Judge and Piccolo (2004, 758), the authors drew upon the results of 20 years of research on the study of transformational and transactional leadership theory by examining 87 studies that met their criteria for inclusion in their database. While their research concluded that elements of

transformational leadership positively correlated with overall follower satisfaction, leader job performance, and leader effectiveness, their review on the literature and research on transformational leadership was short of tying this theory into actual superior organizational performance. A more fundamental question asked by leaders should be if transformational leadership theory is embraced, does organizational performance improve?

Despite the expanding research on this topic, Conger and Kanungo (1998, 4) concluded that "leaders who are perceived as charismatic receive higher performance ratings, are seen as more effective leaders than others holding leadership positions, and have more highly motivated and more satisfied followers than others in similar positions." According to Bruch and Ghoshal (2003, 47), research on this topic is conclusive that leaders who possessed attributes described in transformational leadership theory experienced heightened enthusiasm and excitement by their staff that was directed towards shared organizational priorities.

Further research concluded that not only were transformational leaders better performers themselves but people associated with them were better performers (Cross, Baker and Parker 2003, 52). The effect of transformational leadership style was assumed to enhance organizational performance but the association was seemingly indirect (McColl-Kennedy and Anderson 2002, 545) and inconclusive.

Conclusions on the Study of Leadership

More rigorous empirical study on the performance of organizations led by transformational leaders is limited. Authors are able to identify the existence of transformational leaders as defined by Bass and that the employees of these leaders are more determined and seemingly more satisfied with the performance of their leaders. However,

little empirical study is avaible to conclude that these same organizations have superior organizational performance.

Conger, Kanunog and Menon (2000, 748) apparently agreed when they stated that "there has been a serious lack of research which unequivocally demonstrates causal relationships between specific charismatic leadership components and follower effects." Transformational leaders influence followers to perform "above and beyond the call of duty" (Podsakoff, Mackenzie, Moorman, and Fetter 1990, 137) but their ability to influence superior organizational outcomes remains elusive. Conger and Kanungo (1987, 637) noted that one key difficulty in obtaining empirical data on this topic is the inability of researchers to access transformational leaders. Therefore, as action researchers provide keener insight into the impact of transformational leadership, theorists will be able to tie measures and analyses that will provide rapid advances in the study of this field.

Despite the enormity of the field of study of leadership, researchers are challenged to agree on a definition of leadership. As the field continues to expand, it has yet to identify a unifying theory or model that will provide common direction for researchers (Burns 1995, 2). Nonetheless, the term "leadership" does have a common assumption that it is a group phenomenon involving the interaction between two or more persons. The interaction includes a process of influence whereby the leader exerts intentional influence over the followers (Yukl 1981, 3). Who these individuals are and how this influence is exerted remain topics of research activity. Bass (1995, 38) stated that leadership "has been conceived as the focus of group processes, as a matter of personality, as a matter of inducing compliance, as the exercise of influence, as particular behaviors, as a form of persuasion, as a power relationship, as an instrument to achieve goals, as an effect of interaction, as a differentiated

role, as initiation of structure, and as many of combinations of these definitions."

Hunt (2004, 47) concluded *What is Leadership?* with challenges for future researchers to consider:

1. One's leadership purpose and definition should be considered explicitly.

2. The history preceding a given leadership issue in question should be recognized: Leadership issues do not spring forth from a vacuum, and history matters.

3. The broad organizational and environmental context, within which leadership is embedded, should be emphasized.

4. Leadership as a shared influence process should be considered.

5. A dynamic approach should be used, wherever feasible.

Important to this research is an observation by Bass (1995, 38) that the meaning of leadership may depend, in large part, on the kind of institution in which it is found. The field of hospital administration presents distinctive characteristics that define the nature of leadership for this research. In studying this field, this action researcher is able to explore the organizational history, identify elements of transformational leadership, comment on their influence, and finally, demonstrate specific organizational performance and outcomes related to the influence of leadership behavior.

Strategic Planning

Strategic planning is an important and frequently used management tool (Zuckerman 2005, 2). The concept of strategy has its roots in political and military history (Duncan, Ginter and Swayne 1995, 17). The Greek verb *stratego* meant "to plan the destruction of one's enemies" (Bracker 1980, 219). The military use of strategy involved terms such as

objectives, missions, strengths, and weaknesses, which were all expressions frequently used in strategic planning literature.

According to Ginter, Swayne, and Duncan (14, 2002), "Strategic planning is the set of organizational processes for identifying the desired future of the organization and developing decision guidelines." They also recognized that, "when an organization exhibits a consistent behavior it has a strategy," and "a strategy is the means an organization chooses to move from where it is today to a desired state some time in the future" (Zuckerman 2005, 2).

Numerous conceptual frameworks existed in strategic planning literature and there was even disagreement on its very definition (Kaplan and Norton 2004, 7). Michael Porter, a contemporary leading author on strategic planning, defined strategy as a "set of activities in which an organziation will excel to create sustainable difference in the marketplace" (Kaplan and Norton 2004, 7; Porter 1996, 61). Authors Peter Ginter, Linda Swayne, and Jack Duncan (2002, 14) stated that "strategic planning is the set of organizational processes for identifying the desired future of the organization and developing decision guidelines." Others (Beckham 2000, 55; Luke, Walston and Plummer 2004, 29) provided possible frameworks for conducting strategic planning efforts.

Although the literature on strategic planning continues to evolve, Mintzburg (1994, 23-29) identified five conceptual elements of strategic planning that resonate with theorists. These included:

1. Plan: a guide or course of action into the future
2. Ploy: a specific maneuver intended to outwit an opponent or competitor
3. Position: determination of particular products in particular markets

4. Perspective: an organization's way of doing things
5. Pattern: consistency in behavior over time

Strategic planning, as a business function, has been well-accepted and acknowledged as essential to competitive success by private sector businesses since the mid-twentieth century (Luke, Walston and Plummer 2004, 4). Corporations in the late 1940's and early 1950's embraced planning, programming and budgeting systems (Zuckerman 2005, 3) as the basic planning functions of business. Leading organizations, such as General Electric, recognized the need for more purposeful planning efforts and embraced strategic planning, promoting the value of creating a framework for planning beyond the typical 12-month budgeting cycle (Webster, Reif and Bracker 1989, 5). By the 1990s, corporate market planning focused on maximizing profits through the identification and stratification of market segments (Spiegel and Hyman 1991; Zuckerman 2005, 3). Companies used strategic planning efforts to identify market segments and devise strategies to control them.

In the business sector, accelerated environmental change required business planners to embrace strategic planning (Kaplan and Norton 2004, 2). Zuckerman (2005, 4) described a study conducted by the Buttonwood Group reported in *The Economist* on-line blog that in a 2003 survey of 225 U.S. companies, averaging 3,000 employees and $850 million in sales, annual strategic planning required 10.5 work days for approximately 22 percent of each company's employees. The survey also revealed that the average company spent $3.1 million to produce its strategic plan.

There has been considerable recent interest in the literature on the use of strategic planning in the hospital industry. Zuckerman (2005, 4) stated, "strategic planning has been used by healthcare organizations somewhat sporadically since the 1970's." As government

regulation and intervention increased through the 1980's, hospitals were forced to take a more systematic approach to health care planning. These efforts continued into the 1990's as hospitals emphasized reimbursement maximization but failed to embrace fully many of the fundamental elements of strategic planning. Only the recent arrival of serious competition is driving health care professionals to understand strategic planning but "many health care organizations are fairly high on the strategy learning curve" (Luke, Walston, and Plummer, 2004, xi).

Strategic Planning in the Non-profit Sector

Due to the limited utilization of strategic planning in the hospital industry, a more expanded literature review included the nonprofit sector as a whole. The literature on strategic planning in the nonprofit sector is comprised of four categories: (1) the advocates heralding the benefits, (2) normative frameworks and analytical tools to implement strategic planning, (3) empirical research in the nonprofit sector, and (4) case studies of successful strategic planning initiatives (Kearns and Scarpino 1996, 429).

Throughout the 1970s, advocates demanded that nonprofit organizations make stronger commitments to widely accepted business principles that have proven successful in the market sector. Ring and Perry (1985, 276) challenged the assumption that the principles of strategic planning were effective in business and, therefore, held similar promise in the nonprofit sector. Other notable authors were more critical and emphatic that the nonprofit sector must embrace business practices (Drucker 1990, 32; Firstenberg 1979, 8; Unterman and Davis 1982, 30). In a landmark study of 103 nonprofit organizations, the authors concluded that nonprofit organizations have "not only failed to reach the strategic management state of development, but many of them have failed to reach even the strategic

planning states that for-profit enterprises initiated 15-20 years ago" (Unterman and Davis 1982, 30).

Martin and Singer (2003, 59) explored the issue of priority setting in health care institutions and the importance of defining a desired improvement. According to Trinh and O'Conner (2002, 146), critics of strategic planning in hospitals suggested that strategic planning efforts were futile. Paradoxically, these same critics failed to conclude that the introduction of business practices such as strategic planning were harmful to the improvement of hospital performance.

Nonetheless, Martin and Singer (2002, 59) confirmed that a strategy to improve a hospital's performance required rigorous research combined with normative and empirical methods. Advocates of a systematic implementation of strategic planning utilized normative frameworks and analytical tools to identify numerous approaches for strategic planning in organizations (Atchison and Bujak 2001, 165; Luke, Walston and Plummer 2004, 45; Zuckerman 2005, 16). Webster and Wylie (1988, 26) provided insight into the emerging role of strategic planning in the nonprofit sector and provided empirical research on the implementation of such planning.

As part of a nationwide study of United Way local chapters, authors Webster and Wylie (1988) explored responses from 156 participants. For the purposes of the study, Webster and Wylie (1988, 29) categorized strategic planning into six planning tasks: mission analysis (purpose), internal audit (organizational strengths and weaknesses), external audit (market conditions), forecasting (major trend analysis), strategy identification and selection, and document development. The researchers utilized a regression model to assess the impetus to engage in strategic planning, variations in the planning process, and factors

affecting strategic planning outcomes. They concluded that "there is considerable confusion surrounding such concepts as strategic or strategy planning, strategic marketing, strategic management and strategy formulation" (Webster and Wylie 1988, 26).

Numerous authors (Ashmos and McDaniel 1991, 380; Beckham 2000, 55; Begun and Heatwole 1999, 263) recognized the importance of utilizing strategic planning and creating analytical tools. However, Kearns and Scarpino (1996) and others (Boyd 1991, 353; Bruton, Oviatt and Kallas-Bruton 1995, 16; Powell and Steinberg 2006; Sinha 1990, 479) were vocal in their criticism that a recommendation for action does not necessarily mean action towards strategic implementation. They asserted that although planning occurred, the actual execution of a strategy was suspect. For this reason, the literature in this area demanded the creation of strategic initiatives as well as measurements of success or completion (Kearns and Scarpino 1996, 433).

Lastly, the literature on strategic planning in the nonprofit sector included numerous case studies and some limited action research by practitioners (Knauft, Berger and Gray 1991; Steiner, et al. 1994; Wiesendanger 1994). Anecdotal experiences demonstrated real-life events that invited practitioners in the nonprofit sector to learn from their peers. Unfortunately, critics of anecdotal literature believed that without a balanced representation of both successes and failures, this sector of the literature did not possess the rigorous qualitative research methodologies necessary to draw substantive conclusions (Kearns and Scarpino 1996, 430).

Strategic Planning in Hospitals

Strategic planning in hospitals is a discipline that is embraced only recently by hospital administrators (Luke, Walston and Plummer 2004, 5). At the turn of the century,

hospital administrators focused on seemingly insignificant responsibilities such as meal planning and coal consumption (Tipping 1914, 98; Walsh 1915, 19). Planning work of that era focused on day–to-day operational issues that dealt with the functional aspects of hospital administration.

By the 1960's the integration of science and the professionalization of medicine shifted the focus of care within the health care field away from home care and towards hospital-centered medicine (Starr 1982, 146). Hospital administrators needed to attract patients that were accustomed to the convenience, intimacy, and familiarity of medical care in the home to large, sterile, and impersonal institutional facilities. Hospitals had to overcome their traditional images as dirty facilities for the poor and the destitute (Arndt 2007, 35) and hospital administrators assumed greater responsibility for planning and financial budgeting to respond to the growing complexities of medicine (Starr 1982, 158).

By the 1970's, there was a clear lack of consistency by hospital professionals on the basics of long-range or strategic planning (Perlin 1972, 62). The authors of a survey of 614 nonfederal short-term general hospitals concluded that although most hospitals utilize some form of long-range planning, considerable differences existed in hospital goals, organizational mechanisms, and participation in the planning process (Perlin 1972, 62). Most significant at that time were the constraints to effective planning which included a lack of active involvement of key stakeholders, insufficient resources, inadequate training, external pressures, and lack of useful area planning data (Perlin 1972, 64). Almost 20 percent of the hospitals surveyed believed that information and data from area-wide sources were generally useless. Further, the study's author recognized that unique external conditions impacted each individual hospital (Perlin 1972, 64). This period marked a shift in the expectations of

hospital administrators from internal operational and functional experts to organizational strategists in a dynamic, market-driven industry (Luke, Walston and Plummer 2004, 6).

The evolution of the hospital administrator to hospital chief executive officer (CEO) reflected a transition in hospital administration, according to Beckham (2000, 57). Today's successful hospital chief executive officer must design a strategy that utilizes organizational resources and managerial values in a dynamic environment of opportunities and threats (Hambrick 1981, 263). Because hospitals operate in a competitive environment, CEO's attempt to position their organizations to be high performing and efficient organizations (Luke, Walston and Plummer 2004, xi; Spath 2005, 2).

Clearly, successful organizations adapt to their environments in order to survive and prosper. Scholars define strategic planning as moving from a point in the present to some point in the future in the face of an environment of uncertainty and resistance (Beckham 2000, 55; Kaleba 2006, 74). Uncertainty and resistance to organizational change often emanate from within the hospital as physicians, staff, and community emerge as distinct and powerful internal organizational forces influencing a hospital.

Physicians are an influential internal force within a hospital. They recognize that they must participate in the design and development of a hospital's strategic plan (Ashmos and McDaniel 1991, 375; Biebuyck and Ziegenfuss 1992, 31). While self-interest plays a role in physician involvement, there is an obvious need for physicians to challenge the "forest of competing interests" (Biebuyck and Ziegenfuss 1992, 32). By so doing, physicians are assured that the future will be in the best interests of "high-quality care for patients, for medical student education, and for the creation of new knowledge in medicine and the allied sciences" (Biebuyck and Ziegenfuss 1992, 36).

Another powerful internal influence is employees. Satisfied employees effectively participate in the operations of an organization (Studer 2003, 139) and can be an organization's most valuable asset (Bassi and McMurrer 2007, 1). Utilized ineffectively, employees are the source of organizational poor performance and can contribute to organizational failure (Kersten 2005, 17).

A third internal influencer is the board of trustees. While board composition can affect strategic planning (Delbecq and Gill 1988, 26; Starkweather 1988, 75), board behavior and power can dramatically and directly influence the overall performance of an organization and administrative staff (Alexander, Fennell and Halpern 1993, 75). Recognizing and addressing these powerful internal influencing forces is fundamental to strategic planning.

External forces also create uncertainty and resistance in strategic planning as environmental challenges continue to influence organizational performance. In remarks to hospital CEO's, Thomas C. Dolan, Ph.D., FACHE, CAE, president and CEO of the American College of Healthcare Executives, stated, "Ten to 20 years ago, a trend in one part of the country might take years to get to your area. Today that can happen in a matter of months, and you need to be prepared" (Zuckerman 2005, 1). As such, a strategic plan includes a comprehensive set of metrics and measurements that is responsive to a dynamic external environment.

Finding Measurement Tools

The creation of a hospital strategic plan requires health care professionals to define the present point or current status of an organization. The complexity of identifying overall organizational performance includes an assessment of operational performance, financial

efficiency, clinical efficacy, and community expectations (Zuckerman 2005, 7). Layered within these dynamics is the influence of key internal stakeholders such as physicians, board members, employees, and volunteers.

Developing an acceptable measurement tool to determine operational performance is challenging. In assessing operational performance, the criteria established by the National Baldrige Quality Award provide a recognized quality system and a comprehensive and thorough evaluative tool in measuring the performance of a hospital (Spath 2005). The Baldrige criteria require an organization to conduct a self-assessment that evaluates the mission, vision, and values of a hospital. The criteria demand that an organization conduct a comprehensive and thorough self-assessment with an accompanying process of implementation and evaluation.

A second measure of organizational performance is financial efficiency. Unfortunately, comparative data in this area are elusive. One industry standard in determining financial performance is the State of the Hospital Industry Report (Cleverly, Cleverley and LaFortune 2006, 1). This comparative database expands primary financial measurements, such as return on equity and total margin into more complex financial instruments. These include a community value index, financial strength index, hospital charge index, and hospital cost index. Comparative data provide both micro and macro value drivers that will allow organizations to determine organizational status for analysis (Cleverly, Cleverly, and LaFortune 2006, 3). Regrettably, hospitals and health care organizations are reluctant to provide comparative data or provide proprietary information on financial performance.

A third area of assessment is quality measurements but comparative data in the area of qualitative efficacy are subjective. Currently, numerous qualitative reports and studies attempt to provide risk-adjusted quality reports for hospitals. Solucients, Inc. (2007) promotes benchmarking data leading to its industry-recognized Top 100 Hospitals listing. Critics of this program point to the subjectivity of the classifications and the inaccessibility of the measurement tools that Solucients Inc. utilizes for its selection criteria. Another well-known data source in comparing qualitative data is the Leapfrog Group Quality and Safety Survey (Leapfrog Group on Health 2007) that utilizes evidence-based hospital information in the areas of surgeon volume, mortality by high-risk procedure, process measures, and coding criteria on volume counts. Other nationally-recognized organizations that provide qualitative studies include the Institute of Medicine (Institute of Medicine of the National Academies 2005), and the Agency for Healthcare Research and Quality (The United States Department of Health and Human Services 2007). Despite the depth and breadth of the information available, professional disagreements exist regarding the comparability of this information.

A fourth measurement tool is the identification of local community expectations. Hospital care is still largely local (Luke, Walston and Plummer 2004, xii) and community expectations are derived from numerous sources in a community. Changing local demographic trends and unique health care needs provide the necessary data set for hospital strategic planners (Hansen 1999, 28). For example, inner-city urban hospitals are challenged with psychosocial issues that dramatically influence pre-natal care and infant mortality. Fast-growing suburban facilities require access to complex and sophisticated diagnostic resources, such as coronary artery bypass surgery, that are only accessible in large quaternary facilities. Community expectations coupled with demographic data provide hospital strategic planners

important information in determining the current status of their organizations (Luke, Walston and Plummer 2004, 87; Mycek 2004, 34).

Conclusions on Strategic Planning in Hospitals

Strategic planning moves an organization from a point in the present to some point in the future in the face of environmental uncertainty and resistance. Defining current status and projecting future expectations based on operational performance, financial efficiency, clinical efficacy, or community values is the foundation of strategic planning (Zuckerman 2005, 16).

Therefore, effective strategic planning requires a hospital to determine current status by evaluating operational, financial, qualitative, and community standards utilizing recognized industry standards as identified above. The hospital professional then conducts a comprehensive and thorough evaluation of determined criteria and seeks benchmarking and comparative data. Defining valid and reliable measures of organizational performance is a key challenge in developing a strategic plan (Griffith and Alexander 2002, 42).

The Baldrige criteria (National Institute of Standards and Technology 2007) require the creation of a vision statement for an organization in order to define a desired future state of being. Spath (2005, xv) argues that the process must be systematic, thorough, and knowledge-driven. Drawing upon data and information that is comparative and empirical, an organization is able to differentiate itself from competitors and determine the impact and influence of both internal and external factors. “Organizational Performance Results” is the terminology used by Baldrige (2007) to determine the success by the organization to achieve measurable improvements.

The complexities of the current health care environment and the importance of evaluating the influence of external uncertainty and resistance require hospital professionals

to embrace strategic planning (Luke, Walston and Plummer 2004, xi). The transformation of hospitals has been rapid and challenging for health care professionals. "In just a few short years, health care transformed itself from a sleepy community service system to a dynamic, market-driven industry. As a result, strategy became a primary basis on which many health care organizations now plot their future," Luke, Walston and Plummer (2004, 6) contended. Health care professionals benefit from engaging in strategic planning and recognize the importance of conducting a comprehensive and thorough scan of the environment in which they exist in order to assess operational performance, fiscal efficiency, clinical efficacy, and community involvement (Hambrick 1982, 160; Zuckerman 2005, 27).

The current literature on strategic planning in the health care sector fails to provide substantive insight for practitioners in the field. Advocates conclude that strategic planning is important just because the business sector utilizes it. Other authors provide insightful frameworks for consideration but fail to reach consensus on normative tools and frameworks. Case studies on strategic planning are extensive but scholars criticize them for failing to provide examples of both successes and failures. Lastly, empirical researchers are able to identify strategic planning processes but are limited in identifying the results of these processes and initiatives.

Today, health care executives embrace strategic planning as a necessity of organizational leadership and have developed complex frameworks and processes. While case studies are available, limited empirical research is provided in the field. The use of action research allows health care executives to examine strategic planning processes and identify empirical data to evaluate the value of these efforts.

CHAPTER 3

HISTORY OF MEDICAL CITY DALLAS HOSPITAL

Medical City Dallas Hospital opened its doors on October 2, 1974 under the direction of Robert J. Wright, the managing general partner of Medical City Dallas Limited and President of Medical Cities, Inc. Mr. Wright, in his role as the administrator of the Southwest Clinic, was the driving force behind taking an undeveloped 40-acre parcel of land on the outskirts of Dallas and creating an integrated medical mall campus. Considered the first of its kind throughout the nation (Corbeil 1999, 5) and a new and innovative concept for the Dallas/Fort Worth Metroplex, Medical City allowed a group of physicians and administrators to integrate physician office practices, outpatient/ancillary services, and hospital services under one roof. Despite sufficient hospital capacity in the region, the founders created a different kind of private healthcare facility that was responsive to physician needs.

Originally, the concept was to create a 125-bed primary care hospital designed to treat less-acute care patients. However, an extensive market survey conducted by Mr. Wright and his colleagues concluded that an acute care hospital supported by sub-specialists was necessary. Further, the design element hospital experts considered unique and innovative at the time (Corbeil 1999, 7; Wright 2008) was the proximity of hospital departments to physician offices, thus creating an integrated and dynamic health care environment. Physicians were steps away from hospital services and the designers envisioned such access to improve efficiency and hospital/physician integration.

Drs. Donald Coney, Ron Underwood, James Bland, and Trevor Mabery were among those who first embraced the concept and were instrumental in attracting other physicians to join the medical staff (Wright 2008). The location of the complex was a critical factor in assuring the success of the facility. Firstly, Mr. Wright identified patient convenience and accessibility as key determiners on site location. Secondly, he insisted that the site be located within 15 minutes of travel for all physicians on the medical staff (Corbeil 1999, 6; Smith 2008; Wright 2008) Lastly, Mr. Wright identified the growing North Dallas community as an ideal location.

Mr. Wright approached developer Trammel Crow to collaborate in the Medical City Dallas development since the Crow Company was developing other projects in the Park Central Area at the time. Other initial general partners included James H. Coker, Robert E. Glaze, and Howard D. Crow. The partners selected a 40-acre tract of land at the southern portion of the Park Central property, known as 7777 Forest Lane, as the future site of Medical City Dallas Hospital (Corbeil 1999, 6; Wright 2008).

The organizational architects of this innovative medical mall concept also desired to defuse the stigma that hospitals were a place where people go to die. The designers incorporated cheerful and welcoming elements including waterfalls, glass atriums, and original artwork throughout the campus. In addition, retail services, restaurants, a full-service bank, and close-circuit in-room televisions were available so that patients, visitors, staff, and physicians could benefit from the medical mall concept.

Prior to opening, the partners selected General Health Services as the hospital operator and American Biomedical Laboratory to provide ancillary services. A physician Steering Committee, chaired by Dr. Frank Seay, was established to formulate the framework

for the hospital's new medical staff. James Bland, M.D. was instrumental in the development of its first by-laws, designing a "democratic open-staff" policy. The medical staff structure was unique in the 1970's and allowed physician inclusion on the medical staff regardless of age, religion, or ethnicity (Brown 2008; Smith 2008). Other members of the Steering Committee included Drs. John William Lanius, Jack Schwade, Ron Underwood, Donald Coney, E. R. Richardson, Fred Owens, Raymond Courtin, Aaron Kriesler, William Phelps, and Trevor Mabery (Corbeil 1999, 8). The Steering Committee selected Dr. Frank Seay as the first president of the medical staff. Within two years, Medical City Dallas had completed its $20 million project and welcomed its first patients on October 2, 1974. The twelve story, 367-bed acute care hospital included oversized ancillary departments connected to some 90 physicians' and surgeons' offices, all of which surrounded a four-story atrium (Corbeil 1999, 8, 9). Shared physician and hospital services included a facility-wide communication system, as well as maintenance, parking and plant, tax, insurance, and security programs. The tenure of the first hospital administrator, Leonard Watson, was short-lived and within the first year, General Health Services, Inc. terminated its operating agreement. Humana, Inc. from Louisville, Kentucky entered into a long-term operating agreement under the direction of President Wendell Cherry.

In September 1975, Humana, Inc. assigned Wayne McAllister as the administrator of Medical City. The investors assumed that such an ambitious project would not achieve financial equilibrium until several years after opening (Smith 2008; Wright 2008). However, by August 1976, Medical City posted its first monthly profit and began demonstrating positive financial performance.

In that same month, Marliese Mooney, a German immigrant well-known among hospital staff for her demanding expectations and dominant personality (Korman 2008; Smith 2008; Wright 2008), became Medical City Dallas Hospital's third administrator. In 1977, Medical City had 3,283 admissions, 3,059 emergency room patient visits, performed 1,721 surgeries, and had an average daily census of 184.2. Serving in this role for seven years and four months, Ms. Mooney was promoted to a regional management role by Humana. Upon her promotion, Jim Bonhanon was hired in January 1984 to replace her.

Mr. Bonhanon's brief seven-month tenure included the opening of the North Tower, professional building C, and a new employee and visitor-parking garage. Because of these construction projects, total bed capacity increased to 545 beds, operating rooms suites increased to 16, and parking spaces expanded to 5,000. With his arrival in August 1984 as administrator, Ira Korman, Ph.D., led Medical City's entry into aggressive marketing and community activity. By the end of his tenure in 1991, Dr. Korman had embarked on several ambitious and innovative initiatives including the expansion of emergency services, installation of a magnetic resonance imaging suite, and one of the first lithotripsy units in the metroplex. In addition, Medical City's aggressive marketing and image campaign highlighted the technological capabilities available at the hospital.

During Korman's administration, he created the Humana Advanced Surgical Institute, which led to the introduction of innovative approaches in minimally invasive laparoscopic procedures (Corbeil 1999, 14; Korman 2008). The opening of the Pediatric Intensive Care Unit and creation of the Craniofacial Center provided the foundation for future expansion into pediatric services and the eventual creation of a children's hospital.

After six years and five months, Dr. Korman handed off administrative responsibilities to Don Stewart who led Medical City into the era of solid organ transplantation. As the result of earlier planning, in the first year, the heart surgeons performed five heart transplants and Medical City was emerging as a prominent tertiary referral center both locally and regionally. Mr. Stewart also oversaw the completion of care tower D, a seven-story, 240,000 square foot mixed use facility combining inpatient services, outpatient departments, and physician offices.

The promotion of Mr. Stewart to a regional position resulted in a succession of hospital administrators - Michael Pugh (11 months), Steve Corbeil (3 years, 2 months), and the arrival of the author/researcher of this project, Britt Berrett, in April 2000. From 1995 to 2000, Medical City experienced four different administrators with unique and clearly distinct leadership styles. The road to Medical City's transformational change began in the spring of 2000 as the newly formed executive staff met in a series of off-site retreats to assess the organization and to define a future.

Leadership at Medical City Dallas Hospital

As part of this research, the researcher conducted interviews with hospital board members, physician leaders, executive administrative staff, and local community leaders. The depth and breadth of these interviews provide insight into the leadership styles and behaviors of the hospital administrators during the development of Medical City Dallas Hospital.

Three distinct leadership styles associated with three administrators were identified: Marliese Mooney – August 1976 to December 1983; Ira Korman, Ph.D. – August 1984 to January 1991; and, Donald Stewart – March 1991 to April 1995. One of the researcher's goals through the interviews and surveys was to identify leadership behaviors and

characteristics that were associated with these health care executives during their tenures as head of Medical City Dallas Hospital.

Numerous models and theories exist to classify and categorize leadership styles and behaviors. In reviewing the leadership behaviors and characteristics of Marliese Mooney, Don Stewart, and Ira Korman, a conceptual model created by Blake and Mouton (1981) integrates both task and relations orientations to evaluate leader behavior. Their managerial grid (see Figure 1) is based on the concept that leaders vary in their concern for people and their concern for accomplishment of tasks.

Based on this evaluative tool, the researcher categorized Marliese Mooney as high in concern for production. Descriptors of her leadership behaviors and style included authoritative, demanding, tenacious, and results-oriented (Brown 2008; Korman 2008; Smith 2008; Wright 2008). Situational contingencies have moderating impacts on relations and task-oriented leadership styles (Bass 1990, 485), therefore, the unique timeframe of Medical City Dallas Hospital was important to note. The organization's financial position was tenuous, organizational performance expectations were demanding, and limited resources were available (Korman 2008; Smith 2008; Wright 2008). Financial performance and adherence to organizational expectations by both hospital and medical staff were strictly enforced. Under her leadership, Medical City Dallas Hospital achieved financial profitably for the first time.

By 1984, Medical City Dallas Hospital was financially stable and positioned to explore new and original initiatives. Dr. Ira Korman was innovative, creative, and a developer of new programs and services (Brown 2008; Smith 2008; Wright 2008). On Blake and Mouton's grid, he establishes himself with more increased concern for relations or

Organization Man Management (see Figure 1). While retaining a level of authority and task orientation, Dr. Korman introduced new programs such as the Advanced Surgical Institute and the foundation for Medical City Children's Hospital. His influence on the overall organization performance exceeded his tenure.

Don Stewart set himself apart from other two identified executives in that he was considered as low on concern for tasks and less engaged in the relational activities. Although authoritative and demanding (Smith 2008, Everly 2008) and with tremendous experience as a hospital executive, Stewart's tenure was unremarkable. The lack of organizational successes during this period, combined with the hasty arrival and departure of two additional hospital chief executive officers leading up to 2000, negatively affected Medical City Dallas Hospital.

The late 1990's was also a period of tremendous industry upheaval as Columbia, a hospital company originally based out of El Paso, Texas, entered the private for-profit hospital industry. Under the direction of Rick Scott, the organization acquired and merged hospitals and healthcare systems, culminating in a 400-hospital national healthcare system. As part of the acquisition frenzy, Columbia acquired Humana, as well as other private for-profit healthcare companies including Healthtrust, AMI, and Hospital Corporation of America (HCA).

At the apex of this growth, the Office of the Inspector General and the Department of Justice investigated several of Columbia's business practices. As a result, Columbia was separated into several smaller healthcare systems. Medical City Dallas Hospital remained part of the approximately 200 hospitals that comprised a significantly reduced Columbia. Dr. Thomas Frist and his leadership team took control of Columbia and renamed the organization HCA.

The executive turnover that was experienced in the late 1990's and the disruption of organizational ownership set the stage for the need for a more dynamic and contemporary approach to leadership at Medical City Dallas Hospital.

Leadership 2000

A new chief executive officer, Britt Berrett, arrived in April 2000 as the ninth president of Medical City. Because of the hospital's faltering performance in recent years, he insisted that the hospital's executive team explore, consider, define, and initiate a new leadership paradigm. The executive team consisted of Sheila Everly, Chief Nursing Executive; Kathryn Engstrom, Chief Financial Officer; Troy Villarreal, Chief Operating Officer; Virginia Rose, Director of Human Resources (HR); Gary Maynard, M.D., Vice President (VP) of Clinical Effectiveness; and Katie Lauer, VP of Business Development. After assuming office, Mr. Berrett eliminated Dr. Maynard's position and Katie Lauer relocated out of the area. The CEO assumed Ms. Lauer's responsibilities. In 2004, the position of Vice President of Strategic Development was created and staffed.

Status of Medical City Dallas Hospital in 2000

In 2000, Medical City Dallas Hospital was experiencing mediocre to poor performance in the areas of employee satisfaction, patient satisfaction, physician satisfaction, community awareness, and fiscal performance. Also important to note was the lack of performance measurement tools available to Hospital Corporation of America (HCA) executives. While this may appear counter-intuitive in light of the literature espousing the ability of private for profit hospital companies to measure performance (Beekun and Stedham 1998, 3; Reeves and Ford 2004, 298; Rosenau and Linder 2003, 219; Sloan, et al. 2001, 1;

Terry 1998, 195), this action researcher reveals a unique characteristic of Medical City Dallas Hospital.

HCA measurement tools to evaluate performance improvements were defined by performance to budgetary financial guidelines. The annual business planning process revolved around financial performance target goals that included: adjusted admissions, net revenue per admission, employee average hourly rate, full-time equivalent employee per adjusted occupied bed, benefits per employee, supplies per adjusted admissions, bad debt as a percentage of gross revenue, all other operating expenses per adjusted admissions, total operating expenses less bad debt per adjusted admissions, and earnings before interest, taxes, depreciation, and amortization (Burroughs 2008).

These financial objectives provided the foundation for the annual business planning cycle. Business planning occurred through a series of hospital-based meetings that resulted in a corporate-mandated, template-driven business plan presentation. The annual presentation did not include strategies or tactics that calibrated with corporate initiatives or projects. The business planning template included the following: market dynamics, financial overview, service line growth, outpatient volume, rural market development, physician recruitment, physician sales, quality, healthy workplace, and support strategies. Based on eight years of use in HCA, these financial performance targets and business plan categories remained constant and consistent, with slight annual variation.

Another area providing possible corporate direction on expected performance criteria was the annual Performance Excellence Program (PEP) or executive incentive compensation plan. Financial performance to budgeted expectations and agreed upon execution of business plan initiatives provided the parameters for executive incentive compensation. Models that

were more recent included employee satisfaction scores, physician satisfaction scores, execution of business plan initiatives, and quality performance matrixes. Nonetheless, in 2000, HCA officials provided the executive team with one expectation – make budget.

HCA did not provide the mission, vision, or values. Nor was the corporation prepared to provide guidance on the creation of a strategic plan. The absence of organizational direction played an important role in the formation of the mission, vision, values, strategic plan, and measurement tools. The executive team developed the strategic plan on its own.

Creating a mission statement

In defining a mission statement, Robert S. Kaplan and David P. Norton (2004, 6) stated, "a mission statement is a concise, internally focused statement of the reason for the organization's existence, the basic purpose toward which its activities are directed, and the values that guide employees' activities. The mission should also describe how the organization expects to compete and deliver value to customers." Healthcare experts (Calhoun, Griffith and Sinioris 2007, 9; Spath 2005, 47) confirmed the importance of the articulation of a mission statement and the integration of the mission statement with the organization's values and vision statement. Spath (2005, 47) further noted that mission statements "clearly express the reason for the existence of the organization." More importantly, "an organization's mission statement should guide the implementation of all strategies."

The nonprofit sector envisioned a mission statement that drove an organization to fulfill a greater moral good or societal obligation. Not only did the devotion to a mission wrap the consumer in a blanket of trust, but it was the basis of an organization's fidelity to a

cause, according to Minkoff and Powell (2006, 591). This clarion call for nonprofit organizations served as a rallying point to engage and enroll workers, volunteers, and donors.

The private for-profit sector shared many of these same needs in creating mission statements. For example, David Packard, co-founder of Hewlett-Packard (HP), described his organization's mission during a 1960 training session held for management trainees:

> I want to discuss *why* [emphasis his] a company exists in the first place. In other words, why are we here: I think many people assume, wrongly, that a company exists simply to make money. While this is an important result of a company's existence, we have to go deeper and find the real reasons for our being. As we investigate this, we inevitably come to the conclusion that a group of people get together and exist as an institution that we call a company so they are able to accomplish something collectively that they could not accomplish separately—they make a contribution to society, a phrase which sounds trite but is fundamental . . . . You can look around [in the general business world] and still see people who are interested in money and nothing else, but the underlying drive comes largely from a desire to do something else—to make a product—to give a service—generally to do something which is of value. So with that in mind, let us discuss why the Hewlett-Packard Company exists . . . . The real reason for our existence is that we provide something which is unique [that makes a contribution]. (Packard 1960, 1)

This mission statement defined the nature of Packard's organization in such a way that gave purpose and meaning for its existence. Although the statement may be lofty and ideological, a mission statement written with specificity could provide clarity in assigning priorities and determining organizational goals (Tuckman and Chang 2006, 633). A mission statement provides direction and focus in a dynamic environment with a multiplicity of stakeholders (Brown and Slivinski 2006, 141; Levin 2000, 93).

Medical City's Experience in Creating a Mission Statement

The determination of a mission statement, identification of values, and creation of a vision statement were important responsibilities of the Medical City Dallas Hospital executive team. In 2000, the mission, vision, and values (MVV) question was plagued with distracting obligations and an abhorence of an over-dramatized process. Troy Villarreal, Chief Operating Officer, summarized the sentiments of the team, "I didn't want to waste all our time talking about mission, vision, and values. I have been in organizations that spent hour after hour, retreat after retreat, talking about this stuff with little or no valuable results" (Villarreal 2008). In her view, Chief Nursing Officer Sheila Everly stated the sentiments of the executive team at the time: "We never really had a mission statement. . . . I guess we just planned from business plan to business plan" (Everly 2008).

The creation of the MVV stalled in the early process of development. Disagreement and confusion emerged as executive team members were challenged to describe the nature of the organization and what it might become in the future. Nonetheless, business planning efforts and executive team relationships strengthened as the executive team wrestled with these important concepts. Donna Davidson (2000, 66) quoted Peter Drucker, "Plans are useless, but planning invaluable." Perhaps despite the best efforts to reach consensus and,

therefore, a conclusion on the mission and values, the process created an environment of spirited dialogue and passionate discussion.

Two critical processes were deployed in the creation of the mission and values statements. Through internal and external scanning, the executive team explored the nature and status of the organization. While these efforts added to the dialogue, executives could not provide specific examples of how input from internal and external processes added to the creation of the mission and value statements (Engstrom 2008; Everly 2008; Rose 2008; Villarreal 2008).

Prior to his arrival as the new Chief Executive Officer (CEO) in 2000, Britt Berrett distributed a survey to the 70 managers and directors. Included with the survey was an invitation to introduce themselves and to provide to the new CEO insight and feedback on the concerns and issues facing Medical City Dallas Hospital. In addition, the CEO conducted an extensive series of interviews and surveys of the executive staff, leadership team, board members, medical staff, and community leaders. By fall 2000, the CEO had conducted over 60 individual interviews with key stakeholders within the hospital organization. In addition, the CEO gathered information regarding the nature of Medical City Dallas Hospital from his attendance at medical staff executive, department, and section meetings.

Several themes emerged from these interviews. Firstly, staff of Medical City Dallas Hospital were conflicted because of its private for-profit hospital status compared to other nonprofit hospitals in the community. Secondly, organizational turmoil and turnover had reduced confidence in senior leadership and the belief that consistent and sustainable leadership was possible. Lastly, fiscal constraints and expectations pervaded the organization and created an environment of "can't do." Numerous other organizational and strategic

challenges faced the newly-formed executive team but the issues of identity, sustainability, and possibility emerged as significant factors in the internal scan.

The external scan of other health care organizations in the region confirmed that Medical City Dallas Hospital was unique and uncharacteristic of other private for-profit hospitals. The five largest hospitals in the Dallas Fort Worth Metroplex, as defined by bedsize and ownership, included:

1) Baylor University Medical Center of Dallas, 997 beds, Baylor Health Care System
2) Parkland Health & Hospital System, 968 beds, Dallas County Hospital District
3) Presbyterian Hospital of Dallas, 866 beds, Texas Health Resources
4) Harris Methodist Fort Worth Hospital, 710 beds, Texas Health Resources
5) Medical City Dallas Hospital, 705 beds, HCA

Notably, private for-profit hospitals throughout the region were typically smaller and located in the suburban areas.

Utilizing an external consulting firm, Medical City Dallas Hospital defined service line performance based on volume and market share. As a result of this process, five service areas were identified as important: pediatrics, women's services, cardiovascular services, oncology, and surgical services. Key stakeholders were identified and surveyed including patients, employees, physicians, HCA, suppliers, and payors.

The executive team identified participation on local community boards as an important tool in conducting internal and external scans. In addition to the Dallas/Fort Worth Hospital Council, Health Industry Council, Citizen's Council, Greater Dallas Chamber of Commerce, and numerous other boards, the executive staff assumed greater visibility in the

community. The intention was to expand community awareness of Medical City Dallas Hospital and also obtain information and perspective from numerous influential community organizations.

Armed with information through the internal and external scanning process and aware of the inability of the executive team to reach consensus on the establishiment of mission and value statements, the chief executive officer made a decision in the fall of 2000 to incorporate the mission statement and the value statement from the parent corporation, HCA. The response by the executive team was not enthusiastic but accommodating as the team members recognized that the task was complete (Engstrom 2008; Everly 2008; Villarreal 2008).

As a result of the process described above, the executive team adopted the following statements for Medical City Dallas Hospital:

Mission Statement

> Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to provide high quality, cost effective healthcare in the communities we serve.

Value Statements

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat those we serve with compassion and kindness.
- We act with absolute honesty, integrity, and fairness in the way we conduct our business and the way we live our lives.
- We treat our colleagues as valuable members of the health care team and pledge to treat one another with loyalty, respect, and dignity.

The decision to impose a mission statement and value statements onto the organization was inconsistent with the literature on the subject. Covey (2004, 219) stated that in order to "help people clearly understand and get commited to signficant goals requires you to involve them in decision making. Together you determine the destination of the organization (vision and mission)." In discussing the success of nationally recognized health care organizations, Patrice Spath outlined the behaviors of recipients of the Malcolm Baldrige National Quality Award for Excellence (2005, 47). She stated that organizations must clearly express the reason for their existence and articulate a mission statement that defines who they are. In the case of Medical City, the corporate mission statement and value statements were utilized because the executive team could not reach concensus.

Establishing the Measurements of Success – the Five Keys

Despite the inability to reach consensus on the mission and value statements, the executive team concluded that it was much simpler to define performance measures or operational levers. During these early meetings, the executive team engaged in spirited discussions and detailed planning to identify stakeholders and their expectations.

A formative resource was the use of *The Balancing Act* by Kerry Patterson, Joseph Grenny, Ron McMillan, and Al Switzler (1999). Best known for their works entitled *Crucial Conversations* (2002), *Crucial Confrontations* (2005), and *Influencers* (2008), the authors discussed the challenges facing leadership in balancing multiple stakeholders and expectations. Their work provided a guide for changing a culture and described the role that leadership played in this effort.

The expectations and needs of identified stakeholders provided the framework for the creation of the operational performance measures. Warren Bennis (1994, 108) described this

process as alignment. This alignment created "a sense of shared objectives worthy of people's support and even dedication." Further, transformational leaders shifted goals and objectives from leader-centric transactional pursuits to stakeholder needs and expectations. By so doing, the goals and objectives, or rather, operational performance measures satisfied the needs of the stakeholders and engaged the full person in the pursuit of these objectives (Sashkin 2004, 173). Essentially, the executive team agreed upon key stakeholders of the organization, including patients, employees, physicians, the corporation, and the community. Measurement tools were developed or incorporated that resulted in lofty goals that fueled organizational planning. These levers or measurements of success were eventually defined by the executive team as the Five Key Indicators of Success or later shortened to the Five Keys.

The authors of *The Balancing Act* (Patterson, Grenny, McMillan, and Switzler 1999, 6) discussed the need for leaders to juggle stakeholder expectations and thereby define measurements of success. Other authors (Kouzes and Posner 2002, 299; Spath 2005, 225; Studer 2003, 61) discussed the importance of accountability in measuring performance. But the concept of expanding the measurement of organizational success from fiscal performance to include stakeholder expectations was new for Medical City Dallas Hospital and for HCA.

Collins and Porras (1994) provided insight on the development of measurement tools in their groundbreaking book on visionary companies entitled, *Built to Last*. They identified and refuted 12 myths long-held to be truths on the nature of successful and visionary organizations. Myth 3 stated that successful companies exist first and foremost to maximize profits (Collins and Porras 1994, 8). Visionary and successful companies "pursue a cluster of objectives, of which making money is only one—and not necessarily the primary one" (Collins and Porras 1994, 8). Based on their research of successful organizations, they

concluded that these companies are guided by core ideology and values and a sense of purpose beyond financial returns. Paradoxically, these same visionary companies outperformed other profit-driven comparison companies, according to Collins and Porras (1994, 55).

The executive team created both numeric and descriptive expectations of the Five Keys:

- Employee pride – achieve world class employee pride, score in the top 10% nationwide as measured by the annual employee pride survey conducted by the Gallup organization.
- Physician engagement –work with engaged and inspiring physicians, score in the top 10% nationwide as measured by a biennial survey administered by HCA.
- Patient loyalty – provide excellence in patient care, score in the top 10% nationwide as measured by the quarterly patient satisfaction survey conducted by the Gallup organization.
- Fiscal performance – fulfill our commitments, meet budgeted financial expectations.
- Community involvement – participate in activities that build our community, achieve highest top-of-mind awareness scores in metroplex as measured by Lonestar Surveys.

Due to the nature of business planning within HCA and Medical City Dallas Hospital, the executive team welcomed the expansion of measurement tools from financially-driven indicators to include patients, employees, physicians, and the community.

Developing a Vision Statement

With the establishment of mission and values statements and the Five Keys, Medical City Dallas Hospital embarked on the development of the vision statement and eventually a strategic plan. A vision statement was "intended to rally the energies, galvanize the aspirations and commitment of organization members, and mobilize them into concerted action toward achieving the desired future" (Levin 2000, 93). A vision statement not only

motivated followers but also provided a structure around which meaning could be defined and action initiated (Mumford and Strange 2002, 109).

Frustration ensued as the executive team struggled to embrace a vision of what the organization could become. Efforts to include consultants and facilitators proved ineffective. However, an unintended consequence of the planning sessions was that the executive team was building strong relationships among themselves. "We had to make some very hard decisions at the beginning but it was clear that we were in this together," according to Human Resource Director Virginia Rose (2008).

Covey presented a unique and introspective view on the characteristics of the highly effective organization contained in his book, *Spiritual Roots of Human Relations* (1970). In *The 7 Habits of Highly Effective People* (1989), he described the habits necessary to enjoy a fulfilling and successful life. This seminal work has become the tome for many and has been followed-up by numerous derivatives of his basic theme that there exists a "deep need for personal congruency and effectiveness for healthy, growing relationships with other people" (Covey 1989, 15). His work included a lengthy description of the issues ailing organizations and provided a framework for creating structure and methodology to address those shortcomings.

In the development of a vision for Medical City Dallas Hospital, key elements contained in Covey's work played an important role in defining the relationships among the members of the executive team and later the entire organization. Covey (1989, 207) described the necessity of a win/win relationship and the importance of interdependence in an organization. To understand individual hopes and aspirations was fundamental. The early meetings of the executive team illustrated the importance of trust in the formation of

camaraderie among the executive team. Consistent with Covey's advice, the eventual success of the organization was foundational to this principle.

Unfortunately, these efforts were chaotic, disruptive, challenging, and frustrating. Despite the establishment of the Five Keys, the executive team identified obstacles that had the potential to prevent Medical City Dallas Hospital from achieving these goals. Limited resources, corporate structure, personnel shortages, and physical plant limitations were a few of the real and perceived limiting factors.

The literature on the formation of teams addressed the challenges and obstacles associated with team creation (Goleman, Boyatzis and McKee 2002, 172; Lencioni 2002, viii) and more importantly, the formation of a vision statement for the organizaiton. Such was the case of the executive team of Medical City Dallas Hospital as it met to discuss the vision and strategic plan of the organization. Action research was invaluable because it provided intimate insight and perspective into real-life situations, complicated by personal biases and perspectives (Brannick and Coghlan 2007, 59; Lewin 1946, 36; McNiff and Whitehead 2006, 8; O'Brien 1998, 3; Reason and Bradbury 2001, 2) The discussion at the executive team level occurred through weekly Tuesday morning meetings, quarterly off-site retreats, and on-going informal dialogue.

Peters (1987, 483) quoted Father Theodore Hesburgh, former president of Notre Dame University, in a May 1987 address : "The very essence of leadership is [that] you have to have a vision. It's got to be a vision you articulate clearly and forcefully on every occasion. You can't blow an uncertain trumpet." Bennis and Nanus (1985, 21) concluded that "leaders articulate and define what has previously remained implict or unsaid; then they invent images, metaphors, and models that provide a focus for new attention. By so doing,

they consolidate or challenge prevailing wisdom. In short, an essential factor in leadership is the capacity to influence and organize meaning for the members of the organization."

Peters (1987, 489) provided a unique insight into the role of the leader in the development of a vision when he quoted Stanford University president Donald Kennedy, "The leader's job is to energetically mirror back to the institution how it best thinks of itself." He suggested that the development of a vision occured as leaders "wallow" in the organization until these truths become increasingly clear. With keen insight, leaders were able to describe the possible future in such a way that is vibrant and empowering. By living in the organization and understanding its unique culture and organizational fabric, the articulation of a vision became self-evident, according to Peters (1987, 492). Peters (1987, 485) further stated that "developing a vision and more important, living it vigorously are essential elements of leadership."

The executive leadership team at Medical City Dallas Hospital continued to struggle with defining the vision statement. The Chief Operating Officer recalled, "I remember the retreats where we discussed what we wanted to be and where we were going. I remember the discussion of becoming a quaternary hospital and to this day I don't know what quaternary means" (Villarreal 2008). Their work concluded with a statement of understanding regarding the future state of the organization as follows:

2000 Vision Statement for Medical City Dallas Hospital:

> We will become a quaternary referral center, providing excellence in care to the communities we serve.

The executive team's inability to articulate a powerful vision statement was consistent with the findings of Collins and Porras in *Built to Last* (1994). Of the 12 myths they identify, Myth 12 states that visionary companies have visionary statements. In fact,

their research concluded that visionary and successful organizations utilized a vision statement as only a helpful step in building a visionary company.

Perhaps the validity of this statement was found in the results of the 2008 Employee Survey. Despite an inability to articulate a powerful and moving MVV that was future-oriented, compelling, bold, aspiring and inspiring (Levin 2000, 92), the employees of Medical City Dallas Hospital appeared to understand the organization's direction. In a survey conducted in May 2008 with over 90 percent staff participation, 90 percent of employees had a clear picture of the hospital's direction, as defined by the senior leadership (see Table 1).

Collins and Porras (1994, 201) observed that, "the essence of a visionary company comes in the translation of its core ideology and its own unique drive for progress into the very fabric of the organization – into goals, strategies, tactics, policies, processes, cultural practices . . . into *everything* that the company does." James MacGregor Burns (2003, 26) described the participatory and democractic nature of transformational leadership that inspired followers. Although the vision was not part of the "daily discourse of the citizenry," the essence of the mission, vision, and values evoked tremendous change, organizational performance, and the realizations of the highest intentions (Burns 2003, 29).

Through the subsequent years, the CEO and the executive team made numerous attempts to create a vision statement that described a "future world where the mission is advanced and where goals and strategy are being successfully achieved in lockstep with the organization's guiding philosophy and values" (Levin 2000, 95). The responsibility to refine the vision statement was shifted to the newly-created Leadership 2005, a multi-disciplinary group of managers, directors, executives, and supervisors that developed the core leadership curriculum later known as Medical City Dallas University (MCDU). Further, this group was

instrumental in the development of the Medical City Dallas Leadership System (MCDLS) which will be discussed later in this research. Efforts to create a vision statement resulted in minor revisions and modifications as follows:

2008 Vision Statement for Medical City Dallas Hospital

> We are committed to excellence and innovation and to inspire other organizations to join in our passion.

Moving forward with the mission, vision, values and 5 keys

While not executed according to proscribed plans of mission, vision, and value statement development (Sashkin 1988, 129; Calhoun, Griffith and Sinioris 2007, 10), the CEO's exhaustive effort to define the unique characteristics of the organization was important**.** The internal scan revealed organizational challenges of identity, sustainability, and opportunity.

Identity

In a predominantly non-profit based health care envrionment, a private for-profit hospital like Medical City Dallas Hospital differentiated itself from other medical care organizations established by the Baptists, Presbyterians, and Methodists. Further, the national and international fame of Parkland Hospital as a public health care system provided a unique comparison to Medical City Dallas Hospital and its private for-profit foundation. Therefore, it was essential to establish the mission-driven nature of health care and the important role that Medical City Dallas Hospital played in giving to the community.

Sustainability

Senior executive turnover was a serious concern for the organization and assurances were necessary to establish credibility. Interviews with medical staff leadership revealed anomosity towards HCA because of its failure to retain chief executive officers (Hopkins

2008; Lenarsky 2008; Vernon 2008). Key constituents confirmed the need for HCA to make commitments that not only would the CEO remain in place but succesion planning would be instituted to establish a continuum of leadership (Lenarsky 2008; Smith 2008; Vernon 2008; Walters 2008).

Opportunity

Perhaps the greatest challenge in communicating the MVV was the inability of physicians and staff to envision Medical City Dallas Hospital as a premier healthcare organization. In a pivotal leadership team meeting, consultants from the Gallup Organization challenged the organization to refuse to wallow in "can't do" and imagine an organization that "can do" (Rose 2008). Gallup surveyed the leadership team requesting a listing of all organizational and departmental awards at local, regional, and national levels that were attainable. Despite a dearth of possibilities from others, the Chief Nursing Officer proposed the designation as a Magnet Nursing Hospital as defined by the American Nursing Credentialing Association (Everly 2008; Villarreal 2008).

Process to communicate the MVV

Prior to 2000, the executive leadership structure at Medical City Dallas Hospital included the chief executive officer, chief financial officer, chief operating officer, and chief nursing executive. The seventy managers and directors of the organization represented the next tier of leadership. Bi-weekly meetings were held with the executive staff and monthly meetings held with the managers and directors.

Immediately the new organizational structure was announced. The senior leadership staff was defined as the Executive Team to include the chief executive officer, chief financial officer, chief operating officer, chief nursing executive, and director of human resources

(who later was promoted to vice president of human resources). The vice president of quality resigned from the organization and the director of business development relocated out of the area. By 2008, the Executive Team was expanded to include the vice president of strategic development & communication, vice president of cardiovascular services, vice president of surgical services, vice president of performance improvement, vice president of operations, and the administrative fellow.

The list of seventy managers and directors was expanded to eighty individuals and retitled the Leadership Team. Monthly meetings were transitioned from an organizational reporting activity to a transformational leadership development effort. In addition, approximately 140 supervisors were identified and included in a defined leadership development initiative entitled Medical City Dallas University (MCDU).

MCDU was a leadership development program that was unique and dynamic. A core planning group of ten members of the executive staff, leadership team, and supervisors was created and entitled Leadership 2005. Through a series of bi-weekly planning sessions a very rudimentary leadership development program with twelve educational sessions was established. These initial programs included training in conflict resolution, diversity, financial and operating performance, hiring for fit, process improvement, and business planning. The program provided information and programs to move the Leadership Team from a managerial function into the assumption of leadership responsibilities. The creation of the Medical City Leadership System was based on these early efforts.

Parallel to these initial activities was the introduction of the MVV and Five Keys by the Executive and Leadership Teams. Focus was placed on the identification of executive and leadership team members and the MVV was aggressively communicated to these targeted

individuals. Meeting agendas were reformatted to include the MVV as headers and footers on all documents. Utilizing principles from Steven Covey's work entitled, *The 7 Habits of Highly Effective People* (1989, 285), weekly Executive Team meetings and monthly Leadership Team meetings included educational sessions, referred to as sharpening the saw, on leadership principles based on the MVV. Audio-visual resources were developed to further communicate further the newly-defined organizational mission, vision, and values. Business planning documents modeled the MVV and strategies and tactics aligned with the Five Keys.

One resource used in communicating the mission, vision, and values was Medical City Dallas University. Utilizing a model of higher education, the chief executive officer was titled the chancellor of MCDU and key leadership staff were titled as appropriate. In 2000, a new school year orientation was held on the campus of Southern Methodist University announcing the mission, vision, values, and Five Key Indicators of Success along with an educational seminar or sharpening the saw session focusing on fundamental leadership skills.

These early efforts of 2000 expanded into a series of structured annual activities including a fall retreat or orientation program to present the upcoming business plan coupled with educational programs and team-building activities. The annual MCDU spring break activity reported prior year performance results of the Five Keys and the distribution of bonus checks tied to organizational and individual accomlishments and the mission, vision, and values.

Armed with the mission statement, value statements, vision statement, and measurement tools (Five Keys), the executive team began a process of communication throughout the organization. The first step was the use of visually and emotionally charged

media. Through a hospital-wide initiative came the creation of a video presentation entitled, *Who is Medical City?* (Rister 2000) – a series of candid and unscripted interviews combined with a historical overview presented in a 45 minute video. Interviews were conducted with past presidents of the medical staff, board members, hospital executives, and staff employees. The power of this presentation was captured in a discussion with one food and nutritional services employee that requested multiple copies so that she could send them to her family in Guatemala. The presentation focused on the unique aspects of Medical City Dallas Hospital and its mission to improve the lives of the patients served.

Harvard Business Review (2003, 51) explored the power in creating dyanmic communication tools in its June 2003 interview of legendary screenwriter Robert McKee. McKee (2003, 52) described the importance of storytelling that "engages listeners on a whole new level." He stated that an important element of a CEO's job is to motivate, inspire, and engage the organization. By utilizing other media than just powerpoint and prepared speeches, the leader was able to "pack enough emotional power to be memorable" (McKee 2003, 52). Little was written on the power of video presentations in the development of organizational culture, however, it was recognized that alternative media were potentially powerful and influential, according to McKee. Copies of the video were distributed to all employees, medical staff, and board members as Christmas gifts in December 2000. Viewing of the video was included in a series of mandatory employee forums.

In addition, traditional organizational communication tools, such as posters and newsletters were utilized. An internal communications coordinator created the bi-weekly *City Vines* on-line newsletter and quarterly *City Views* magazine. Bianca Jackson (2008), communications coordinator stated, "our internal publications help to crystalize the mission,

vision, and values. By sharing the latest medical advances, employee accomplishments, or organizational awards and patient stories, *City Views* documents the moments that make Medical City such a special place."

Other communication tools utilized to communicate the mission, vision, and values included the introduction of City Forums and City Life. City Forums were mandatory employee hour-long informational sessions that were presented by the Executive Team over a two week period. The chief executive officer opened each quarterly sesssion with a discussion on the mission, vision, and values of the organization. Following this initial presentation, members of the executive staff provided status reports and information related to the Five Keys. These sessions concluded with each employee receiving a gift of appreciation such as shirts, chairs, coolers, and first aid kits.

The chief nursing executive stated, "the forums are used to communicate important issues, new programs, reinforce the mission, vision, and values, Five Key updates, create alignment, assure consistent messaging, raise awareness, keep the entire executive team in front of the staff and make relevant all these issues to the individual" (Edmonson 2008). The chief operating officer confirmed the importance of communicating the mission, vision, and values as well as recognized that the forums provided a "communication tool and feedback loop to our staff . . . how as an organization we are doing, and where we are heading. The use of the City Forums contributes to the culture of communication at Medical City Dallas Hospital and provides an opportunity for senior leaders to use factors of transformational leadership" (Schmidly 2008).

In a study conducted by senior leadership on the effectiveness of City Forums the following was concluded:

> Forums provide opportunities for leaders to hit on several factors of transformational leadership. The first factor of transformational leadership is charisma or idealized influence. The forum venue allows nearly all employees to see and gain access to senior leaders and identify with the goals of excellence and innovation and feel the passion and experience the charisma of senior leadership. The second factor is inspirational motivation. During the forums, the leaders communicate the vision and mission of the organization which can inspire employees to identify with these values and commit to excellence in the areas where they contribute. The third factor is intellectual stimulation . . . the forums provide an opportunity for senior leadership to mold the culture of the hospital and inspire others to be committed to excellence. The City Forums are an impactful vehicle for communicating to all hospital employees. The forums provide the senior leadership of Medical City Dallas Hospital an opportunity to stay visible, stay connected, establish rapport with the staff, and provide directed, purposeful communications on issues important to the continued success of the hospital. (Lines 2008, 5)

In 2000, the Executive Staff discussed the importance of communicating the mission, vision, and values with greater emphasis on individual staff engagement. An employee educational program was developed entitled City Life. Presented by the chief executive officer, employees were scheduled throughout the year to attend this mandatory educational program. To ensure compliance, attendance at this program was included in the mandatory educational requirements associated with healthcare employment such as job specific skills assessments. The program included portions of the video presentation *Who Is Medical City?*

The importance of embracing the mission, vision, and values throughout the organization was the focus in the creation of the guest relations department in 2001. Led by Alan Butler, who also assumed responsibility for campus security responsibilities, a multi-disciplinary committee was formed to identify employee service standards. Behaviors and activities were determined to be essential in providing care to patients. These service standards include: accountability, appearance, attitude, call lights, commitment to co-workers, communication, customer waiting, elevator etiquette, privacy, stewardship, team, and telephone etiquette. Each service standard included a specific set of behavioral

expectations. Orchestrated by the guest relations department, educational programs and training were provided throughout the organization focusing on the patient's experience and in alignment with the mission, vision, and values and Five Keys. The City Life meetings were modified to embrace not only the mission, vision, and values but also the newly-formed service standards.

By 2004 it was decided to suspend the City Life program. The guest relations department assumed responsibility to provide more department specific training and education in the area of patient loyalty. Further, a mystery shopper program was initiated to pinpoint specific department opportunities for improvement. In 2008, City Life was reintroduced, focusing on one of the Five Keys, patient loyalty, and an educational program was created to provide additional training for all employees on the patient's experience.

Concurrent with organizational strategies to communicate the mission, vision and values, MCDH leaders recognized the need to ensure that new employees were educated on organizational expectations. Beginning in 2000, the monthly new employee orientation program was reorganized to introduce the unique cultural aspects of Medical City Dallas Hospital. Mandated by federal and state regulations, health care workers are required to participate in extensive preemployment training and orientation. In addition to safety, risk, infection control, ethics and compliance, and human resources, new employees are provided training in guest services and the service standards. The concluding presentation by the chief executive officer discussed the organization's culture, the mission, vision, and values.

Two significant areas of activity evolved through the creation of the mission, vision, values, and the Five Keys. Firstly, leaders recognized the need to establish a leadership model that aligned with organizational activities and that provided a structural framework for

leadership development. While initial activities were positive and successful, the efforts were chaotic and unorchestrated. “There was plenty to do so we just did. I don’t think we ever gave much thought to a system or process on leadership” (Rose 2008).

Secondly, Medical City Dallas Hospital needed to establish not only an organizational framework but introduce discipline in the planning process to respond to a dynamic and competitive market place. The annual business planning process proved ineffective as external forces accelerated their influence. HCA designated the Dallas/Fort Worth metroplex as “ground-zero” nationwide for all new and entrepeneurial initiatives in direct competition with traditional hospital services. Medical City Dallas Hospital combined a leadership development system with the creation of a comprehensive strategic planning process that resulted in signficant organizational accomplishments.

Achieving Magnet Designation – 2003

The Magnet Recognition Program was developed by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association, to recognize health care organizations that provided nursing excellence (Amercian Nurses Credentialing Center 2008). The program was based on quality indicators and standards of nursing practices as defined in the American Nurses Assocation’s Scope and Standards for Nurse Administrators which embraced, supported, and advocated the development of excellence in nursing practices.

The Magnet designation process included the appraisal of qualitative factors in nursing that demonstrated strong visionary nursing leadership and that elevated the reputation and standards of the nursing profession (American Nurses Credentialing Center 2008). The three stated goals of the Magnet Recognition Program were to promote quality in

a setting that supported the professional practice of nursing, to identify excellence in the delivery of nursing services to patients, and to disseminate best practices in nursing services. After an extensive study conducted in the early 1980's and the creation of the ANNC as a subsidiary of the American Nurses Association in 1990, the first organization to receive Magnet designation was the University of Washington Medical Center in Seattle, Washington in 1994.

Applications to the ANCC for the Magnet Recognition Program were received monthly from hospitals and health care organizations nationally and internationally. An extensive application was submitted, followed by an in-depth site visit by representatives of the American Nurses Credentialing Center. As part of the evaluative process, the Magnet Model was utilized to assess the framework of nursing practice and research within a health care organization. The five components of this model included: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and, empirical quality results.

In defining transformational leadership, the ANNC stated that today's leaders were required to "transform their organization's values, beliefs, and behaviors . . .the transformational leader must lead people to where they need to be in order to meet the demands of the future. This requires vision, influence, clinical knowledge and a strong expertise relating to professional nursing practice" (American Nurses Credentialing Center 2008). Transformational leaders in nursing created the vision for the future and the systems and environment necessary to achieve that vision. The ANCC model stated that the intent of the model was not to fix broken systems but rather to empower the staff to transform the organization to meet the challenges of the future.

In 2003, Medical City Dallas Hospital was the first health care organization in the northern Texas region to receive this award and the 94th worldwide to be designated as a Magnet Certified Health Care Organization. By 2008, only 294 hospitals and health care organizations of an estimated 7,000 hospitals nationwide had been so designated including organizations such as Stanford Hospital and Clinics, the Mayo Clinic College of Medicine, M. D. Anderson Cancer Center, and The Johns Hopkins Hospital. In 2007, Medical City Dallas Hospital was the first in the region to be redesignated as a Magnet facility.

Numerous studies confirmed that organizations achieving Magnet designation consistently demonstrated higher average job satisfaction by nursing personnel (Aiken, Havens and Sloane 2000; Kramer and Schmalenberg 2004; Laschinger, Shamian and D.Thomson 2001; Upeniekes 2002) . In a review of the literature by author Diane Brady-Schwartz (2005, 397), the author concluded that the Magnet Recognition program fostered excellence in nursing services and improved job satisfaction and retention by creating a transformational work environment.

Best Places to Work – 2004

In 2003, the Dallas/Fort Worth metroplex was emerging from an economic downturn as the result of the collapse of the information technology industry (Paton 2003, 3B). In response, the *Dallas Business Journal* created the Best Places to Work recognition program. The companies selected were chosen after a survey of both management and other employees. Input from other employees was given more weight than management comments in the final score.

The *Dallas Business Journa*l joined with representatives from Choice Staffing, Haynes and Boone L.L.P., People Solutions, and the Dallas Human Resources Management

Association in developing the survey that evaluated companies and their workplaces, including their culture, benefits, and uniqueness. The Best Places to Work committee also developed a system for evaluating how employees rated their work environments (Paton 2003, 4B). After a review of national surveys and research data identifying characteristics that distinguished companies from one another in terms of work place environments, the committee created five categories for evaluation: business success, personal and professional development, culture, benefits, and leadership.

The *Dallas Business Journal* solicited applications and received over 300 nominations from throughout the metroplex. Finalists completed a thorough employer survey and questions were weighted to achieve a composite score. A specified percentage of total employees was required to complete an employee survey and weighted values were assigned to each question. The combined scores were determined based on an assignment of 60% weighted on the employee response score and 40% on the employer composite score.

The intent of this program was to honor businesses, but in the words of Huntley Paton, publisher of the *Dallas Business Journal*, "The most powerful advantage that I can think of is having a business and work place that brilliant, good people feel drawn to. A team of employees who are inspired and excited about coming to work every day is a competitive edge that will keep you growing through good times and bad and keep the competition scrambling to keep up" (Paton 2003, 3B).

In the first year of the recognition program, Medical City Dallas Hospital was selected as a finalist in the large business category. In 2004, the hospital was awarded the *Dallas Business Journal* Best Place to Work recognition. In describing the organization, the *Dallas Business Journal* in its headline stated, "Medical City Dallas Cultivates Employee

Pride" (*Dallas Business Journal* 2004, 11B). In a quote from an employee, the Journal reported, "The management here is awesome. Our facility has grown so much this past year. We are on a continuous path of achievement. People care here. If you are having a bad day you don't have to look far for a smiling face to brighten your day!" Another employee stated, "I've lived through many senior administrative changes through the years here. This leadership team is by far the most responsive, visionary, and forward-thinking group we've ever had. They fully walk and talk the mission/vision statement. They hold us accountable and are teachings us (and expect us) to hold each other accountable. We're goin' places" (*Dallas Business Journal* 2004, 11B). In follow up to this recognition, Medical City Dallas Hospital elected to co-sponsor the program and regularly participates in the annual recognition banquet.

Best Place to Work – 2005 and 2009

In 2005, the Texas Association of Business recognized Medical City Dallas Hospital as one of the Top 50 Best Places to Work in the State of Texas. A survey process included 25 percent of the employees who were asked questions regarding compensation and benefit practices, leadership, vision and mission commitment, and senior leadership trust (Rose 2008). For 2009, the award was again given to Medical City Dallas Hospital. Recognition of this achievement was published in *Texas Monthly* magazine.

Internal Employee Surveys – 1999 - 2008

HCA conducted internal assessments of employee engagement and satisfaction regularly. Initially adminstered by the Gallup Organization and later by Lightspeed Research-The Foresight Group in 2004, annual employee surveys provided information on employee

perceptions and attitudes. A 35-question survey was administered through HCA, with Medical City Dallas Hospital achieving participation rates in excess of 90 percent since 2003.

Table 1. MCDH Employee Engagement Survey Comparison 1999- 2008

Survey Question	1999 Results	2008 Results	2008 HCA Results
Overall Engagement	50	86	76
Q1: Satisfaction with facility as a place to work	50	93	89
Q6: Supervisor shows sincere interest in me	51	86	78
Q10: Supervisors coaches/guides me	45	83	74
Q13: Senior leaders available/approachable	36	84	72
Q17: Senior leaders give clear picture of direction	37	90	69
Q28: Count on senior leaders to follow through	39	80	64
Q:24 Kept informed of what is happening here	37	80	68
Q26: Satisfied with amount of voice	37	72	63
Q3: I make an important contribution	50	96	94
Q:15 Work contributes to overall success	50	97	93
Q32: Employees are treated with respect	54	84	71
Q30: Recommend facility as a great place to work	56	90	76
Q34: Plan to be working here 1 year from now	56	91	85

* Figures reported in percentages of those indicating agree and strongly agree

In 1999, less than 50 percent of the staff participated in the survey. Further, the composite score was 3.24 compared to the HCA national average composite score of 3.53 (Medical City Dallas Hospital 2008, 116). These results classified Medical City Dallas Hospital in the bottom quartile of the company. In a follow-up study conducted by the Gallup organization requested by Medical City Dallas Hospital, employee engagement was further explored. Based on a proprietary evaluative tool, Gallup estimated that 38 percent of all hospital employees were actively disengaged.

In 2008, the 2,272 surveys completed by employees presented a significant improvement in overall employee perceptions and attitudes. The overall engagement score of

86% compared with priors year of 84% and 81% and the HCA overall engagement score of 76%. In the categories of leadership effectiveness and culture and recognition, the questions demonstrated significant improvement from 1999 to 2008 and variance from HCA results.

As part of the 2008 annual employee survey, 5,524 verbatim comments were received with 511 specific to senior leadership and management (Lightspeed Research - The Foresight Group 2008, 113-134) :

- I like the fact that I feel as though I could approach our senior managers. I've never had the need to do so, but I sincerely believe that the personality I witness during the quarterly City Forums is the person I will encounter face-to face.
- Excellent leadership team, dedicated, motivated and visionary.
- Their door is always open and communication is always kept open.
- This is the best I have ever experienced in 13+ years with HCA. Keep doing what you are doing!
- The other reason I stay at MCD is the Senior Leadership. I have the same values and goals that they live by while here. XXX and XXX enthusiasm is contagious!
- I have been at 2 other HCA facilities and consider the senior leadership involvement more than the two of them combined. Thank you.
- TOP NOTCH I say it every year- I totally trust Sr Leadership and am confident that they will do what they say they will do. It's refereshing to have a mission/vision that is lived out and supported every single day. They also care about us as individuals. I never feel like I am working in a factory – they know each of us and show they care about us both personally and professionally. They also seek our ideas and opinions. It's much easier to buy into things when the Sr Leadership has made an effort to see how things they implement will affect us.
- Engaging, energetic and making a great impact on the organziation.
- XXX XXX is an exceptional leader who cares about employees and sets a good example every day.
- Senior Leadership is creative, fun, and intelligent. They put quality of care first, and all seem to have a good understanding of what it takes to make a dynamic organization.

- I have been at Medical City for 29 ¾ years. We currently have the best Executive Team that we have ever had. They are open and accessible to line staff as well as managers.

- Nothing to say!!!! I love the senior leadership team !!!! That's what brought me back to Medical City, after been gone for a few years . . . Keep up the good work.

- I feel like the communication between the senior leadership and the floor staff has really improved over the past year.

- They have been wonderful setting goals for us to achieve and guide us to the right place.

- Enthusiastic and shows warmth and friendliness to employees. I have worked in 4 different hospitals and this one's the best so far (Medical City).

- I think the hospital senior leadership does a great job of being approachable and sharing their vision about the direction of the facility . . . .

- No improvements needed. The Senior Leadership Team is visible, accessible and engaged. They also serve as strong advocates for patients and employees.

- I have not been here long enough to know if they are true to their word, but I have heard good things about them all.

- MCDH Senior Leadership does a good job in presenting the mission and values and course of progress of the organization.

In a study conducted by Alex Edmans of the Wharton School of Business at the University of Pennsylvania, employee satisfaction and long-run stock performance were correlated. Based on their study of *Fortune* magazine's Best Companies to Work For in America from 1998 through 2005, the award recipients earned 14% more per year and outperformed industry-and characteristics-matched benchmarks; controlling for risk, it yielded a four-factor alpha of .64% (Edmans 2007, 1). In commenting on the results of the study in an on-line university newsletter, the author stated, "One might think this is an obvious relationship—that you don't need to do a study showing that if workers are happy, the company performs better. But actually, it's not that obvious. Traditional management

theory treats workers like any other input—get as much out of them as possible and pay them as little as you can get away with" (Knowledge @ Wharton 2008). Edmans (2007, 18) concludes that, "If superior employee satisfaction caused even a portion of the 64 basis point monthly abnormal return, the employee-friendly programs can substantially improve shareholder value."

Recognized as a High Performing Facility – 2005

HCA was the largest private hospital company in the world with 189 hospitals and outpatient facilities throughout the United States and Europe. In 2006, hospitals owned and operated by HCA performed 140,365 deliveries or 5.18% of all newborn deliveries nationwide. In the same year, HCA hospitals peformed 12,518 open heart by-pass surgeries or 4.7% nationwide; and, 31,128 joint replacements or 6.17% nationwide. In total, HCA hospitals treated 1,765,704 inpatients or 4.76% nationwide (Fainter 2008, 2). In 2006, HCA hospitals treated 14 million patients; employed 190,000 nurses, technicians, and health care workers; credentialed an estimated 37,000 active staff physicians; cared for 5.3 million emergency room visits; and provided an estimated $1.9B in uncompensated care (Fainter 2008, 2).

As part of a 2005 extensive internal study of organizational performance, HCA evaluated the 189 hospitals to determine the characteristics of top performers. The goal of the study was "to identify best practices that could increase employee enagement, patient satisfaction, and physician satisfaction throughout the HCA system" (Wolf 2008, 38). It was theorized that high performing facilities (HPFs) could be identified and performance characteristics effectively shared throughout the organization. Eleven hospitals were identified through a performance matrix which included employee engagement, patient

satisfaction, nursing measures, employee turnover, and comparative financial measures. Each of the identified facilities demonstrated top levels of performance overall and consistency in a three year period from 2002 to 2004 (Wolf 2008, 39).

HCA conducted a series of on-site visits. Over the course of the study, almost 160 one-on-one interviews with senior leadership and directors or managers were held; 64 focus groups, including over 700 staff-level employees, were conducted; and, almost 2,000 surveys were collected (Wolf 2008, 39). The authors identified seven central characteristics of high performing facilities (HPFs). These include: visionary leadership; consistent and effective communication; select for fit and ongoing development of staff; agile and open culture; service is job one; constant recognition and community support; and solid physician relationships.

Medical City Dallas Hospital was identified as a high performing facility and studied along with ten other hospitals within the HCA analysis. These facilities included: Greenview Hospital, Bowling Green, Kentucky; Hendersonville Medical Center, Tennessee; Horizon Medical Center, Dickson, Tennessee; Medical Center of Plano, Plano, Texas; Methodist Ambulatory Surgery Hospital North West, San Antonio, Texas; Redmond Regional Medical Center, Rome, Georgia; Round Rock Medical Center, Austin, Texas; Skyline Medical Center, Nashville, Tennessee; Texas Orthopedic Hospital, Houston, Texas; and, West Houston Medical Center, Houston, Texas.

Internally, HCA classified hospitals on their size and complexity, based on a graded scale which ranges from level A through F. Medical City Dallas Hospital was a level F hospital, defined by annual net revenues in excess of $333 million. Classified as the largest hospitals of HCA, Medical City Dallas Hospital was joined by Southwest Texas Methodist,

San Antonio, Texas; Chippenham/J-W Hospital, Richmond, Virginia; Sunrise Hospital, Las Vegas, Nevada; Oklahoma University Medical Center; Centennial Medical Center, Nashville, Tennessee; Westley Medical Center, Wichita, Kansas; Henrico Doctors Hospital, Richmond, Virginia; Medical Center of Jacksonville, Florida; Trident Regional Medical Center, Augusta, Georgia; Swedish Medical Center, Denver, Colorado; and, Good Samaratin Hospital, San Jose, California. Medical City Dallas Hospital was the only level F facility identified in the HPF study.

The authors reported that HPFs had significantly higher employee engagement scores, having over four more engaged employees for every one at the low performing hospitals (5.68 vs. 1.63). The term engaged employee was defined by the Gallup organization as individuals embraced in the organization's success and performance (Coffman 2002). Engaged employees were more profitable, more customer focused, safer, and more likely to withstand temptations to leave (Wolf 2008, 41).

High performing facilities were also found to have a significantly greater retention of employees, with a 7 percent gap in turnover between high and low performers. Turnover from 2000 to 2004 decreased by 3.9% in high performing facilities and increased 1.4% in low performing facilities. Nothwithstanding the financial impact of staff turnover, the cultural implications represented a significant issue for an organization. Lastly, the study reported that on average high performing facilities enjoyed superior financial performance, exceeding low performers over the course of the study by a 5% margin (Wolf 2008, 41).

The importance of the study and the identification of Medical City Dallas Hospital as a high performing facility was a significant conclusion. In an internal report (HCA 2005), high performing facilities generated $15 million more in average EBDITA per facility;

$32,000 more in revenue/bed than low performers; and achieved higher average EBDITA as a percentage of net revenue by six basis points compared to low performers (Wolf 2008, 7).

In studying the uniqueness of high performing facilities, the issue of visionary leadership followed a consistent path of "getting clear about its identity—its vision, core values, and beliefs—and then the process leads the user through strategizing, designing, and measuring value" (Wolf 2008, 42). According to the author of the study, "Medical City is a unique organization. Throughout our interviews it was clear that the staff understood the direction and the vision. They had attained a level of communication and camaraderie that is usually seen in a smaller organization and rarely exhibited in a facility as large and complex as Medical City. More importantly there was a consistent and almost fanatical obsession with excellence in everything . . . in how they treated patients, how they recognized their accomplishments, how they served in the community" (Wolf 2009). These observations align with elements described in transformational theory.

Healthy Work Environment Assessment- 2008

Building on the study on high performing facilities and as a follow-up to employee engagement surveys, HCA embarked on a Healthy Work Environment intiative. Coupled with aggressive and comprehensive programs and initiatives that were targeted at the changing needs of the health care workers (Rose 2008), a series of evaluative tools were utilized to assess organizational status related to employee engagement and performance. The Healthy Work Environment assessment tool (Healthy Work Environment - Vulnerability 2008) provides an overall index based on staffing practices; recognition/culture; leadership effectiveness; compensation, benefits and employee safety; and, voice/communication.

Based on this evaluative tool, in 2008 Medical City Dallas Hospital achieved an indexed overall score of 93.0, the highest of all 189 HCA hospitals.

Concurrent with this evaluation, Baird Borling Associates, a nationally-recognized consulting firm on employee engagement, was retained by HCA to conduct on-site survey of all facilities. The survey at Medical City Dallas Hospital was conducted from July 7 through 11, 2008. The assessment process included 45 individual interviews with members of management and the senior leadership team, in addition to 14 focus group meetings involving a total of 146 non-supervisory employees. Participating in the focus group were 66 registered nurses, 33 allied health professionals, 14 administrative/ clerical secretarial staff, 16 technical/patient support staff, and 17 service/support/ maintenance staff. Approximately five percent of all hospital employees participated in this survey.

The report concluded:

> Consistently positive feelings were expressed by management interviewees and employee focus group participants, as most reported that the current CEO has turned the facility around after years of high CEO turnover and a history of hospital performance issues . . . . Nearly everyone agreed that the focus and value system of the hospital is now centered on achieving excellence, and toward that end Senior Leadership is working to put the right people in the right places, in both leadership and staff positions. Senior leadership functions as a strong team where everyone seems to be 'on the same page' and the group speaks with one voice. Particular attention during the interviews and group meetings was given to the CEO, who was singularly credited with transforming the culture of the organization over the past 8 years. . . . The efforts of the Senior Team, and particularly the CEO, were said to have achieved a significant cultural transformation throughout the hospital. Particpants both expressed and reported a very strong buy-in for the vision, mission, and values of the organization and support for the numerous initiatives that have been put in place to strengthen the hospital and its image in the community. Focus group participants and management interviewees agreed almost unanimously that Senior Leadership is doing all the right things to foster an engaged workforce. (Baird Borling Associates 2008, 1, 5)

Texas Award for Performance Excellence - 2005

The Texas Award for Performance Excellence (TAPE) is an award presented to Texas-based organizations by the Quality Texas Foundation. Established in 1990 by Governor Ann Richards, the Quality Texas Foundation is a cooperative effort between the Governor's office, the Texas Department of Commerce, and Texas businesses. The mission of this non-profit organization is to provide a Baldrige-based methodology for organizations to achieve and sustain world-class performance (Quality Texas Foundation 2008). Aligned with the principles of the nationally recognized Malcolm Baldrige Award for performance excellence, the TAPE is available to businesses, healthcare, education, and non-profit organizations throughout Texas.

After an extensive application process, candidates are evaluated on criteria of leadership, strategic planning, customer and market focus, measurement and analysis, human resource focus, process management, and business results. Organizations that achieve cumulative scores are advanced to site visit status. A panel of Quality Texas Foundation judges conduct an on-site survey focusing on the aforementioned criteria. In 2006, Medical City Dallas Hospital was one of only four recipients of the Texas Award for Performance of Excellence and the second health care organization in the State of Texas to be so recognized.

In 2006, Medical City Dallas Hospital applied for the Malcolm Baldrige National Quality Award. The Malcolm Baldrige National Quality Award was established by the U.S. Congress in 1987 to recognize organizations for their achievements in quality and business performance and to raise the awareness about the importance of organizational excellence. The Baldrige National Quality Program was managed by the U.S. Commerce Department's National Institute of Standards and Technology (NIST). The application process was

coordinated by NIST with assistance from the American Society for Quality (ASQ), a national assocation of quality professionals. This non-profit association is comprised of 80,000 individuals and 700 corporate members throughout the United Stated and 62 other nations (Spath 2005, 13). Since the creation of the award, eligibility was limited to three categoies: manufacturing, service, and small business. In 1998, two additional eligibilty categories, namely education and health care, were added.

Health care organziations used the Baldrige Criteria to identify organizational strengths and key areas for improvement through a self-assessment application that was submitted for review to a panel of ASQ surveyors. The application was comprised of seven categories including: leadership; strategic planning; focus on patients, other customers, and markets; measurements, analysis, and knowledge management; staff focus; process management; and, organizational results. The Baldrige Criteria provided a proven quality system, designed by leading U.S. quality management experts, representing a wide variety of industries, companies, and backgrounds (Spath 2005, xv). More importantly, the Baldrige Criteria provided an effective self-assessment tool for health care organizations.

The 2006 Malcolm Baldrige National Quality Award – Feedback Report (2006) provided a comprehensive assessment of the leadership system and strategic planning process which was described as "developed and deployed" (National Institute of Standards and Technology 2006, 2). The report was analyzed by the executive and leadership team of Medical City Dallas Hospital. In 2008, the organization submitted a second application and self-assessment. The feedback report noted significant improvement in a number of areas. In describing their findings on the leadership system, the surveyors concluded:

> The leadership system translates intentions into outcomes and results through visionary leadership and deployment of MCDH's core values.

> Processes have been put in place to balance and integrate stakeholders through focused deployment of MCD's strategy. . . . Administrative and medical staff leaders reaffirm the mission, vision, and values (MVV) through the annual Strategic Planning Process (SPP) . . . . Visionary leadership and a focus on achieving excellent care for patients allow MCDH to address the needs of its key stakeholder groups. (National Institute of Standards and Technology 2008, 2)

Hospital of Choice Award – 2008

On December 10, 2008, Medical City Dallas Hospital was notified by the American Alliance of Healthcare Providers (AAHCP) that it has been chosen as a recipient of the Hosptial of Choice Award for 2009. Recipient hospitals were recognized for friendly and courteous staff members that provided accurate and timely information to patients and families, including discharge plans and billing processes. Honored hospitals were selected that pursued excellence in "developing relationships with physicians and healthcare organziations in the community" (Rose 2008). The AAHCP examined health care systems based on a comprehensive review of available measures and frameworks based on safety, effectiveness, patient centeredness, and timelines of care (American Alliance of Healthcare Providers 2009).

Other Recognitions

In 2003, *Dallas Child Magazine* recognized Medical City Dallas Hospital as the Top Employer for Family Friendly Workplaces. The Worksource of Dallas County recognized Medical City Dallas Hospital as the Outstanding Employer in the Dallas/Fort Worth region and also received the Alfred P. Sloan Foundation Award for Workplace Flexibility in 2005. In 2002, 2004, and 2005, the Health Industry Council recognized Medical City Dallas Hospital as the Champion in Health for Exemplary Workplace Wellness Programs.

Individual awards were also common. In 2007, the president and chief executive officer and the director of environmental services were selected by the *Dallas Business Journal* as their Health Care Hero – individuals recognized for exemplary performance and commitment to excellence in health care (Nielsen 2007, 14B). The chief financial officer, was selected by the *Dallas Business Journal* in its 2007 recognition as the Best Chief Financial Officer of Dallas/Fort Worth. The hospital Chef received the Professional Chef Award by the ASHFSA in 2006, 2007, and 2008.

The chief nursing executive was selected by the Texas Nurse Assocation, District 4 as the 2008 Nurse of the Year and by the Nursing Management Congress as the Visionary Nurse Leader for 2008. He was also the recipient of the NurseWeek and Nursing Spectrum award for Advancing and Leading the Profession of Nursing for 2008. From 2000 through 2008, the annual Great 100 Nurses recognition program has selected 33 nurses from Medical City Dallas Hospital as recipients of this prestigious award.

Investing in Medical City Dallas Hospital

Investment into the infrastructure of Medical City Dallas Hospital has been significant. In 2003, HCA approved a $212 million expansion plan which was later amended to a total capital investment in excess of $253 million. The first phase included the construction of a 4,000 square foot 24 hour child care center, operated by Children's Choice Learning Centers. Able to provide comprehensive services to 300 children, the creation of the center was heralded as a demonstration of the commitment of the organization to the staff and their families (Rose 2008; Stern 2008). In consideration of child care expenses, 25 scholarships were established for hospital staff in need of assistance. Scholarship criteria require scholarship recipient families to maintain superior work performance.

The following phases included the construction of a new six story critical care tower comprised of 44 new intensive care beds, 72 telemetry beds, a dialysis center, a new 50 bed adult and pediatric emergency department, and a clinical decision unit. Also located in the new critical care tower is a new state of the art educational center including a 240 seat conference center, class rooms, and an emergency preparedness command center. Included in the educational center is the creation of the organizational development department and a computer training center. "We thought it was important to include an expanded educational and organizational development center. By putting this center on the first floor we were saying to our organization that our foundation was on education and training" (Rose 2008).

The master site expansion plan added a new outpatient diagnostic center that became the anchor for the development of an outpatient boulevard to include imaging, diagnostic testing, and clinical space. Additional funding approval was obtained for sophisticated diagnostic equipment such as a 64 slice CT scanner, a three unit digital mammography center, and a 3.0 tesla magnetic resonance imaging center. Outpatient diagnostics was also upgraded with a patient archiving retrieval system that digitized all diagnostic imaging into easily accessible medical record information.

Surgical services were also expanded from 21 main operatories to 31 surgical suites and two endovascular suites. The recovery area was expanded to 54 beds. Sterile supply was relocated and expanded to service the expanded surgical capabilities. Women's services was expanded through the construction of two new floors adding 56 private gynecological and obstetrical beds. The skilled nursing unit was closed and the area was converted into medical and surgical private suites. The skilled rehabilitation unit was downsized and eventually closed providing the necessary space to convert this area into private medical and surgical

rooms. Renovation projects were approved to convert all patient rooms to private ones allowing the total bed capacity to expand from 590 to 705 beds. Other necessary support space and services were funded such as parking, medical office space, and patient support services.

Improving financial performance justified additional capital investment. From 2000 through 2008, capital investment in construction and equipment totaled $255.6M. As of 2008, Medical City Dallas Hospital was the recipient of the largest single facility hospital expansion program in the history of HCA (Burroughs 2008). Completion of the Medical City Children's Hospital tower was scheduled for the spring of 2010 at an estimated additional cost of $51 million of construction and equipment. The tower included an outpatient clinic, congenital heart surgery intensive care unit, an expansion of the neo-natal intensive care unit, and capacity for the expansion of pediatric telemetry beds.

The funding for the expansion and reconfiguration of Medical City Dallas Hospital was a departure from previous efforts on single asset recapitilization by HCA. The director of operations finance - planning stated, "The investment into Medical City was unprecedented but it was clear that the organization had a clear vision and a compelling strategy. Besides, they were proving that they could deliver on their commitments and every indicator was moving in the right direction" (Yousuf 2008).

Conclusion

Medical City Dallas Hospital's experiences from 2000 through 2008 demonstrated a journey of success and accomplishment. Mission, vision, and value statements provided a sense of the organization's purpose and potential. They helped stakeholders understand the organization and what it was intended to achieve (Mumford and Strange 2002, 113). The

creation of the Five Indicators of Success or Five Keys established organizational measurements of performance for the strategic planning process.

Despite a chaotic and ineffective MVV process, the organization embarked on a journey of organizational performance improvement that is rarely experienced. The numerous awards, recognitions, and surveys confirmed the transformation of the hospital. How that was accomplished is the essence of this research and is contained in the theory that transformational leadership drives improved organizational performance as measured by the strategic plan.

CHAPTER 4

LEADERSHIP DEVELOPMENT AT MEDICAL CITY DALLAS HOSPITAL

James MacGregor Burns (2003, 15) describes the importance of developing a leadership model in *Transforming Leadership.* He stated that we are all theorists of causation and confirms the value of a model in order to explore, discuss, and challenge theories. While the creation of a model does not substantiate its value, the model does provide a structure for analysis. Further, a model in the development of theory provides insight and perspective to test behaviors and actions. Christensen and Raynor (2003, 66) suggested that the use of theoretical models would allow the "work coming out of the academic world be put to better use." Likewise, the creation of models from industry would provide insight and perspective for use in the academic world.

Industry leaders such as Bank of America, General Electric, IBM, Lufthansa, PepsiCo, Pfizer, Royal Dutch Shell, and RBC Financial Group were recognized for their work in identifying and developing leaders through the creation of leadership models (Conger and Ready 2004, 41). These organizations translated the term leadership into a clear framework that outlined leadership behaviors that were consistent with organziational mission, vision, and values. Further, their leadership models set out a list of tangible and measurable competencies, skills, and mind-sets that provided developmental benchmarks for leaders in an organization. PriceWaterhouseCoopers (2008, 18) consulting firm stated, "a distinctive leadership framework will help oranizations clarify what successful leadership looks like, build leadership capability for the future, and redefine measures of success."

In 2005, The National Center for Healthcare Leadership (2005, 1) published a review of leadership competency models with practicing health leaders and managers across the administrative, nursing, and medical professions, and early, middle, and advanced career stages. Its work attempted to incorporate benchmark data from other health sectors and insurance companies, as well as composite leadership competencies from a group of global corporations. At the end of its research, The National Center for Healthcare Leadership (2005, 2) concluded that a leadership competency model unique to health care was of "significant value." They further stated that, "Health is a mission and values driven industry. We found that top performing organizations, be it a hospital, a pharmaceutical company, a biotech start-up or an insurance company, have at the core of their strategies sustaining health, wellness, a quality of life, and ensuring that effective treatment is available and provided when people need it."

Due to the extraordinarily complex nature of the health care system and the necessity for multiple stakeholders to collaborate and reach consensus among independent constituencies, leaders must "have an impact" and "exercise influence, consensus and coalition-building competencies at higher levels than their counterparts in other sectors" (The National Center for Healthcare Leadership 2005, 2). These same health care leaders are "especially challenged to create work climates that motivate high-quality, patient-centered care and retain high-demand talent in a very competitive marketplace" (The National Center for Healthcare Leadership 2005, 2). In response, Medical City Dallas Hospital recognized the organizational and environmental challenges and embraced an organizational leadership development effort.

The Medical City Leadership System

The Medical City Leadership System (MCDLS) was based on the premise that leadership was a process of translating intentions into strategies and results. It was a defined leadership model that provided a visual representation of the integration of the mission, vision, and values (MVV) through the execution of behaviors of leadership. The strength of the MCDLS was the reliance on processes to balance and integrate the needs of numerous stakeholder groups and to provide the methods and follow-through required to deploy strategies. Important to the creation of the leadership model was simplicity. Conger and Ready (2004, 44) warned that leadership competency frameworks fail because they are "complicated, conceptual, and built around current realities." The authors stated that a complicated model and exhaustive list of competencies may capture complex realities; they also dilute the attention and create a "blurry picture of which competencies are priorities in the organization" (Conger and Ready 2004, 44).

Figure 2. The Medical City Dallas Leadership System Model

The creation of a visual representation enhances the ability of the organization leaders to conceptualize the model, utilize the model, and teach the model. A description of the necessary leadership competencies provides insight and perspective for leaders within the organization. More importantly, the model and competencies described to the organization what is important and "the way we do things around here" (Spath 2005, 47).

Creating the Model

In 2000, leadership development planning was under the direction of the MCDU planning group. This multi-disciplinary group was sanctioned to conduct a gap analysis on leadership competencies and to develop a twelve-month leadership education program. Monthly four-hour seminars were scheduled along with an annual spring break activity and fall planning retreat. Early efforts in the development of a leadership system were fragmented and evolved slowly. From 2000 through 2006, the MCDU planning group met and conducted monthly MCDU training sessions with limited resources.

In 2005, the Medical City Dallas Hospital department of education was renamed the department of organizational development and, in 2006, it was relocated to a newly-constructed educational and conference center that included four classrooms, a 20-bay computer educational center, and a 250-seat auditorium. In the process of creating the Medical City Dallas Leadership System model (See Figure 2), Mark Atkinson, an outside consultant, was hired in 2006 to provide expertise and experience. Atkinson began a comprehensive and thorough assessment of the leadership development initiatives and the consolidation of these efforts into the Medical City Leadership System and the integration of MCDU.

Concurrent with these efforts, the author and researcher entered the doctoral program

of public affairs at the University of Texas at Dallas. Increased scrutiny and self-examination created a sense of urgency on part of both the researcher and the organization to identify processes, systems, and theories that would combine activity at Medical City Dallas Hospital in the area of leadership with best practices found elsewhere. Combining the discipline of academic knowledge with practitioner experience proved important in developing a leadership model.

Christensen and Raynor (2003, 68) challenged business executives to embrace a more disciplined approach to leadership. Their article, entitled "Why Hard-Nosed Executives Should Care About Management Theory," recognized that organizations are reluctant to embrace theories because managers associate theory with the word "theoretically," which connotes "impractical." They challenged executives to observe organizational behaviors and categorize these behaviors.

The field of public administration also suffered from this inability or reluctance to combine theory with industry practice. Vincent Ostrom (1989, 29) stated in *The Intellectual Crisis in American Public Administration*, "Much of the research in American public administration has made little use of the predictive value of theory to drive the hypotheses from theory and the use of evidence to support or reject the hypotheses as a test of theory."

The Medical City Leadership System was an attempt to respond to these criticisms and develop a comprehensive and robust model. Executive resources were re-focused on leadership development. In 2006, Virginia Rose's responsibilities as Vice President of Human Resources were expanded and she was promoted to the position of Vice President of Strategic Development. Although the CEO assumed personal responsibility for leadership development, Ms. Rose played a critical role into coordinating and aligning these efforts.

"Initially we were trying to pull together all our previous efforts into some type of structure or system. Eventually we got our acts together and started defining a system that would take us into the future," she stated (Rose 2008). The creation of a leadership development system required the formulation of structure and objectives.

The stated objectives for the Medical City Leadership System (Medical City Dallas Hospital 2007, 2) were as follows:

1. Build a leadership pool of individuals capable of carrying MCDH into the future two, five, and ten years from now.
2. Build leaders who will provide creative, effective solutions in the fluid future.
3. Create a system and processes that are not person-dependent.
4. Build a system of processes that are a leadership incubator for HCA.

In principal, the members of the MCDU planning group agreed to use a focused, competency-based model to allow leaders within the organization to develop other leaders. Agreement was reached on differentially investing in leadership development throughout the organization. Unique individual needs and circumstances required different approaches and resources; therefore, the development group produced a comprehensive and dynamic approach. Based on business drivers and priorities, the leadership model gave leaders business-critical competencies and measured leadership performance through standards and feedback.

In addition to the creation of the Medical City Dallas Leadership system, several other strategies were initiated. The creation of an acceleration pool, an executive resource board, and the commitment to hold talent development meetings were specific activities identified (Medical City Hospital 2007, 17). "It was clear that the organization recognized

the opportunity to create a leadership system that was unique to health care, but more importantly, was a natural extension of all their earlier work. It seemed that they had all the fundamentals moving in the right direction but the MCDLS put structure around all those activities" (Atkinson 2008).

Alignment with HCA and their work on leadership competencies was important. In 2007, HCA (2007) produced the HCA competency directory, which included 43 unique and specific competencies. "Our executive jobs have changed over the last 10 years but our competency models hadn't changed," stated Ann Hatcher, vice president of talent management for HCA. "While there are a tremendous number of competencies, it gave us a starting place to discuss the needs of executive talent. Deployment of these competencies has occurred through annual performance review – not consistently but we are moving in the right direction" (Hatcher 2008).

Reflecting on Conger and Ready's (2004) admonition to keep competency frameworks simple and concise, the MCDU planning group aligned its research with the HCA report. At off-site meetings, the group discussed and considered the unique characteristics and challenges of the Medical City Dallas organization. They identified eight leadership competencies deemed essential for leaders' success as well as discussed organizational knowledge necessary to lead in this unique environment. The planning group also provided advice and counsel on job challenges, and outlined possible "derailers" for individual success.

Competencies, Organizational Knowledge, Job Challenges, and Derailers[2]

The MCDU planning group identified eight core competencies thought to be critical to the success of leaders within Medical City Dallas Hospital (see Table 4.0). These included: (1) cultivating clinical and business partnerships; (2) patient relations; (3) driving execution; (4) health care financial acumen; (5) setting business strategy; (6) accelerating change; (7) coaching and developing others; (8) and inspiring a common vision (Medical City Dallas Hospital 2008, 20).

The first competency, cultivating clinical and business partnerships, allowed leaders to integrate diverse opinions, goals, and objectives of key stakeholders in order to advance clinical and business goals. Key actions included identifying partners, establishing collaborative relationships, supporting partners through shared goals, and collaborating to resolve problems. Leaders were able more easily to navigate a dynamic health care environment by establishing partnerships and collaborative relationships.

The group placed meeting patient and patient family needs; taking responsibility for a patient's safety, satisfaction, and clinical outcomes; and using appropriate interpersonal techniques to resolve difficult patient situations and regain patient confidence under the umbrella of the second competency, patient relations competency. Leaders in the hospital were required to focus on patient relations by seeking to understand patient needs. At Medical City Dallas Hospital, the expectation was not only to meet those expectations but to exceed them.

The third competency, driving execution, meant translating strategic priorities into

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[2] The majority of the competency material comes from internal documents created by DDI while in the employ of HCA. Additional descriptors ("Key Actions") have been added beneath each competency as they relate to Medical City Dallas Hospital

operational reality and aligning communication, accountabilities, resources, culture, and processes that ensured that strategic priorities yielded consistent sustainable results. Setting operational priorities and implementing communication strategies were two key actions to driving execution. Further, identifying needed resources, aligning those resources, measuring performance, and creating accountability for performance were behaviors central to the success of leaders.

Understanding the financial aspects of health care was a critical and fourth competency for Medical City Dallas Hospital leaders. The analysis of financial data allowed leaders to assess the strengths and weaknesses of organizational strategies from a perspective other than clinical outcomes. Tying financial and clinical outcomes together provided alignment and assured ongoing organizational viability. Understanding the dynamics of revenue and expenses and relating this information to guide operational decision-making was a key leadership competency.

Setting business strategies required the establishment and commitment to long-term business strategies after considering clinical and financial data, resources, market drivers, and organizational values. Gathering and systematically analyzing this information and determining strategic priorities allowed leaders to outline strategic plans. Anticipating and responding to shifts within the market, technology, or policy environment that influenced the delivery, management, and financing of health care was the fifth competency necessary for leaders at Medical City Dallas Hospital.

Continuously seeking and encouraging others to find innovative ways to improve results by transforming organizational culture, systems, or products and services was critical to the sixth competency, accelerating change. Adapting strategically to emerging market

demands, technology, and internal initiatives expanded planning competencies to implementation. Leaders were expected not only to lead change but also accelerate change in a dynamic health care environment.

Medical City Dallas Hospital recognized that the seventh competency, coaching and developing others, was a core competency for leaders. Clarifying performance expectations and providing timely feedback ensured that strategies and initiatives were supported by the entire leadership structure. Evaluating skill gaps and guiding the development of leaders fostered collaborative relationships throughout the organization.

Lastly, a core competency of leaders of Medical City Dallas Hospital was to sell passionately the organizational vision. By creating a clear and compelling view of the future state, leaders would ensure that others understood and felt how clinical and business outcomes would be different when the organization's vision was achieved. Competent leaders were able to inspire a passion and lead through the creation of a common vision. Atchison (2006, 51) referred to this as the x-factor. "It is that special dynamic that is difficult to define, is impossible to teach, but is very obvious when present" (Atchison 2006, 51). David P. Engel, trustee and immediate past chair of Christus Spohn Health System in Corpus Christi, Texas, shared his experience in combining passion and a vision, "I am able to picture in my mind what needs to be accomplished – I get a very clear picture. And I feel blessed that I am able to help others see the picture . . . it is a combination of seeing a picture and communicating passionately" (Atchison 2006, 52).

In addition to the aforementioned eight leadership competencies, the MCDU planning group identified three aspects of leadership foundational to the MCDLS: organizational

knowledge necessary at Medical City Dallas Hospital, unique job challenges, and leadership derailers for success.

The MCDU planning group provided invaluable and unique perspective on the key elements of organizational knowledge deemed necessary for successful leaders. Organizational knowledge deemed critical for leaders in Medical City Dallas Hospital included (Medical City Dallas Hospital 2008, 10-11):

> Accounting/Finance –Understand the vernacular and critical metrics; understand metrics, why they change, how to get them changed; understand how the department is valued in the context of the hospital as a whole.
>
> Budgeting – Know how to use various methods of budgeting, including zero-based budgeting.
>
> Human Resources – Understand how to operate talent-based staffing processes; participate actively in recruitment and selection/ and be able to effectively and fairly work with the compensation system and process.
>
> Technology – Know to whom to go and how to get resources or answers to technology issues and questions.
>
> Long-range Planning – Understand and give to area's role and impact in the overall picture of MCDH's long range planning.
>
> Patient Care and Service – Understand direct patient care deeply enough to explain how individual jobs in their area impact the patient and service standards.
>
> Performance Management – Know how to hold performance-focused conversations with clarity and specificity and how to hold individuals accountable. Provide effective coaching and feedback; know how to praise accurately and effectively and understand individual jobs sufficiently to describe the job's impact on the Five Keys.
>
> Quality Metrics – Identify key quality measurements, understand what they mean, and know how to initiate and execute change in these areas. Understand how quality is measured.
>
> Sales and Marketing – Know where and how to find those data that allow MCDH to identify marketplace opportunities and to assess accurately the viability of new services or related initiatives.

Corporate Support – Know what resources and services are provided by HCA and how to access these resources.

Connect with the community by giving service – Actively participate in giving back to the community by participating in community sponsored activities, programs, and events.

The MCDU planning group also provided invaluable insight into activities and tasks determined to be critical for leaders to navigate at Medical City Dallas Hospital. Even if a leader possessed the aforementioned competencies and organizational knowledge necessary, individual leaders faced potential obstacles. By identifying job challenges to conquer, the organization provided insight into activities that needed to be experienced in order for leaders to succeed at Medical City Dallas Hospital. These job challenges included (Medical City Dallas Hospital 2008, 9-10):

Lead a multi-disciplinary project or performance improvement team focused on both clinical and non-clinical issues and with clinical and non-clinical team members.

Become heavily involved in launching a new service line program and/or closing a service line or program; the experiences gained at both ends of a service line's life cycle are unique and valuable.

Develop or maintain responsibilities and alliances with external partners

Deal with conflict and change; build relationships with a variety of stakeholders (peers, staff, clinical personnel, patients, etc.) in the context of significant conflict or change in the environment of those same stakeholders.

Lead a successful initiative; not all initiatives are successful and those that are bring a level of growth and experiences beyond that provided by an initiative that fails to achieve the desired results.

Grow the revenue and patient count in a department.

Lead a significant capital investment project or analysis.

Manage through a full-cycle of business; manage productivity with the least disruption possible; manage all the basics.

Work and problem solve with physicians.

> Work with division or corporate on internal mandates, pushing on the idea and the bounds of the mandate, determining what is right for MCDH and how to translate it to the staff.

Lastly, a unique aspect of the Medical City Dallas Leadership System was the identification of organizational derailers. Derailers were behaviors and attributes thought to cause leaders to fail, despite previous success. These activities could thwart the attainment or implementation of organizational goals. The characteristics identified as derailers included (Medical City Dallas Hospital 2008, 9-10):

- Argumentative
- Does not build relationships
- Does not develop/execute through others
- Does not project confidence
- Egotistical
- Fails to have and set high expectations
- Lack of personal or professional progress
- Lack of humility, kindness, or caring
- Refuses to recognize or utilize staff input
- Not introspective or open to feedback
- Fails to value patient care
- Perfectionist
- Risk Averse
- Volatile
- Unable to handle workload
- Department-centric
- Ducks responsibility for failure
- Cutting, snide, passive-aggressive remarks
- Hoards information
- Unable to lead performance-based change
- Militaristic leadership style
- Failure to value quality

The Leadership Process

The MCDLS model provided a visual representation with the mission, vision, and values (MVV) at the center surrounded by the five key indicators of success (Five Keys) (See Figure 2). Using the Five Keys as anchors, the leadership team as outlined in this process, annually set direction, communicated and deployed that direction, monitored execution (both

operational and strategic execution), then learned and innovated based on what was observed in both process and outcome measures for individual leaders and the leadership team as a whole.

Setting Direction

Figure 2 described the leadership process through which the MCDLS focused on the organization's mission, vision, and values to set direction. The mission statement was described as the definition of the organization, the vision statement was what the organization would become, and the value statements were the rules under which the organization would abide (Calhoun, Griffith and Sinioris 2007, 9; Kaplan and Norton 2004, 6; Levin 2000, 93). Tying the leadership process to this framework provided alignment with the MVV. "We wanted to make sure that the development of leaders at Medical City Dallas Hospital aligned with our strategic planning efforts and mission statement. It is hard to separate the two so we built a model that worked in concert with one another" (Rose 2008).

Key stakeholders, as identified in Figure 2, participated in planning each year and in the ongoing update sessions. In addition, measurement tools, as identified in Figure 2, provided the framework to assess individual leaders and overall leadership performance. The process was designed to gain input from all stakeholders for consideration during the various phases of the leadership process through the methods shown in Figure 2. This assured the integration of stakeholder needs during the set direction activity and facilitated clear, concise communication and deployment as the leadership process moved from planning to deployment.

The MVV were linked to leadership performance through a set of organizational goals and objectives known as the Five Keys. By defining organization goals and objectives, the

establishment of leadership direction was made simple. “It was clear that we would be measured on our performance of the Five Keys. We saw a lot of people try to work around the system . . . but eventually we realized that he (the CEO) wasn’t kidding. Our performance was being measured by the Five Keys” (Hill 2008). The strength of the mission, adherence to the values, and fulfillment of the vision were heavily dependent on the Five Keys. These indicators of success ensured alignment and consistency of purpose and facilitated the integration, communication, and deployment throughout Medical City Dallas Hospital with associated measures. More importantly, these indicators were used throughout the organization not only to drive leadership development and strategic planning but also to execute day-to-day operations.

Medical City Dallas Hospital leaders communicated MVV and the Five Keys through several approaches, including forums, meetings, media, education, and councils as shown in Figure 2. To support these methods, full deployment was reinforced through: staff performance reviews and goals based on the Five Keys; departmental business plans and goals aligned to the strategic plan and the Five Keys; leader and staff agendas formatted to the Five Keys; and visual representation on web sites, postings, correspondence, and internal marketing.

In setting the direction for the organization, it was important that the stakeholders supported the process. The stakeholders judged leaders’ commitment to MVV as they observed personal actions in key meetings, deliberations, and problem-solving settings. Leaders’ actions reflected a commitment to the organization’s values as they modeled the values and behaviors as part of their positions. Sashkin (2004, 183) described the principle of trust in setting the direction of an organization and the importance of leaders not only

"talking the talk but walking the walk." Goleman, Boyatzis, and McKee (2002, 160) discussed the importance of relationships and how these relationships were the foundation of trust as leaders demonstrated their commitment to the direction set by the organization's mission, vision, and values. In setting the direction for the organization, leaders at Medical City Dallas Hospital embraced the MVV as part of the leadership development system.

Communications and Deployment

In discussing nationally recognized health care organizations of excellence, Spath (2005, 39) confirmed the importance of not only setting the direction of an organization but integrating these efforts throughout the organization. "Organizational excellence requires more than the right mission, motivation, ideas, planning, and funding. . . . The organization's direction is well defined and communicated."

Leaders utilized communication approaches as shown in Figure 2 to present, discuss, and reinforce the mission, vision, and values. This communication began at the new employee orientation where senior executives presented, discussed, and taught the mission, vision, and values of the organization. This indoctrination continued throughout the organization utilizing communication tools, programs, and vehicles such as *City Life*, City Forums, *City Vines*, and *City Views*, which were all internal programs and publications targeted at specific audiences and orchestrated in coordination with other communication efforts.

New leader orientation was another communication tool utilized. New managers and directors were paired with experienced leaders as peer mentors. A two-day educational program focused on organizational knowledge and leadership competencies was later expanded to include new supervisors. Jennifer Tertel (2008), Director of Human Resources,

stated, "New leader orientation is more than providing information and resources for new leaders. We provide a better understanding of the expectations of Medical City and how the mission of the hospital is important. The mission and vision statement are not intuitive . . . we need to make them real and teach how they apply in a leader's day-to-day responsibilities."

New medical staff members also received an orientation to the MVV along with the code of conduct and behavioral expectations. Medical staff leaders were informed of their leadership roles and were mentored by the Council of Presidents and Past President's Council to reinforce values and behaviors important to the organization. Medical Directors and key physician leaders attended annual board retreats, strategic planning sessions, and one-on-one training sessions with executive leaders.

Monitoring

The monitoring of results was a step in evaluating the effectiveness of the Medical City Dallas Leadership System. The most recognized tool utilized by the leadership at Medical City Dallas Hospital to monitor performance and identify trended outcomes was the Big Blue Report. The Big Blue Report was a monthly monitoring tool that identified performance measurements based on the Five Keys (see Figure 2). Fifty-nine measurements were contained in the Big Blue Report and these measurements or indicators aligned with the Five Keys. In addition, these indicators allowed the trending of organizational performance in each of the Five Keys. The executive team reviewed this report and sanctioned task forces to respond to declining performance. Other concerns were delegated to existing hospital committees to be addressed. The inclusion or exclusion of individual indicators was reviewed annually and modified as necessary.

Clearly, the monitoring function was critical in the dynamic field of health care, an industry experiencing unprecedented change. Patients, employees, physicians, the board, and the corporation were five internal stakeholders that required monitoring. In developing the MCDLS, the executive staff identified these five key stakeholders as critical in envisioning the future success of the organization.

Monitoring the Five Keys

The patients' experiences were core to the mission, vision, and values of the hospital. The nature of their health care needs combined with their unique characteristics provided important insight for hospital leaders (Ford and Fottler 2000, 18; Kenagy, Berwick, and Shore 2007, 661-665). An understanding of a patient's personal expectations and experiences played an important role in the MCDLS.

The Gallup Organization authored numerous texts on the importance of employee engagement (Clifton and Rath 2004; Coffman and Buckingham 1999; Nelson and Clifton 1992). While contrarians suggested that "employees are a necessary evil" (Kersten 2005, 21), others recognized the importance of the intellectual capital of employees. In assessing the engagement of employees, the hospital administrators utilized numerous tools including surveys, focus groups, and performance measurements.

As key stakeholders in hospitals, physicians played a complicated and important role at MCDH. In a private for-profit hospital model, members of the medical staff are independent contractors, individuals petitioning for permission to obtain credentials to practice medicine within the hospital. The individualistic behavior of physicians and the importance of surveying this stakeholder group were critical to the success of the MCDLS. In a 2005 national study, *Strategies for Strengthening Physician-Hospital Alignment*, sponsored

by the American Hospital Association's Society for Healthcare Strategy and Market Development and conducted by Mitretek Healthcare, confirmed that physician-hospital alignment was one of the major challenges hospitals and health care systems experienced (McGowan and MacNulty 2007, 26). The inclusion of the medical staff in the leadership development system assured the alignment of stakeholder interests and provided insight into activities that would improve overall outcomes (Schwartz and Cohn 2002, 270).

The board of trustees was also influential in the MCDLS as board members represented the will and interest of the community. Board members attempted to reflect the community as a whole and thereby hospital administrators realized it was critical to assess board members' views, expectations, and behaviors. Their influence was well-documented (Kalzuny and Veney 1972; Masoti 1984; Starkweather 1988; Unterman and Davis 1982) in earlier literature and best summarized by Ostrower and Stone (2006, 612), "Boards are charged with ultimate responsibilty . . . and play a critical role in connecting individual institutions to their larger environment."

Lastly, the corporation (HCA) presented an important external role in influencing the mission, vision, and values of the organization. Corporate mandates and performance expectations influenced leaders' behaviors. Unlike community nonprofit hospitals, private for-profit hospitals must respond in an environment ultimately governed by corporate ownership.

Internal and external scanning of these customers or stakeholders was an essential element of the Medical City Dallas Leadership System. Through monitoring and innovating, the organization was able to respond to a dynamic and changing environment.

Learning and Innovating

As part of the learning and innovation phase, leaders within the organization were heavily involved in ongoing research and benchmarking that resulted in new and improved ways of operating. Leaders recognized and supported individuals who created or adopted innovative approaches through processes. For example, the creation of the Bright Ideas program (Burroughs 2008) rewarded and recognized innovation in cost reduction and process improvement. Innovative ideas were identified by individual employees and championed by members of the leadership team through to implementation. Initiatives that had received recognition for innovation ranged from reductions in bio-hazard waste through the implementation of a micro-wave waste disposal system to the introduction of a facility-wide patient tracking system. However, learning and innovation were not reserved exclusively for financial performance improvement. Aligning with the Five Keys, other innovations included the creation of City Gourmet, a food service in-room delivery program for all in-patients (Moser 2008).

The Center for Nurse Excellence at Medical City Dallas Hospital promoted innovation in nursing research and evidence-based practice efforts. Led by the chief nursing executive, 35 nursing research studies were initiated in 2002. By 2006, ten of the research projects had advanced and were presented at national conferences. The creation of the Center for Nurse Excellence amplified the efforts of leaders from throughout the organization to identify and engage in multi-disciplinary projects aimed at improving the patient's experience.

The Medical City Dallas Leadership System provided a framework to ensure the continuity and congruency of organizational mission, vision, and values. Leadership

continuity and development were strengths of Medical City Dallas Hospital. Sustainable operations were assured using defined and repeatable processes that were communicated through the MCDLS, and sustainability was assured by the analysis and planning of change and uncertainty through the processes as outlined.

Medical City Dallas University

A unique element of leadership at Medical City Dallas Hospital was the educational and training program entitled Medical City Dallas University (MCDU). This innovative program was a leadership development program that was dynamic and responsive to the needs of the organization. Initially targeting the leadership team estimated at 80 managers and directors, MCDU was expanded to include over 140 supervisors. The creation of a leadership-training program or corporate university has "proven to be a powerful vehicle for instilling common culture and values. The university has provided a medium for introducing a consistent new language and developing a set of core competencies for leaders" (Bersin & Associates 2007, 1).

In 2000, under the direction of the chief executive officer, a group of executive staff, leadership team members, and supervisors established MCDU 2005, a leadership development-planning group tasked to identify leadership gaps and create a core curriculum. A precursor to the establishment of the MCDLS, this planning group actively identified opportunities for leadership development. Reluctant to embrace an established or pre-packaged leadership program such as DDI, Covey Leadership System, or Studer (Rose 2008), the group created a 12-month training and educational program. This group evolved into MCDU 2007, MCDU 2010, and Leadership 2012.

The MCDU leadership program provided mandatory monthly four-hour leadership

development sessions, annual off-site business planning sessions, and spring break celebrations. The planned curriculum for 2008 included: coaching and developing leaders, accelerating change using PDCA[3], measuring improvement of outcomes using PDCA, employee engagement, driving execution, coaching/developing others, accelerating change through innovation, the patient promise, and driving execution. In addition, modified and shortened leadership education was provided to supervisors and leads. "We wanted to provide the same content to our supervisors but couldn't find a way to free them up for an entire morning. Our compromise was to put together on a monthly basis two one-hour educational sessions that gave supervisors a brief overview of the content" (Rose 2008).

Other Initiatives

MCDU promoted, fostered, and developed the knowledge and skills necessary to achieve desirable supervisory, managerial, and leadership outcomes through a number of additional initiatives and programs. The CEO book club offered a unique opportunity for information sharing, discussion on core competencies, strategic challenges, and planning as it related to leadership development and health care business knowledge.

Individualized assessment and education was provided through a new leader assessment tool. All new leaders joining MCDH completed the Talent Plus or Gallup Perceiver interview (Tertel 2008). This information was shared with the hiring manager or director and was used as a coaching tool to enhance defined leadership attribute strengths and develop areas of opportunities, both personally and professionally.

Every day from 9:00-10:00 a.m., the executive and leadership teams participated in

[3] PDCA refers to the quality improvement model of Medical City Dallas Hospital – Plan, Do, Check, and Act

organizational rounding. No organizational meetings were scheduled during this period and leaders were tasked to visit patients, families, or other departments to observe, engage, discuss, identify, celebrate, and resolve. Informal and formal surveys were conducted as sanctioned by the executive team. Results of these surveys were consolidated in the Big Blue Report and discussed at the weekly executive team meeting.

Reward and recognition was an important element in the leadership environment at Medical City Dallas Hospital. Annually, each manager and director was budgeted $100 per employee for individual or group recognition activities or awards. The department of environmental services utilized these resources to celebrate annual environmental services week with a fiesta and mariachi band. Bob Bellido (2008), director of environmental services, stated, "Our team loves to get together and eat. A large part of the team are Hispanic so we pull together a big party with a great band . . . it is our way of saying thanks for all you do." Nursing services in the south tower took a different approach. "We wanted to do something different for the nurses and we have a lot of part-timers so we decided to buy everyone a fleece-lined embroidered jacket. It has been a big hit and I see the nurses wearing them all the time" (Edmonson 2008).

The organization also celebrated successes through a well-scripted series of events and activities. Upon receiving the Magnet Certification in Nursing, a hospital-wide announcement was held in the auditorium with cowbells and party-makers. Banners and internal announcements were placed throughout the hospital. A celebration breakfast, luncheon, and dinner were served. Establishing the scope and magnitude of each celebration was never pre-determined. "We got this celebration thing figured out. We know what our team likes through trial and error. It is the decision of the executive team to decide the

magnitude of each celebration but overall we pace this very nicely," according to Virginia Rose (2008). Monthly leadership meetings began with an agenda item entitled "kudos." Leadership members are invited to recognize and celebrate individual or department specific achievements. Individual department meetings followed this same format including the reading of complimentary letters and individual achievements. "When done right, recognition becomes an effective retention tool, enhances communication and trust, and improves employee productivity" (Elton and Gostick 2001, 14).

Succession Planning/ Sustainability

Prior to 2000, succession planning for executive staff was designed and managed through HCA, where senior leaders were moved within and promoted throughout the 189-hospital network, providing strong motivation and a structured career path. The Talent and Executive Recruiting Department of HCA identified high potential candidates for future leadership positions within the organization and guided their development. The Chief Operating Officer (COO) Development Program, Chief Financial Officer (CFO) Development Program, and Chief Nursing Officer (CNO) Development Program were three such programs. Leaders were developed through learning activities and rotational assignments to "round out" their leadership abilities. "Our work on succession planning has shifted from replacement planning – finding the next executive – to succession planning, identifying the skills and competencies needed for future leaders in HCA," stated Ann Hatcher, vice president of talent management for HCA.

However, prior to 2000, no succession planning process or program was in place at Medical City Dallas Hospital for leadership positions at the director, manager, or supervisor levels. In response, and concurrent with the creation of the MCDLS, the organization defined

and sanctioned the creation of a Leadership Development Program (LDEV) for the identification, education, and promotion of leadership talent within Medical City Dallas Hospital. Building on the work of MCDU, the LDEV focused on succession planning and sustainability. MCDH's Leadership Development system (LDEV) was built on the premise that there is no substitute for experience coupled with strong coaching and mentoring by current leaders (Atkinson 2008). As a means of leveraging and integrating MCDH's LDEV with that of HCA, MCDH formalized the competency-based leadership development framework that utilizes similar or identical models, language, approaches, tools, and systems in order to produce a pool of talented, successful leaders. This process targeted specific leaders from across MCDH to include in an Acceleration Pool (AP), which made use of assessments, development plans, job assignments, training, mentoring, and coaching to help speed their development. The executive staff acted as an Executive Resource Board, leading this process, reviewing the development of each participant every six months.

On May 29, 2008, the first LDEV accelerator pool meeting was held in the home of the CEO to introduce the program to the nine participants in the AP and their executive sponsors. The objectives of the program were to identify talent for development from throughout the organization and to create a structured approach to identifying, training, and expanding leadership competencies and job challenges. The program included a web-based leadership assessment tool and the creation of a leadership journal and development plan (Atkinson 2008; Medical City Dallas Hospital 2008).

Leadership 2012 listed all members of the leadership team from 2000 through 2008 and identified 137 managers and directors that were employed at Medical City Dallas Hospital and participated in MCDU. Of this list, eighteen were promoted to senior and

executive positions in health care. Eight were promoted to assistant vice president positions, two within MCDH and six externally. Twenty-three were promoted to director positions, nine internally and fourteen externally. Twenty-nine were promoted to manager positions, nineteen internally and ten external to HCA. Forty-seven employees of Medical City Dallas Hospital were promoted to supervisory positions, thirty-seven to internal positions, and ten to external positions. Based on this analysis, Medical City Dallas Hospital through MCDU advanced 124 individuals into greater leadership positions. Since 2000, only seven leaders of 137 individuals remained in their current leadership roles and responsibilities in 2008.

Leadership Development of Medical Staff

While somewhat different because of a system of elected leadership, medical staff leadership development and succession was built on the same principles of experience coupled with mentoring and coaching. Annually, a slate of Medical Staff Executive Staff was nominated and presented to the medical staff for ratification. These included president-elect, secretary, and three at-large members. The Medical Executive Committee also included department chairperson that had been selected by their individual departments of Medicine, Surgery, OB/GYN, Pediatrics, and Laboratory Science.

Before serving his or her term, the president of the medical staff served for a year as the president-elect, was the chair of the Performance Improvement Council, and was a member of the Council of Presidents, which also included the current and immediate past president as members. As a Council, these three physician leaders dealt with issues specific to the medical staff, including disciplinary issues. After serving as the president, the immediate past president served as the head of the Privileges & Credentials Committee and appointed the committee to nominate the next President. This allowed new presidents to

evolve into their roles under the tutelage of two prior presidents and allowed the past presidents to have two years to influence incoming physician leaders.

In addition to the elected medical staff official structure, Medical City Dallas Hospital created five planning and advising councils to set direction, communicate, deploy, monitor, learn, and innovate (cardiovascular, pediatrics, oncology, surgery, and women services). In collaboration with administrative leadership, the organization was able to coordinate and establish organizational goals and objectives that are consistent with the mission, vision, and values. These councils also aligned with the organization's centers of excellence in pediatrics, oncology, cardiovascular, surgery, and women's services. Medical and administrative staff jointly chaired monthly meetings with key and critical issues communicated through existing organizational structures.

As part of the shared governance model, and in an effort to develop medical staff leaders, numerous educational programs were made available. Biennially, the president's council and members of the executive staff attended a four-day off-site medical staff leadership program. Issues covered included the privileging and credentialing of new physicians, disruptive physician management, governance, and leadership.

In addition, key individuals attended a leadership strategy session with the executive staff twice a year. A group of approximately 60 elected and potential medical staff leaders participated in a four-hour strategic planning session that reviewed the mission, vision, and values. The strategic direction of the organization was discussed and priorities were set.

Conclusion

Since 2000, Medical City Dallas Hospital has pursued a strategy of leadership development. Initially the organization failed to recognize or embrace a conceptual model,

however, it was clear that its work was transformational and aligned with the theory of transformational leadership. In response to the need for health care leaders to create theoretical frameworks for study and to chronicle the transition from a toxic organization into a high performing facility, Medical City Dallas Hospital created the Medical City Leadership System (MCDLS). The Medical City Leadership System was created to identify specific activities and processes in order to translate intentions into strategies and results. In addition to the MCDLS conceptual model, the planning group identified behavioral competencies necessary to lead the organization, organizational knowledge required to function effectively, job challenges or tasks critical for leaders to experience, and possible behavioral derailers that would impede a leader's progress.

Beginning with a fragmented and unstructured approach to leadership development, Medical City Dallas Hospital was able to create conceptual models and constructs to lead the organization. By so doing, the hospital team established theoretical frameworks for analysis and study which were critical to the success of the organization. Combining these conceptual models or theories on transformational leadership with comprehensive strategic planning was the next step in moving the organization from a toxic work environment into a high performing facility.

CHAPTER 5

STRATEGIC PLANNING AT MEDICAL CITY DALLAS HOSPITAL

Strategic planning is creating a "set of organizational processes for identifying the desired future of the organization and developing decision guidelines" (Duncan, Ginter, and Swayne 1995, 17). More importantly, it is a means that "an organization chooses to move from where it is today to a desired state sometime in the future" (Zuckerman 2005, 2). This research utilized the concept of strategic planning to provide a structure for determining organizational performance standards and assessing the influence of transformational leadership on the desired outcomes. The following is a history of the strategic planning at Medical City Dallas Hospital (MCDH) and the initiatives and tactics that aligned with the theory of transformational leadership.

History of Strategic Planning at Medical City Dallas Hospital

Historically, strategic planning at Medical City Dallas Hospital was corporate-mandated annual business planning cycles. Under the purview of the executive team, the annual business plan was comprised[4] of rudimentary planning components that included an assessment of strengths, weaknesses, opportunities, and threats (SWOT). Absent were discussions on mission, vision, and values. Division budget targets were the foundation of the

[4] Much of this chapter was written in the passive voice because the author was the primary actor in conceiving and implementing the strategic plan. In an effort to place more emphasis on the action taken rather than on the actor, the passive voice was utilized.

business plan. The 189 hospitals of HCA were divided into three groups, east, central, and west. Each group was comprised of approximately five divisions. Each division was geographically oriented. Ten hospitals comprised the north Texas division: Medical Center of Plano, Medical Center of McKinney, Medical Center of Denton, Medical Center of Lewisville, Medical Center of Las Colinas, Medical Center of North Hills, Medical Center of Arlington, Plaza Medical Center, Green Oaks Hospital, and Medical City Dallas Hospital. Annually, the division president, located in Las Colinas, Texas, was assigned financial targets by group leadership. Individual hospital financial targets within the division were decided by division leadership. Informal negotiations regarding budgeted expectations led to the final budget presentations. The budget presentation and business plan were consolidated into one annual 3-4 hour meeting in October. Additional negotiations to establish annual targeted performance measures were finalized by the end of October and the budget was closed in November for the upcoming year. In January, the Board of Trustees received a report outlining the goals and objectives for the year.

In 1997, the process was formalized by requiring department specific business plans to be incorporated into a facility business plan. Format and content were at the discretion of the individual departments. Organization-wide initiatives were not identified. External and internal scanning was not part of the planning process. The addition of department specific business plans was unique to Medical City Dallas Hospital and not part of an overall HCA initiative.

In 2000, the process was reengineered to include mission, vision, and values. Formats for department specific business plans incorporated the Five Keys as planning templates. The integration of Medical City Dallas University (MCDU) provided a fall venue for an annual

strategic plan presentation to the leadership team. A summary of the external and internal scan was presented. Strategic initiatives were outlined and facility volume targets established. Department business plans were consolidated under the direction of individual members of the executive team. Early efforts to accumulate department specific business plans into one consolidated document were abandoned. Responsibility for the calibration and coordination of individual departments for alignment with the overall business plan was delegated to members of the executive team. This approach ensured that the organizational and departmental strategic planning efforts aligned with the Five Keys, mission, vision, and values.

As part of the preparation of the business plan, semi-annual meetings were held with the Council of Presidents to outline issues, concerns, and opportunities. Annually, the Board of Trustees held a retreat to provide input and feedback on planning efforts. On-going organizational communication and frequency were held as outlined in Table 2.

In 2004, the process was refined. The external and internal scan confirmed that five service lines represented significant strategic importance and opportunity. They include pediatrics, cardiovascular, surgical, oncology, and women services. These service lines were the Five Centers of Excellence – those service lines on which MCDH would focus energy and resources, cultivate future success, and meet community needs. MCDH also formed the Strategic Planning (SP) Team consisting of a subset of the executive team and representatives from a crosscut of the organization. This team ensured broader involvement and a more complete use of the organization's knowledge assets. "The environmental assessments confirmed that we should focus on five service lines . . . . By involving more

members of the leadership team, we established a very comprehensive plan, but we still needed to create a model or structure" (Rose 2008).

The following year a significant and important step occurred in the strategic planning process. Because of the pursuit of the Malcolm Baldrige National Quality Award for performance excellence and in fulfillment of the application for the Texas Award for Performance Excellence (TAPE), a strategy matrix was designed. Measures and outcomes were linked through the strategic direction to the action plans. The organization employed a ten-week planning process whereby ten teams of seven to ten members met weekly to: 1) complete a full market assessment for their service lines; 2) define strategic objectives; 3) conduct an evaluation phase to determine the feasibility of tactics including access, marketing, and financial information; 4) conduct business plan development, including action plans, pro formas, implementation and measurement plans; 5) hold a divisional/group approval process whereby the plans were presented to division leadership to request approval and capital dollars to achieve desired outcomes; and 6) implement activities that included project management and status reporting processes including measurement of outcomes. These elements were incorporated into a five-year strategic plan.

Strategic Planning Process at Medical City Dallas Hospital

Strategic planning occurred formally each year, with every other year being an update to the five-year strategic plan. Figure 5.0 shows elements of the planning process contained in the Medical City Dallas Strategic Planning document (Medical City Dallas Hospital, 2008).

The five-year planning process involved approximately 70 individuals from throughout the organization who were either: 1) key subject matter experts; 2) leaders of

specific centers of excellence; 3) staff members that provided a bedside perspective as to patients' and families' needs and expectations as well as key information needed in the evaluation of specific resources, capital or other organizational or departmental necessities.

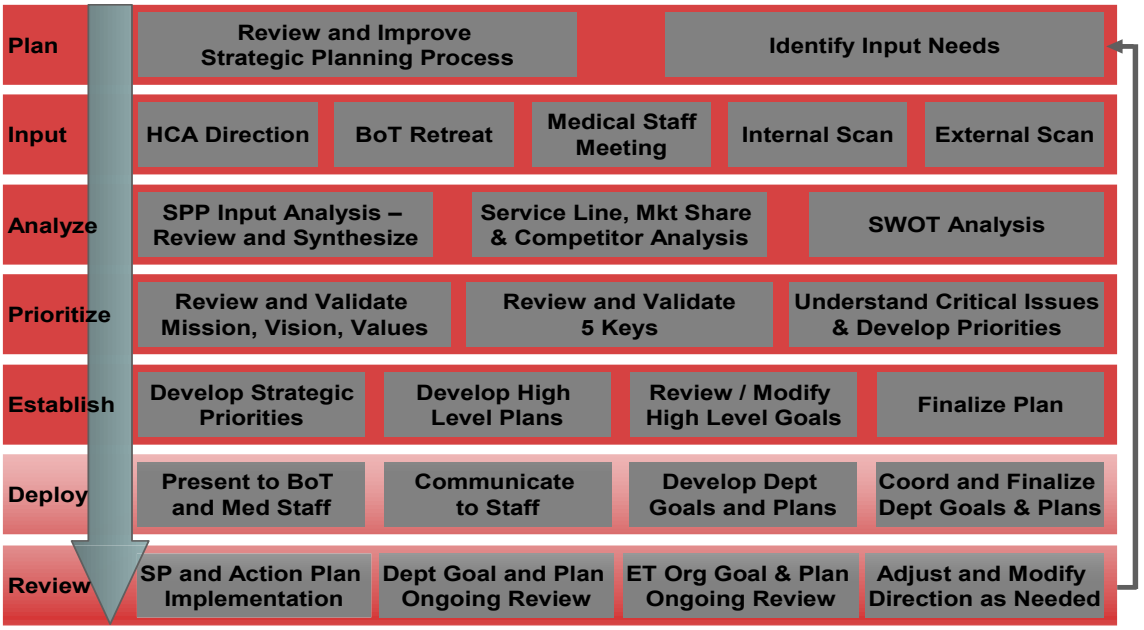

Figure 3. Strategic Planning Model for Medical City Dallas Hospital

The five-year planning process involved approximately 70 individuals from throughout the organization who were either: 1) key subject matter experts; 2) leaders of specific centers of excellence; 3) staff members that provided a bedside perspective as to patients' and families' needs and expectations as well as key information needed in the evaluation of specific resources, capital or other organizational or departmental necessities.

Environmental scanning occurred formally and informally throughout the year, using those inputs shown in Figure 5.1 for each of the different stakeholder's perspectives. In addition to weekly executive team meetings, monthly meetings were held with the board of trustees, leadership team, medical executive committee, and the performance

improvement/patient safety council to provide ongoing insight into areas of opportunity and concern for these stakeholder groups.

Quarterly off-site executive staff meetings synthesized the input and status reports from each of these areas. Course corrections and opportunities for improvement were included in long-term strategic planning efforts. Semi-annual medical staff retreats sought guidance from the medical staff around subject matter, programs, and processes. At these retreats, physicians provided perspectives from the medical staff.

Semi-annual meetings with the past presidents of the medical staff identified additional issues. Annually, a consulting firm presented an extensive market analysis and external environmental scan. Throughout each year, the organization utilized several methods to gain legitimate and clear market information to compete effectively. The strategic plan integrated information from local publications, networking with key organizations, and a database that provided regular scans of competitor information. Each of these environmental scan sources was an important input to the biennial comprehensive strategic planning session, and the annual strategic plan update.

Present within all strategic planning activities was awareness and compliance with accreditation, regulatory, and ethical requirements, as well as organizational practices, measures, and goals. Parameters of performance were clearly defined as listed in Table 3. These parameters, identified by the hospital, included accreditation requirements, environmental laws, patient privacy and safety rights, workplace safety and diversity laws, fiscal compliance, and governance. In a highly regulated environment, Medical City Dallas Hospital was required to adhere to defined compliance practices and measurements as it traversed the seven steps of its strategic planning process.

The Plan Phase confirmed the vision statement and the status of performance on the Five Keys. In addition, the hospital's management leadership evaluated prior year strategic planning efforts based on successes and performance. Enhancements were planned for the coming year. As part of this improvement cycle, the types and sources of information required to make informed decisions were chosen.

Table 4. Sources of Input for Strategic Planning

Input Type	Input Source	Stakeholders
Customer and market needs and community	Service demand in Primary Service Area (PSA) and Secondary Service Area (SSA), patient verbatim from Gallup survey, physician interviews and verbatim from Gallup survey, HCACPS CMS tool, community needs assessment, family advisory board, patient advocacy manager input and guest services coordinator, diversity advisory council	Community, patients, physicians
Patient safety and medication errors	Internal performance data, emerging issues from national publications and associations	Patients, physicians, employees
Competitive environment	Discharge and market share, competitor filed financial data, business plans from media publications	Community
Lifecycle of healthcare services and technology changes/risks	New technology or procedures from media and vendor information and from site visits, interviews with physicians, input gathered through associations and research, global health care trends from professional organizations and physicians	Community, physicians
Staff resources	Internal performance data (turnover, vacancy rate, etc.), staff survey, certifications, educational preparation	Employees, patients, physicians
Physician resources	Physician risk assessment	Physicians
Other resources	Physical plant and medical office availability	Employees, physicians
Financial risks	Internal performance data and corporate initiatives	Employees, corporate
Societal risks	Emergency readiness, agency reports on health risks, PSA and SSA demographics, info from educational agencies, uninsured population performance data and policies	Community
Ethical risks	Internal performance data, internal and external audits, external publications denoting concerns	Community, physicians, patients, corporate
Regulatory risks	Regulatory information from agencies, industry publications/associations, HCA direction	Corporate, community,
National and global economy	Changes in insured population, published sources for impact of economy and changes in managed care industry (national and local news agencies)	Community
Partner and supply capability	Supplier performance, corporate information, vendor literature, literature about vendors	Corporate, community
Other unique factors	HCA (largest health care organization in the US) leverage and cost efficiencies information provided by Corporate, Baldrige feedback	Corporate, community

The Input Phase was a series of meetings and activities to gather information from various stakeholder groups. Input gathering occurred both formally and informally. In addition to board retreats, executive team retreats, leadership meetings, and strategic planning meetings, the organization received direction from the corporate stakeholder, HCA.

The organization engaged in an informal process of information gathering. Executive team members were primarily responsible for gathering input from key stakeholders during daily rounding and employee forums. The informal internal scanning of the environment provided unique perspectives that were synthesized as part of the analyze phase. Informal external scanning occurred through the involvement and participation by leadership in local, regional, and national organizations.

Formal input gathering was structured and orchestrated to include all key stakeholders as outlined in Figure 5.1. These included employees, physicians, patients, community, and corporate (HCA). Input from stakeholders provided direction to the plan and the executive team discussed needed directions and high-level goals for the prioritize phase.

In addition to key stakeholders, comparative data sources were utilized to identify clinical and non-clinical measurements. Due to the complexities of the health care environment, Medical City Dallas Hospital was required to seek out comparative sources locally, regionally, and nationally. As outlined in Table 5, the comparative data sources originated from professional organizations, government agencies, and private institutions as described in terms of measurements and uses.

As part of the **Analyze Phase**, every third year the staff undertook a comprehensive planning effort that analyzed inputs from the internal and external environmental scans. In the other years, a strategic planning team of executive team members was created to review

and analyze updated inputs to modify current understanding and trends in performance. The team also conducted a service line analysis, a market share analysis, and a competitive analysis through data from external scans. During both years, a SWOT analysis was created to understand areas of greatest importance for both short- and long-term planning.

The **Prioritize Phase** was a continuation of the planning activity as executive and strategic planning teams reviewed the SWOT elements to identify possible adjustments from the perspective of the mission, vision, and values to ensure alignment. This validated and identified needs for modification to the strategic plan. The Five Keys were also considered critical to prioritize directions and opportunities most important to the success of the organization. "We made sure that we were focused on the Five Keys. At one point I tried to push the addition of a sixth key but that idea was killed. It was clear that we were fanatical about achieving success in the Five Keys" (Villarreal 2008). Using these alignment decisions as a guide, the team prioritized the most important strategic challenges and advantages and created objectives to address them.

During the comprehensive planning activity every other year, the management team began the **Establish Phase** with the creation of a draft strategic plan that synthesized information from the Prioritize phase. In the other year, the strategic planning team updated marketing plans and suggested updates to strategic priorities for each objective to identify the highest impact areas of improvement. High-level plans for these priorities were captured for deployment to appropriate departments through the business planning process in later stages. A Gantt chart was developed to plan the design and implementation of action plans (called tactics), with timelines and responsibilities assigned in order to evaluate feasibility of the overall strategic plan from a capacity point of view. Longer-term capital and construction

plans were included in the Gantt chart to ensure all information was integrated into a single direction.

Following the planning meetings, presentations and documents were prepared to communicate the proposed plan to the remainder of the executive team. These documents were circulated for review prior to the Finalization meeting, which was held to understand the background of the plan, make comments and modifications, and finalize the strategic plan. In light of the proposed strategic plan, the Five Keys goals were reviewed by the executive team to ensure the attainment of these goals.

The **Deploy Phase** communicated the results of the strategic planning to the board of trustees and medical staff, during which comments were considered and plan adjustments were made as needed. The strategic plan was presented to all members of the leadership team during the fall MCDU retreat. Members of the leadership team developed department specific plans and updated existing plans to support the organizational strategic plan and to ensure that they were in alignment with the strategic plan and the Five Keys. This process aligned actions, measures, and goals throughout the organization. As departments determined financial resource requirements to accomplish their business plans, executive team members prioritized them into MCDH's shorter- and longer-term budget projections, ensuring the capability of the hospital to fulfill its plans.

Financial and human resources were allocated to support business and tactical plans once priorities for action were identified. Priorities allowed allocation of additional funds and staff to accomplish goals. One of the strategic teams in the planning process was a financial team, which was responsible for identifying key capital plans. In addition, a member of the finance department was assigned to each strategic team so that financial data

could be modeled as necessary for each team to determine resources and capital needs to accomplish its plan. A pro-forma was also completed for each team that determined resources and financial implications as well as expected volume of patient activity both inpatient and outpatient. The pro-forma also included financial modeling and performance to be obtained from the tactics. During budgeting, the required resources were allocated to the teams and business departments to support the accomplishment of their action plans.

To ensure adequate resources to meet current obligations, funds for new initiatives were included with overall hospital budgeting. The finance department performed analyses to ensure the availability of adequate financial resources to support current operations and to fund new business investments. For current operations, these analyses included balance sheet entries, income statements, and cash flow statements. They also included a comparison of current liabilities versus current assets to produce financial ratios to help track liquidity (Current Ratio, Quick Ratio), safety (Debt to Equity, Debt coverage ratio), profitability (Revenue Growth, Net Profit Margin, Return on Equity (ROE), Return on Assets (ROA), and Total Assets), and efficiency (Days in Receivables, Accounts Receivable Turnover, Days in Accounts Payable, Accounts Payable Turnover). For longer-term investments, analyses included discounted cash flows, return on investment (ROI), or return on invested capital (ROIC).

Quarterly employee forums were utilized to communicate the elements of the strategic plan, as well as their alignment with the mission, vision, and values, and the accomplishment of strategies. These mandatory meetings began with an overview by the chief executive officer on the mission, vision, and values of the organization. Each member of the executive team participated in outlining the status of each of the Five Keys and

recognized accomplishments. Employee input was generated through informal conversations prior to and at the conclusion of each of the ten scheduled presentations. "The best thing we have ever done is the employee forums. We all know how we are doing and where we are going. And they are a lot of fun" (Rose 2008). The employee forums were utilized to deploy and communicate the strategic plan throughout the organization.

Lastly, the **Review Phase** updated the strategic plan through a series of weekly, monthly, quarterly, and annual activities that were utilized during the input phase. These ongoing updates allowed the team to correct direction or respond proactively to risks and opportunities. On a monthly basis, the strategic planning tactical team of ten members, representing the seven to ten planning teams, met to discuss ongoing progress on action plans as well as to provide a forum for information sharing.

The Review Phase occurred throughout the remainder of the year as action plans were implemented at the organizational and departmental levels. Departments managed their performance to these plans and reported to the leadership team. The executive team reviewed performance weekly against the Five Keys and initiated actions throughout the year to ensure progress in line with organizational directions. As gaps in performance were noted, appropriate action was taken by either realigning resources to accomplish the plan or modifying direction. Throughout the year, the strategic plan was updated with new or modified plans to reflect any changes to the environment.

Annual department plans addressed Medical City Dallas Hospital's short-term planning horizon - one to two years. Long-term planning horizons were three to five years. These planning perspectives aligned with budgeting cycles and to the improvement cycles associated with various accreditation bodies. They also allowed for incorporating changes in

the local market and health care industry, while setting long-term overall direction for continuity. The planning process incorporated these timelines by defining the periods used for forecasting and researching, using the time horizon for creation of capital plans, facilities plans, and projection of human resource plans, as well as delineating timeframes for accomplishing goals.

External Scanning – Looking at the Market and Environment

During the strategic planning process, patient and other customer segments were identified along with new markets and/or service analyses of area demographic data and service usage. These analyses evaluated the services used by previous, current, and potential patients and stakeholders. The markets served were segmented into five geographical service areas: a primary service area (PSA) and four secondary service areas (SSA) (downtown, north, east, and west). Demographic data were used to determine the segments to target, and discharge data were used to confirm the service lines that were most strategic in each service area. Direct marketing to targeted patient segments provided further information on these segments. Significant marketing and sales efforts were directed to physicians with specialties within the Centers of Excellence (COEs) in the identified primary and secondary service areas. In addition, a physician sales team targeted physicians using analysis lists by age, volume, zip code, and specialty. Notably, targeted evaluation of physician stakeholders in the five centers of excellence in the identified primary and secondary service areas represented over 50% of all inpatient activity and 75% of contribution margin.

Within each service area, patients were segmented by access mode (emergency department, inpatient, or outpatient), and by service line (e.g., the five COE areas: women, pediatrics, cardiovascular, surgery, oncology, or a non-COE area). COE-specific marketing

was used to target segments based on geography and demographics (gender, age, income). Physicians were segmented by specialty (including COE areas) and by target relationships with physician groups serving the same target populations, thus increasing referrals and penetration of high potential communities.

Segmentation of the five payer segments included insurers, government, employers, self-insured, and the uninsured. Vendors and partners (beyond physician partners) were segmented by service / product type such as pharmaceutical, equipment, technology, and general medical suppliers. Regulatory organizations were segmented by focus (legal, accreditation, or regulatory) and by scope (national or state).

Results from external assessments were also reviewed, including audits and certification application, such as the Texas Award for Performance Excellence and the Malcolm Baldrige National Quality Award. The executive team used the assessments to determine improvements during planning. The external scan provided information on demographics, customer segmentation, changing market needs, payer information, competitor performance, and market share. Other external information included results of surveys, regulatory issues, service line performance, and external consulting resources. By design, the planning process evaluated strengths, weaknesses, opportunities, and threats through a SWOT analysis. Figure 5.1 outlines the types of information gathered from key stakeholders.

Aligning and Measuring the Results

Annually, over 700 quality indicators were identified and reported by Medical City Dallas Hospital (Weber 2008). These indicators ranged from infection rates to medication administration errors. In addition, corporate, federal, and state mandates required the

reporting of in excess of 600 financial and performance indicators (Burroughs 2008) (see Table 5).

Due to the tremendous amount of data gathered, Medical City Dallas Hospital embraced strategic planning processes to identify critical measurements to determine organizational success. In consideration of the mission and vision of the organization and in alignment with the stakeholders, the executive team identified five key indicators of success or the Five Keys, as mentioned earlier. Tying performance measurements with key stakeholders provided the empirical foundation for strategic planning (Martin and Singer 2003, 59).

The Big Blue Report

Key metrics were populated into a balanced scorecard (Kaplan 2001, 355), or the "Big Blue Report" (see Tables 6 and 7). The report was categorized into the Five Keys based on performance in comparison to targeted objectives. Monthly performance was measured by percentage of attainment of an identified target. Each of the Five Keys was expanded or "layered" into individual reports or Layer 2 Rollups. For example, attainment of overall patient loyalty targeted objective scores was comprised of five separate performance indicators which included compliance with caring model, staffing turnover, cycle times, complaints, and patient loyalty. While the concept of a dashboard report was not unique, Medical City Dallas Hospital created its own process and system to identify performance measurements and targets. More importantly, the goals and metrics were supported throughout Medical City Dallas Hospital by having departments align their departmental objectives with the hospital-wide targets.

The Big Blue Report allowed senior leaders to monitor monthly the performance of

the strategic plan with specific indicators, goals, and data collection requirements. These measures allowed progress to be tracked towards achievement of the strategic objectives. Often, this goal-setting approach resulted in an indicator becoming "red," which meant that strategy performance was not meeting intended objectives. Red indicators changed from month to month as organizational performance varied. As issues were identified, the executive team: 1) assigned ownership to a senior leader, 2) reached consensus on performance to be achieved, 3) evaluated and explored extenuating circumstances, 4) identified trended performance, and 5) approved response to the issue.

In addition, the organizational goals were aligned through evaluations of the leaders. During annual evaluations, each departmental leader set goals for the upcoming year that reinforced the hospital's overarching objectives or strategic plan and his or her role in attaining them. Monthly, departments reported status on their tactics that supported their goals and provided focused improvement reviews. In addition to executive team review, Medical City Dallas Hospital's performance of the Five Keys was shared with the leaders and with all employees at quarterly forums. These same metrics were discussed with the medical staff at the semi-annual medical staff strategic planning retreat.

Using performance reviews, Medical City Dallas Hospital was able to measure and align performance on multiple levels (see Table 8). In addition to review of performance by executive and leadership staff, the organization embraced on-going and structured performance reviews in numerous areas including revenue integrity, capital utilization, facility security, new product selection, survey readiness, policy and procedure compliance, medication safety, to name a few.

Measuring and aligning the performance of Medical City Dallas Hospital was a

fundamental leadership responsibility. Bass (1990, 218) stated that organizations led by transformational leaders were more likely to be highly effective in achieving results and that "transformation-like leadership resulted in more productivity at lower costs than did authoritarian or democratic styles" (Bass 1990, 219). Utilization of the Big Blue Report, leadership goal setting, staff communication, and physician participation provided alignment and accountability for organizational performance. By tying these efforts into the measurement of performance of the Five Keys, Medical City Dallas Hospital was ensuring synchronization with the mission, vision, and values.

In researching the presence and impact of transformational leadership for this dissertation, three areas of quantitative performance were selected from organizational performance and outcome measures: profitability, productivity, and cost management.

Profitability

Hospital profitability was measured by net revenue and net income. Net revenue represented the collection of funds from multiple funding sources including federal, state, and private payers. Reimbursement for services was based on a complex and dynamic set of criteria that ranged from daily per diems to diagnosis related groupings or a discounting on charges. Increased net revenues on static volume or activity indicated a higher level of reimbursement for services due to improved compensation, increased acuity, or a combination. During the period studied, Medical City Dallas Hospital eliminated low acuity services such as skilled nursing and rehabilitation. High acuity and high reimbursable health care services were expanded in the areas of pediatrics, cardiovascular, and surgical services.

Net income was calculated by subtracting operational expenses from net revenue. Improved net income was a measurement of both revenue enhancement and cost reduction.

Medical City Dallas Hospital monitored and measured both net revenue and net income. Organizational profitability was tied to staff productivity.

Productivity

Productivity was a measurement of organizational use of human resources through staffing matrixes and patterns. A significant component of the cost structure for Medical City Dallas Hospital was salaries, wages, and benefits, which represented 43 percent of total costs in 2007. HCA measured productivity through a number of indicators including equivalent employees per occupied bed (EPOB), salaries, wages, and benefits compared to net revenues, net income, and adjusted admissions. Adjusted admissions were determined by total hospital inpatient admissions and an equivalency factor of outpatient activity based on revenue. The seemingly complicated concept of adjusted admissions was an industry standard that allowed comparative analysis utilizing both inpatient and outpatient activity.

Cost Management

While staffing expenses comprised a major portion of total operating costs, cost management represented total operating expenses. Measurements in this category included total operating expenses and performance that were evaluated against adjusted admissions. Total operating expenses included salaries, wages, and benefits, supplies, contract services, professional services, legal and accounting, marketing and advertising, postage and transportation, travel and entertainment, and dues and subscriptions.

Additional areas related specifically to nursing performance were included in the research for this dissertation. These included nursing vacancy rates, nursing turnover rates, nursing certification rates, registered nurses with a bachelor's degree in nursing, and the average years of employment for nursing. Researchers with the American Nursing

Credentialing Center (2007) identified these specific criteria as critical in determining organizational performance and the presence of transformational leadership (Edmonson 2008).

Nursing vacancy rates and turnover rates were measures of organizational ability to staff nursing positions. Vacancy rates were an industry-wide measurement of staffing effectiveness. In addition, a significant measurement of performance was the ability to retain staff within the organization. An early study by Medical City Dallas Hospital estimated the replacement cost to train one nurse at $11,000 (Rose 2008). The impact of staffing vacancies was significant from both a financial and clinical perspective (Burroughs 2008, Edmonson 2008, Rose 2008).

Staff certification and advanced education among employees were also critical. Improving performance in this area resulted in heightened levels of professional performance (Edmonson 2008). In addition, advanced education and certification increased the ability of staff to care for more complex and acutely ill patients. Attainment of a bachelor's degree in nursing was another important indicator.

Aligning and measuring the results of strategic planning was a key leadership responsibility. The development of the Five Keys and the Big Blue Report focused leadership on specific performance criteria. For purposes of this research, specific performance criteria in alignment with the Five Keys and Big Blue Report have been presented in order to determine the impact of transformational leadership on the performance of Medical City Dallas Hospital.

Elements of Transformational Leadership in the Strategic Planning Process

Transformational leadership theory states that transformational leaders inspire and

motivate followers to pursue outcomes centered on a sense of purpose and an idealized mission (Sashkin 2004, 173). The definition of transformational leadership was elusive (Burns 2003, 2); therefore, the HCA study on high performing facilities (Wolf 2006) was the framework for describing the theory. How this theory was incorporated into the strategic planning process and manifested in day-to-day strategies and tactics was demonstrated in this research.

Visionary Leadership

Medical City Dallas Hospital's vision statement provided clarity of purpose and direction for the organization. "Instead of our typical annual business cycle that focused on the financials, we were planning for the future and our approach was balanced . . . we had Five Keys and each was equally weighted," stated John Hill (2008), Chief Operating Officer. The articulation of a vision statement provided a stated purpose that transcended a single financial target.

The review phase of the strategic planning process was also enhanced because weekly, monthly, quarterly, and annual activities were focused on the fulfillment of the vision. The successes or failures of strategic initiatives were measured against the Five Keys. "With all the priorities out there, we knew what *our* (emphasis not in original) priorities were so we could focus," according to Tim Burroughs (2008), Chief Financial Officer.

Between 9:00 a.m. and 10:00 a.m. each day, every member of the leadership team was expected to visit other departments, converse with patients, or tour the facility. The daily "rounding" was mandatory and meetings were not scheduled during this time. In addition, the executive team distributed survey questions from the annual employee survey. This survey approach was intended to stimulate conversation and create opportunities for

dialogue. Survey results were compiled into the monthly Big Blue Report and reviewed by the executive team. Information from these interactions was used in the input and analyze phase of the strategic planning process.

Consistent and Effective Communication

The strategic planning process included a comprehensive and thorough communication plan to all stakeholders at all levels of the organization as part of the deploy phase. Quarterly, employees were presented with the status of the Five Keys in a forum setting. The leadership team met annually in the fall for a four-hour strategic planning session. Annual board retreats were used to review and update the strategic plan. The creation of a medical staff strategic planning group consisted of physician leaders from the five centers of excellence - cardiovascular, women's, pediatrics, surgical, and oncology. A member of the board of trustees functioned as the coordinator of these efforts.

Medical City Dallas University was an important communication vehicle for all phases of the strategic planning process. Input was gathered through the monthly MCDU seminars. A participative approach was taken in discussing the status of the Five Keys and leadership team members were actively involved in the prioritization and deployment of strategies.

Communication tools were also deployed to maximize organizational awareness and communication. An internal communication specialist was responsible for several publications including *City Vines*, a monthly on-line newsletter; *City Views*, a quarterly internal news magazine; and *In Magazine*, a community magazine targeted at the identified external market. Efforts to create an internal news and information television channel were abandoned.

Select for Fit and Ongoing Development of Staff

Through a behaviorally-based Gallup Perceiver Interview[5], potential employees' talents and skills were evaluated to determine leadership characteristics. The managers aligned the specific job responsibilities with an applicant's identified talents. Tools, such as the "Four Keys Coaching Interview," facilitated a consistent performance management approach to retain talent and to ensure that strategic initiatives could be executed through the deploy phase. This dialogue tool was used to discuss an employee's strengths, as well as his or her motivational needs, expectations, and aspirations; methods to assess progress; best development approaches; and most effective methods of motivation and recognition. These efforts aligned human resources with the strategic plan.

Succession planning was also important as leaders were expected to maintain continuity and performance of strategic initiatives. Not only did the organization focus on the entry of new talent, existing personnel (or talent) was encouraged to assume greater responsibility and involvement in organizational goals and objectives. From 2000 through 2008, 137 different individuals were on the leadership team at Medical City Dallas Hospital. Since 2000, only seven retained the same job responsibilities. Clearly, succession planning as previously outlined played a critical role in ensuring continuity in strategic planning and organizational performance.

Agile and Open Culture

The deploy and review phases of the strategic planning process required

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[5] The Gallup organization has developed a proprietary survey tool to evaluate characteristics and behaviors aligned with categories of leadership. Leaders are provided training on conducting surveys and their results are submitted to the Gallup organization for compilation and interpretation. This confidential report is returned to the leader conducting the interview. Employment is not determined by this survey tool, but rather is utilized as a management tool.

organizational responsiveness to strategic initiatives. An agile and open culture allowed leaders to respond to a changing environment. "Our teams need to modify their plans from shift to shift, day-to-day, and week-to-week. If we didn't have an environment of openness, it would be impossible to do what we do," stated Cole Edmonson (2008), chief nursing officer (CNO).

New employee orientation included a one-hour informal presentation by the chief executive officer, the distribution of his personal business card, and a request for a personal e-mail to the CEO. Quarterly, the CEO and CNE participated in informal "chat and chews" with targeted employee groups such as new nursing students, departments, and new employees to discuss informally the organization. Supervisors were included in the monthly leadership meeting to enhance communication and increase collaboration.

Openness also included a respect for diverse opinions, experiences, and viewpoints. The annual diversity fair was heralded as a demonstration of the organization's willingness to embrace cultural diversity. Faraaz Yousuf (2008), vice president of operations, stated, "I came to Medical City because I knew my opinion would be respected . . . that my voice would be heard and I could make a difference."

Service is Job One

The Five Keys established priorities for the strategic planning process and encouraged responses to expectations of the five key stakeholders, namely employees, patients, physicians, the corporation, and the community. Throughout the strategic planning process, these stakeholders were considered. Several strategic initiatives aligned with this leadership behavior, such as the creation of the service standards and caring model.

In 2008, Medical City Dallas Hospital identified patient loyalty as a lagging indicator

as part of the input and analyze phases. In response, the executive staff conducted focus groups with 500 employees and determined staff expectations for customer service. As a result, the organization created the Medical City Dallas Hospital Promise, a commitment to the patients and their families. A comprehensive training and communication plan was developed and all employees attended mandatory three-hour customer service training.

The input phase involved extensive meetings and communication. In addition to the outlined communication processes, Medical City Dallas Hospital established a parents' advisory council and family advisory council that were instrumental in identifying needs and expectations. "The parents' advisory council was critical in the development of the congenital surgery unit and the children's tower. Their input was invaluable," according to John Oneill (2008), chief executive officer of Medical City Children's Hospital.

Constant Recognition and Community Outreach

Reward and recognition were an important element of the culture of Medical City Dallas Hospital. They were translated into the strategic planning process as leaders identified and celebrated organizational successes. Throughout the review phase, attainment of objectives was celebrated as part of the quarterly forums, monthly leadership meetings, weekly executive team meetings, monthly medical executive committee meeting, and the monthly board meetings.

Membership in local and national organizations by members of the leadership team provided information regarding environmental changes. As part of the input and analyze phases, this information was utilized to prioritize strategies and allocate resources. Executive team members actively participated in the Dallas/Fort Worth Hospital Council, Health Industry Council, Greater Dallas Chamber of Commerce, North Dallas Chamber of

Commerce, American College of Healthcare Executives, and the American Hospital Association. A study conducted by Medical City Dallas Hospital of the leadership team identified 238 different community organizations throughout the area with which individuals participated and/or affiliated (Lines 2009). These affiliations and participation provided insight into market conditions and were incorporated in the planning, input, and analyze phases of the strategic planning process.

Board members of Medical City Hospital Dallas also participated in numerous local, regional, and national organizations. These included local organizations such as the Dallas Citizen Council to regional agencies like the Texas Healthcare Trustees Association, and the Texas Medical Association Foundation. Several nationally recognized organizations were also included namely, the Center for Non-Profit Management and the National Academies of Science. In total, Board members affiliated with sixty-eight community organizations. As a result, their input was critical in assessing the environment and strengthening the prioritize phase of the strategic planning process.

Solid Physician Relations

As a private hospital, MCDH was challenged with understanding the needs of the medical staff. With few exceptions, members of the medical staff were independent private practitioners or independent contractors. Establishing strong physician relationships was critical in each of the phases described in the strategic planning process. Medical City Dallas Hospital created five medical staff strategic planning groups to provide input and prioritization of resources and strategies. The five planning groups aligned with the centers of excellence and were utilized to identify needs and issues. Their involvement was critical in the deployment and review phases.

Importance of Employee Engagement in Strategic Planning

"Companies that fail to invest in employees jeopardize their own success and even survival," according to Bassi and McMurrer (2007, 1). At Medical City Dallas Hospital, the importance of employee engagement in strategic planning was critical. Not only was employee involvement actively pursued and embraced as part of the strategic planning process, employees were identified as key stakeholders and one of the Five Keys. The importance of engaged employees in the strategic planning process is described by Atchison (1999, 23): " . . . while satisfied employees are content with the way things are, motivated employees work toward the way things will be."

Over a span of twenty-five years, the Gallup organization interviewed more than one million employees (Coffman and Buckingham 1999, 27) and attempted to analyze organizations to determine the characteristics of strong workplaces. Their use of employee surveys aligned with others in the field that attempted to assess intellectual capital (Saint-Onege 1996), human capital (Snell and Dean 1992), knowledge management (Hiebeler 1996), and learning organizations (Argyris 1991). Ulrich, Zenger, and Smallwood (1999, 53) stated that although these concepts subtly differ, all agreed on the importance of involved employees in executing a strategy and creating results. Further, a strong workplace with high performing employees was fundamental to organizational performance (Coffman and Buckingham 1999, 23; Edmans 2007, 1; Hewitt Associates 2004, 1; Knowledge @ Wharton 2008, 1; Pfeffer and Veiga 1999, 37; The Beryl Institute 2007, 1).

Through an annual employee survey, Medical City Dallas Hospital attempted to evaluate workforce satisfaction and engagement. "We utilize the annual survey to assess employee engagement. Our employee pride survey helps us understand the status of the

workforce," according to Jennifer Tertel, director of human resources. The employee pride survey evaluated importance and satisfaction in factors such as overall satisfaction, leadership effectiveness, staffing/workload, voice/communication, compensation practices, culture/recognition, and overall engagement. Feedback was analyzed at the corporate, division, hospital, and department levels.

From the survey, department action plans were developed by leadership and staff to address opportunities for improvement that were most important to the workforce. Action plans were evaluated by leaders and staff as to their success and alignment with the organization's mission, vision, and values. Questions were used to assess satisfaction and the level of engagement (based on Gallup research) as compared to other HCA facilities. Each question was correlated to the specific effects that it measured.

The vice president of strategic development provided a summary report to the board of trustees and the medical executive committee each year identifying high-level, mid-level, and low-level performance in both organizational expectations and results and the action taken with regard to these areas. This report identified organizational needs and improvement trends that resulted in departmental or organization-wide opportunities.

As part of the strategic planning, deployment, and review processes, initiatives and activities that aligned with the theory of transformational leadership were utilized. While this listing is not complete, it demonstrated actions that confirmed the importance of integrating employee involvement in the strategic planning process. Clearly, the presence of transformational leadership behaviors was fundamental in the strategic planning process at Medical City Dallas Hospital.

Conclusion

Strategic planning at Medical City Dallas Hospital began as a corporate-mandated business planning cycle. Medical City Dallas Hospital developed a comprehensive model for strategic planning with a defined planning process. The influence of transformational leadership was identified throughout the strategic planning process. The seven characteristics or behaviors of transformational leadership that were listed in the HCA study of high performing hospitals (Wolf 2006) played a role in this strategic planning process. The improvement in performance of Medical City Dallas Hospital resulted from the fulfillment of the strategic plan. Specific results that demonstrated the successful execution of the strategic plan will be discussed in the following chapter.

CHAPTER 6

THE INFLUENCE OF TRANSFORMATIONAL LEADERSHIP IN STRATEGIC PLANNING AT MEDICAL CITY DALLAS HOSPITAL

Bass (1985, 32) suggested that transformational leadership would account for a greater share of the variance in performance outcomes when compared with more traditional transactional styles of leadership (see also Dumdum, Lowe and Avolio 2002, 35). However, measuring performance outcomes has been elusive as industry-specific studies have only attempted to determine the existence of transformational leadership in an organization. In 2002, Dumdum, Lowe and Avolio conducted a meta-analysis of over 100 studies on contemporary empirical research from 1995-2002 on transformational leadership. Their work built on earlier studies by Lowe and Kroeck (1996, 385) that attempted to identify the existence of transformational leadership in organizations by utilizing the multi-factor leadership questionnaire.

In their meta-analysis of transformational leadership literature, Dumdum, Lowe, and Avolio (2002, 35) stated that the most widely accepted evaluative tool in assessing leadership styles was the multi-factor leadership questionnaire (MLQ). Researchers utilized this instrument to decide if elements of transformational leadership existed and to determine the perceived effectiveness of the leader and satisfaction of those led. The authors concluded that all transformational leadership scales were highly and positvely correlated with the effectiveness and satisfaction criteria (Dumdum, Lowe, and Avolio 2002, 44).

However, little empirical evidence existed that demonstrated a connection between transformational leadership and the execution of strategic change (Waldman and Javidan 2002, 183). Dumdum, Lowe and Avolio (2002, 62) recommended that future research concentrate on measuring outcomes such as trended productivity criteria, growth rates in knowledge, learning capacity, and strategic organizational performance. Clearly, they postulated that improvements in organizational performance as the result of transformational leadership would align with the improved utilization of human resources and overall organizational performance.

Bassi and McMurrer (2007, 115), in the *Harvard Business Review,* concluded that the investment in human capital management (HCM), such as leadership development, job design, and knowledge sharing, is imperative for many companies to achieve long-term competitive advantage. The *McKinsey Quarterly Report* (Bryan 2000) reported that archaic performance measures are geared to the needs of 20th century manufacturing companies. Changing times demanded new and innovative measures of the "contributions made by their talented people" (Bryan 2000, 57). The author called for the creation of new metrics to measure profit per employee and a quantitative analysis of profitability per employee. Viewing profit per employee as a measure of organizational performance put the emphasis on the return on talent and aligns with the tenets of transformational leadership.

This research utilized the HCA study on high performing hospitals to define transformational leadership. This definition aligned with the widely-accepted elements of transformational leadership in the literature. The presence of transformational leadership at Medical City Dallas Hospital is confirmed through the following results.

Transformational Leadership at Medical City Dallas Hospital

In May 2008, an employee survey was conducted by Lightspeed Research – The Foresight Group (2008), on the behalf of HCA. All 189 hospitals of HCA were surveyed nationwide with 149,722 participants. The North Texas division of HCA, comprised of ten hospitals, had 9,166 participants. Medical City Dallas Hospital had 2,272 participants. The results from Medical City Dallas Hospital are also contained in the results of the North Texas division and, therefore, positively affected the latter's results.

The survey of thirty-five questions based on a five-point scale was divided into seven categories: leadership effectiveness, staffing/workload, voice/communication, compensation practices, culture/recognition, outcomes, and work schedule. The results of this annual survey were trended over nine years and compared to the ten North Texas division hospitals and the other 188 HCA facilities. The overall employee engagement scores indicated consistent and improving results for Medical City Dallas Hospital.

Table 9. Employee Engagement Scores 2000 – 2008 Overall Mean Score

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Medical City	3.35	3.71	3.79	3.99	4	4.13	4.15	4.23	4.33
HCA	3.53	3.65	3.73	3.81	3.81	3.87	3.87	3.88	3.88
Difference	(.18)	.06	.06	.18	.19	.26	.28	.34	.45
Difference %	(5.1%)	1.6%	1.6%	4.7%	5%	6.7%	7.2%	9%	11.6%

Since 2000, Medical City Dallas Hospital has increased overall employee engagement scores by .95 basis points or an improvement of 29.3% in comparison to HCA which has improved by .35 basis points or 9.9% over the same time period. In 2000, Medical City Dallas Hospital's employee engagement score was in the bottom quartile of the HCA survey. In 2008, Medical City Dallas Hospital increased its difference from the corporate

average from a negative 5.1% to a positive 11.6% and is ranked fifth of all 189 hospitals and number one of all level F facilities and number one in the North Texas division.

This research expanded the level of analysis and conducted a self-administered questionnaire of the 72 members of the leadership team at Medical City Dallas Hospital in November 2008. Eighteen questions were selected from the 35-question survey and re-categorized into seven specific areas. These areas or categories were defined by the HCA study on high performing facilities (HCA 2005) as attributes of transformational leadership. These included visionary leadership, consistent and effective communication, select for fit and on-going development of staff, agile and open culture, service is job one, constant recognition and community outreach, and hospital-physician relationships.

A listing of the seven behaviors attributed to transformational leadership and the results of the 2008 employee survey accompanied the questionnaire. The researcher requested members of the leadership team to provide their opinions on the results. Fifty-seven anonymous surveys were returned within two weeks (79% response rate) regarding the seven aspects of transformational leadership. Their responses as identified numerically are contained herein and confirm significant differences in the results in comparison to the North Texas division hospitals and the other 188 HCA facilities. As noted by the Gallup organization (Coffman 1999, 28, 247), fully engaged employees are those that can answer with a "strong affirmative" and therefore, the results of the survey indicating strongly agree are highlighted.

Visionary Leadership

Three questions from the employee engagement survey aligned with the concept of visionary leadership. In describing this behavior, the HCA study of high performing facilities stated that visionary leadership was available, approachable and open, and operated with minimal micro-

management. In addition, visionary leadership provided clarity for organizational goals and objectives. Consistently, the senior leadership of Medical City Dallas Hospital was scored superior in response to all three questions in comparison to the North Texas Division and HCA.

Table 10. The senior leadership team gives employees a clear picture of the direction in which this facility is headed.

	Medical City	North Texas	HCA
Strongly Agree	**57%**	**39%**	**28%**
Agree	33%	38%	41%
Neither Agree or Disagree	7%	13%	18%
Disagree	2%	6%	9%
Strongly Disagree	1%	3%	4%

Table 11. Senior leaders are available and approachable.

	Medical City	North Texas	HCA
Strongly Agree	**51%**	**39%**	**32%**
Agree	33%	38%	40%
Neither Agree or Disagree	10%	12%	15%
Disagree	4%	7%	8%
Strongly Disagree	2%	4%	4%

Table 12. I can count on senior leaders of this facility to follow through and do what they say they will do.

	Medical City	North Texas	HCA
Strongly Agree	**45%**	**32%**	**24%**
Agree	35%	39%	40%
Neither Agree or Disagree	13%	185	21%
Disagree	5%	7%	9%
Strongly Disagree	2%	4%	5%

In response to these survey results, members of the leadership team commented as follows:

Respondent 3 – I think our high scores reflect the honest, open relationship that our executive team has with line employees. Staff are not "afraid" to talk to the executive team, and really feel that the communication goes both ways.

Respondent 6 – The leadership team is truly visionary. I have been here 10 years, and can see the changes mirror the vision. Senior leaders go beyond "approachable" and seek out questions and concerns. This is a leadership team that you can believe.

Respondent 10 – In leadership meetings and forums senior leaders provide information and a clear picture of the mission, vision and values and Five Keys so that all in attendance are "on board."

Respondent 12- The strategic plan, the vision and direction of the organization is reinforced by the CEO at new employee orientation to all staff members... everything is centered around the Five Keys which provides a stable focus for the leadership and staff.

Respondent 13 – Employee forums appear to be very effective with a great turn out. I continually feel motivated by the enthusiasm and charismatic leaders which are a major component of transformational leadership as well as in support of our mission and vision.

Respondent 15 – Medical City employees view senior leaders as approachable and willing to listen.

Respondent 26 - There are no deep dark secrets, people trust what the leadership team decides is ultimately in their (the employees and the patients) best interest, and they value that. They feel that they can approach any one

> member of the leadership team, and they will be respected for their comments or input or just a mere observation.
>
> Respondent 30 – MCDH senior leaders utilize forums, rounds, the hospital leadership team and various internal publications to communicate a clear and concise message on the direction this organization is headed . . . . I have not known a time where senior leaders have not followed through or have not done what they said they would do.
>
> Respondent 42 – Senior leadership has carved out a very clear and purposeful MVV that focuses on the care and improvement of human life. This is executed by forming strategies aligned with the Five Keys of success. These keys are communicated in all meetings and are the structure for our business plans and strategy. These strategies along with measures, integrate accountability, trust and respect among leadership and staff.

These comments are consistent with observations by other organizations. In the 2006 Malcolm Baldrige National Quality Award – Feedback Report (2006, 8), the surveyors stated, "Senior leaders regularly communicate performance excellence criteria and organizational values, e.g., orienting of all new staff to organizational values, mentoring managers, and ensuring that new medical staff receive orientation to the mission, vision, values, and code of conduct. Leaders at all levels model MCD's values and behavioral expectations."

Consistent and Effective Communication

The second behavior or characteristic of transformational leadership was consistent and effective communication. Utilizing the resources, strategies, and tactics identified in the Medical City Leadership System (MCDLS) and the strategic planning process, leadership effectively communicated throughout the organization. The HPF study defined this behavior as multi-way communication that included not only "what" needed to be communicated, but also the "why" it was important to the organization (Wolf 2008, 3). Two questions probed

the level of communication and the results for Medical City Dallas Hospital exceeded the comparative groupings of the North Texas Division and HCA substantially.

Table 13. I am kept well informed of what is happening here.

	Medical City	North Texas	HCA
Strongly Agree	**48%**	**34%**	**26%**
Agree	37%	40%	42%
Neither Agree nor Disagree	9%	14%	17%
Disagree	4%	8%	11%
Strongly Disagree	2%	4%	5%

Table 14. Sufficient effort is made to get the opinions and thoughts of people who work here.

	Medical City	North Texas	HCA
Strongly Agree	**48%**	**37%**	**29%**
Agree	34%	38%	39%
Neither Agree nor Disagree	9%	12%	15%
Disagree	7%	10%	12%
Strongly Disagree	2%	4%	5%

Respondents to the survey stated:

> Respondent 15 – Employees are surveyed each year to solicit their thoughts and opinions. The results are communicated back to staff as well as acted upon in the following year.
>
> Respondent 16 – Each department takes the results from surveys or interactions with staff to develop action items that the team can work on to make improvements. The action plans are not developed by management to be

> rolled out to staff, however, are taken by the unit level employees so that it becomes truly the department's plan not leadership's.
>
> Respondent 26 – People feel valued, when they have an opportunity to express their ideas or feelings on certain issues, or to be kept abreast of process changes, restructuring, etc. Here at MCDH, that is quite evident, because when people are kept informed, and they feel they have a voice, they are better performers, and are more engaged.
>
> Respondent 30 – A strong and consistent effort is made to solicit the opinions and thoughts of employees at all levels of the organization.

These responses confirmed that consistent and effective communication was utilized, as described in the strategic planning process of Medical City Dallas Hospital in Chapter 5. The establishment of the mission, vision, and values provided the foundation for the organization to communicate strategies and tactics. The addition of the Five Keys provided greater clarity of organizational objectives.

An assessment conducted by Baird Borling Associates (2008, 5) concluded: "Senior leadership functions as a strong team where everyone seems to be 'on the same page' and the group speaks with one voice. . . . Participants both expressed and reported a very strong buy-in for the vision, mission, and values of the organization and support for the numerous initiatives that have been put in place to strengthen the Hospital and its image in the community."

Select for Fit and On-Going Development of Staff

The high performing facility (Wolf 2008, 4) study described this behavior as "an unwavering commitment to wait for the right person in the hiring process versus simply hiring a 'warm body' and a corresponding courage to let people go who do not fit." Defining this behavior was much more difficult but several actions by Medical City Dallas Hospital confirmed a commitment to organizational fit and on-going staff development.

Seven questions from the employee survey were identified as indicators of staff satisfaction and alignment with organizational fit. In comparison to the North Texas Division and HCA, MCDH's results demonstrated substantial difference. Each question identified was scored superior to the comparative groups by a margin of 8-15 % in the strongly agree category.

Consistently, in excess of 50 % of the employees of Medical City Dallas Hospital strongly agreed with the statements on employee placement and job responsibilities as well as opportunities for advancement. When asked if diversity in the organization was valued, 87 % of the employees strongly agreed and agreed. In comparison, the North Texas Division and HCA achieved aggregated comparative scores of 77 % and 71 % respectively. The celebration of diversity was identified as a significant issue by the leadership team that commented on the results of the survey.

Table 15. I feel I make an important contribution to my facility, patients, and fellow employees.

	Medical City	North Texas	HCA
Strongly Agree	**74%**	**66%**	**61%**
Agree	22%	29%	33%
Neither Agree or Disagree	2%	3%	4%
Disagree	1%	1%	2%
Strongly Disagree	1%	1%	1%

Table 16. The people I work with help each other out when someone falls behind or gets in a tight spot.

	Medical City	North Texas	HCA
Strongly Agree	**60%**	**51%**	**46%**
Agree	30%	35%	37%
Neither Agree or Disagree	5%	7%	8%
Disagree	3%	5%	6%
Strongly Disagree	2%	2%	3%

Table 17. My facility is a place where differences are valued and people feel included.

	Medical City	North Texas	HCA
Strongly Agree	**53%**	**38%**	**29%**
Agree	34%	39%	42%
Neither Agree or Disagree	8%	13%	17%
Disagree	4%	7%	9%
Strongly Disagree	1%	3%	4%

Table 18. I am satisfied with my opportunities for development.

	Medical City	North Texas	HCA
Strongly Agree	**50%**	**38%**	**30%**
Agree	33%	38%	40%
Neither Agree or Disagree	8%	12%	15%
Disagree	6%	8%	10%
Strongly Disagree	3%	4%	5%

Table 19. My supervisor takes an active interest in my skills and career development.

	Medical City	North Texas	HCA
Strongly Agree	**51%**	**42%**	**35%**
Agree	31%	35%	37%
Neither Agree or Disagree	10%	13%	16%
Disagree	5%	6%	8%
Strongly Disagree	2%	4%	4%

Table 20. I am satisfied with the amount of voice I have in the decisions that affect my work.

	Medical City	North Texas	HCA
Strongly Agree	**40%**	**30%**	**23%**
Agree	36%	39%	40%
Neither Agree or Disagree	12%	16%	19%
Disagree	9%	11%	13%
Strongly Disagree	3%	4%	6%

Table 21. All employees are treated with respect regardless of their job.

	Medical City	North Texas	HCA
Strongly Agree	**52%**	**38%**	**29%**
Agree	32%	39%	42%
Neither Agree or Disagree	8%	11%	14%
Disagree	6%	8%	10%
Strongly Disagree	3%	4%	5%

> Respondent 1 - I think our scores are high in this category due to the very high level of trust, openness, and appreciation exhibited by senior leadership which I think trickles down to all levels of medical city.
>
> Respondent 2 - The cultural committee provides numerous events during the year that helps a diversity of feelings but shared values.
>
> Respondent 9 – There is a culture of continuous learning at Medical City. The CEO has a book club and invites the managers and supervisors to a meeting to discuss the book selected.
>
> Respondent 14 – The grow your own nurse program is a wonderful addition . . . . This really opens the doors for employees.
>
> Respondent 16 – As a result of the movements to transformational leadership within, our organization has provided many employees within the organization to grow . . . . This truly is a unique facility that provides endless opportunities for growth. As I have worked in this facility for 19 years I have seen an evolution of leadership in the organization. There is a true sense of commitment to all who work here. We are taught how to be leaders and to be true team players within the organization. Couldn't think of a better place to be.
>
> Respondent 26 – People feel that they make a difference and are recognized for their unique talents that each and every one of them brings to the table.

On-going staff development was identified as a significant element of transformational leadership and Medical City Dallas Hospital demonstrated commitment to this behavior. The creation of Medical City Dallas University and the Leadership System were two structured programs utilized to develop staff. In addition, a significant list of educational resources and programs including a nursing school and back to school program were made available to all staff.

Agile and Open Culture

The unique cultural difference at Medical City Dallas Hospital is reflected in the definition of this behavior (Wolf 2008, 4), "a sense of pride, collaboration, respect and a strong focus on quality are central to the organization's 'way of being,' and a constant sense

of reflection and continuous improvement allow these organizations to keep pace with and lead change." The Baird Borling survey (2008, 2) confirmed the uniqueness of this culture: "Nearly everyone agreed that the focus and value system of the hospital now is centered on achieving excellence and toward that end Senior Leadership is working to put the right people in the right places, in both leadership and staff positions."

Table 22. Overall, how satisfied are you with your facility as a place to work?

	Medical City	North Texas	HCA
Very Satisfied	**56%**	**40%**	**35%**
Satisfied	37%	51%	54%
Dissatisfied	2%	6%	7%
Very Dissatisfied	4%	3%	3%

Responses from the leadership team confirmed that the organization was open and responsive. The Medical City Dallas Hospital culture was described as a "blame-free environment where employees feel part of a family" (The Beryl Institute 2007, 8). Employees were encouraged to make decisions and pursue initiatives in alignment with the mission, vision, and values.

> Respondent 1 - When senior leaders round, they are very open and approachable . . . . I think we do have room for improvement with agility. Change is embraced readily but we are not always as agile as we should be.
>
> Respondent 7 - I drive over 70 miles one way each day to work and have for eight years. I love working at Medical City and cannot imagine working anywhere else. . . .When we achieve great things we all share them together and when someone is sad we all grieve together.

Respondent 10 – There is a culture of trust and partnership among the staff.

Respondent 27 – Because of rounding staff feel comfortable in approaching leaders with issues.

Respondent 28 – I don't see any degree of "micro-management" from the hospital senior leadership. Just solid support.

Respondent 30 – From the moment I first visited Medical City during the interview process, this organization has displayed the most vibrant and welcoming culture of any previous place of employment.

Respondent 30 – Medical City is a loyal organization to its employees, patients, and to others they serve.

Respondent 33 – I think we have a flexible workplace and our leadership team allows the staff to just do their job and provides the opportunity to do it well. Goes back to leadership style.

Respondent 42 – I would not drive over an hour to work at a facility that I am not satisfied with. Medical City is the home that I have wanted throughout my entire career. I pass many hospitals on my way to work daily and none of them compare to the experience that I have had at Medical City.

However, not all surveyed felt this same sense of family or community. Four percent of the employees surveyed strongly disagreed and two percent disagreed. In comparison, the North Texas Division employees scored nine percent dissatisfaction with this question and ten percent throughout HCA.

Service is Job One

Patient loyalty and physician engagement were identified as two of the Five Keys for Medical City Dallas Hospital. The creation of the Caring Model and the Service Standards (Rose 2008) demonstrated a commitment to the patient's experience. In describing this commitment, the Beryl Institute (2007) prepared a white paper that highlighted high performing organizations where customer service was superior. The Beryl Institute focused on Medical City Dallas Hospital and stated, "To realize this goal, the service standards are

communicated and reinforced throughout the organization via in-service educational sessions, videos, and informal meetings with the CEO. Fun is a key component – and it is not unusual to find the CEO dressed as a super hero (Batman is a favorite) to reinforce the 'patient first' philosophy."

Table 23. I can do what is necessary to serve my patients / customers without asking someone for permission.

	Medical City	North Texas	HCA
Strongly Agree	**61%**	**53%**	**47%**
Agree	30%	35%	39%
Neither Agree or Disagree	4%	6%	8%
Disagree	3%	4%	5%
Strongly Disagree	1%	2%	2%

The leadership team responded to the superior results in this area and identified the mission, vision, and values as guiding principles. Employee empowerment through education and training was also highlighted as important. The Five Keys allowed staff and leaders to take the initiative to respond as deemed appropriate.

> Respondent 16 – I definitely can say that as managers, leaders and staff members within this organization our mission, vision and values provide a framework for us to be able to offer excellent customer service.
>
> Respondent 22 – I am confident that senior leaders will support any decision that I make to deliver the best service possible and leave the customer with a positive experience.
>
> Respondent 27 – We have worked to empower staff to make decisions. This comes through mentoring and coaching.

> Respondent 31 – Employees make sound decisions in the absence of detailed instructions. They make inventive and resourceful decisions, thoroughly analyze conditions and reach independent decisions.
>
> Respondent 42 – The leadership at Medical City allows me to function in a way that is right for my department as long as I practice under the Five Keys.

Constant Recognition and Community Outreach

Results in this area aligned with transformational leadership behaviors and have been structurally reinforced throughout the organization. Employees recognized on-going coaching and mentoring as well as recognition by supervisors for contributions to the organization. The HPF study described this process as both formal and informal.

Medical City Dallas Hospital established $100 per employee for reward and recognition to be utilized by leadership teams and departments. These individual department initiatives were augmented with hospital-wide recognitions, such as hospital week and holiday celebrations. Recognition also occurred during monthly leadership team meetings where a 30 minute segment was dedicated to staff and team celebration for achievement. Informal recognition occurred through daily rounding, personal notes, and city light awards.

The Baird Borling assessment (2008, 12) also identified the same attribute:

> Many said they like the recognition activities the Hospital offers for employees, and mentioned such examples as health fairs, lunches (department and organizational), giveaways at the open forums, a wellness program with points awarded for healthy behavior along with a health insurance discount, and reinstatement of the holiday turkeys. Several also said they appreciate the services offered to employees in-house, such as a bank, post office, restaurants, dentists, and pharmacy. Several also expressed great pleasure that the children of employees are recognized for their achievements as well. All of this led many to conclude, 'They (leadership) care about us.'

Table 24. My supervisor does a good job of coaching me / guiding me.

	Medical City	North Texas	HCA
Strongly Agree	**53%**	**44%**	**38%**
Agree	30%	34%	36%
Neither Agree or Disagree	9%	12%	14%
Disagree	5%	6%	7%
Strongly Disagree	3%	4%	4%

Table 25. My supervisor recognizes my contributions.

	Medical City	North Texas	HCA
Strongly Agree	**55%**	**45%**	**39%**
Agree	31%	36%	40%
Neither Agree or Disagree	8%	10%	12%
Disagree	4%	5%	6%
Strongly Disagree	2%	3%	4%

Table 26. My supervisor shows a sincere interest in me as a person, not just as an employee.

	Medical City	North Texas	HCA
Strongly Agree	**61%**	**52%**	**47%**
Agree	25%	29%	31%
Neither Agree or Disagree	7%	9%	11%
Disagree	4%	5%	7%
Strongly Disagree	3%	4%	5%

> Respondent 14 – I feel there is a delicate balance that has to be maintained with this.
>
> Respondent 26- There is a bond established. There is trust. Everyone is treated with respect and dignity. People feel that if they want to advance in their career, the opportunities, and the resources are available to them.
>
> Respondent 47 – I am doubtful that I would be as successful in my position without the coaching and guiding I have received from both the CEO and CNO. Britt refers to it as a mentoring moment - - and I have benefitted from several "mentoring moments."

Not included in the results of the employee survey was the on-going community outreach. Medical City Dallas Hospital was recognized by the *Dallas Business Journal* (Pearson-Hormillosa 2008, B3) as the recipient of the Business Philanthropy Award for 2008. In 2008, community activities included raising $195,000 for the construction of a new community outreach center, hosting the Mike and Mike ESPN2 television and radio show, and raising an additional $100,000 for pediatric cancer research. Since 2000, Medical City Dallas Hospital employees have raised over $800,000 for charitable organizations, such as Habitat for Humanity, March of Dimes, American Heart Association, the Genesis Women's Center, and the North Texas Food Bank (Jackson 2008).

Hospital- Physician Relationships

Unique to health care but still aligned with the tenets of transformational leadership, the HPF study identified solid physician relationships as foundational to successful health care organizations. Medical City Dallas Hospital had a medical staff of 1,100 credentialed physicians and a medical staff structure comprised of elected and appointed medical staff leadership. As a private hospital, these physicians functioned as independent contractors, participating in hospital activities and functions as granted by the board of trustees.

Functioning under a separate governance structure, the alignment of the medical staff with the mission, vision, and values of the organization was recognized as a challenging and complicated effort. More than 70 physicians participated in strategic planning groups and the hospital participated in numerous communication processes to ensure engagement. Employee recognition of these efforts is reflected in the survey results.

Table 27. In my work group, employees are treated with respect by physicians / medical staff.

	Medical City	North Texas	HCA
Strongly Agree	**46%**	**37%**	**30%**
Agree	37%	42%	44%
Neither Agree or Disagree	8%	11%	14%
Disagree	6%	7%	9%
Strongly Disagree	2%	3%	4%

Respondent 5 – The physicians I work with verbalize to physicians outside their immediate circle to go see Britt or John when they have complaints. This is not the norm in other facilities.

Respondent 8- The Five Keys sets an expectation of the leadership team to develop a positive working relationship with the physicians. If the physicians demonstrate behavior that does not foster a healthy work environment, the behavior is addressed immediately.

Respondent 16 - The leadership within Medical City has established a standard of physician behavior and it is reflected in the way the physicians interact with staff. Over the past years, senior leadership has been faced with some tough issues regarding physician behavior which directly impacted revenue. These tough decisions gave the employees at Medical City a renewed sense of commitment to those who work so closely with physicians. Everyone feels that each employee and each physician are held to the same standards of how they treat one another in the work place. These types of decisions have positively impacted the relationships between physicians and employees.

> Respondent 43 – Healthcare consists of an interesting chemistry of caregivers with varying degrees of education and expertise. Adding to this challenge is the physician component, where the physician, in most cases, is not employed by the hospital. Given most medical care is driven by physician order, a good relationship with staff and physician is crucial. MCD has the best and brightest medical staff with many pioneers in their field. It is clear from the survey that the physician relationship is intact and the staff feel respected and appreciated by the physicians. Additionally, there is an expectation from our senior leadership that physician behaviors align with the customer service standards that support our MVV.

Quantitative Outcomes and Performance Results

The effort to confirm the existence and influence of transformational leadership at Medical City Dallas Hospital led the researcher to evaluate quantitative outcomes and performance results. These results were categorized by profitability, productivity, and cost management. In addition, results were analyzed against the performance of three other comparative HCA groups: North Texas division hospitals (10), high performing facilities (11), and level F hospitals (12). In order to maintain the confidentiality of organizational profitability, productivity, and cost management, specific facility performance measures were reported on year over year improvement and in comparison to other hospital groupings.

Profitability

Due to proprietary concerns and the confidential nature of profitability, the researcher was challenged to provide data on the financial performance of Medical City Dallas Hospital. Action researchers struggle with the ethical dilemma of adherence to organizational expectations of confidentiality and the publication of compelling information for researcher purposes. In addition, health care organizations are challenged to produce hospital reports on

profitability that are not amended, reclassified, or subject to interpretation, rendering comparative analysis difficult.

However, in 2009, The Goldman Sachs Group, Inc. (Gnall, et al. 2009) published a comprehensive market overview of projected hospital performance into 2010. Its analysis included research on eight of the largest for-profit hospital companies: HCA, Community Health, Health Management Associates, Iasis, Lifepoint, Tenet, Universal Health, and Vanguard. Its research is included because of the publication of individual hospital profitability based on comparative publicly accessible data. The information is sourced from The American Hospital Directory (AHD). The AHD provides online data for over 6,000 hospitals. The database of information about hospitals was built from both public and private sources including Medicare claims data (MedPAR and OPPS), hospital cost reports, and other files obtained from the federal Centers for Medicare and Medicaid Services (CMS). The Goldman Sachs Report utilized this proprietary database to provide a comparative report from calendar year 2007 based on earnings before depreciation, interest, taxes, and amortization (EBDITA).

Table 28 compares the most profitable hospitals by company and selected other HCA facilities. While the researcher cannot confirm nor deny the veracity of the information published by Goldman Sachs, the information does provide a comparative overview of the profitability of Medical City Dallas Hospital to other public and private for-profit hospital companies. Based on this report, Medical City Dallas Hospital was the most profitable for-profit hospital of the eight companies analyzed. Further, Medical City Dallas Hospital's profitability exceeded the next largest facility by $ 14,706,000 and represented 5.9% of total EBDITA for HCA.

Table 28. Comparative Report on Hospital, Location, Profitability, and Ownership

Hospital	Location	EBDITA ('000)	Ownership
Medical City Dallas Hospital	Dallas, TX	$193,308	HCA
Methodist Hospital	San Antonio, TX	179,232	HCA
Del Sol Medical Center	El Paso, TX	119,602	HCA
The Woman's Hospital of Texas	Houston, TX	95,845	HCA
CJW Medical Center-Chippenham	Richmond, VA	95,817	HCA
Oklahoma University Medical Center	Oklahoma City, OK	87,798	HCA
Centennial Medical Center	Nashville, TN	85,211	HCA
Memorial Hospital	Jacksonville, FL	81,602	HCA
Conroe Regional Medical Center	Conroe, TX	81,473	HCA
Clear Lake Regional Medical Center	Webster, TX	77,759	HCA
Lutheran Hospital of Indiana	Fort Wayne, IN	$105,596	Community Health
Medical Center of Southeastern	Durant, OK	$89,856	HMA
Pioneer Valley Hospital	West Valley, UT	$65,935	Iasis
Memorial Medical Center	Las Cruces, NM	$50,074	LifePoint
Providence Memorial Hospital	El Paso, TX	$59,829	Tenet
Summerlin Hospital Medical Center	Las Vegas, NV	$ 52,259	Universal Health
Baptist Medical Center	San Antonio, TX	$52,529	Vanguard

In regards to profitability, four categories were examined with comparative data from internal HCA documents. The four areas studied included profit margin, net income, net income per employee, and net revenue per employee. Profit margin was determined by dividing net income into net revenue. This calculation provided a profitability index of net

income based on activity, namely net revenue. In effect, the organization's ability to generate profit as a percentage of total activity was determined. Total net income was calculated by subtracting total expenses including depreciation, interest, taxes, and amortization from net revenue. Lastly, net income and net revenue were compared to total employed staff.

The profit margin of Medical City Dallas Hospital was averaged for the three years preceding the introduction of transformational leadership (1997-1999) and this average was compared to the most recent three years (2005-2007). Clearly, the influence of transformational leadership transcends annual variations in performance influenced by external and internal dynamics previously described in this research; therefore, a three year average was determined.

In comparing these two data points, the Medical City Dallas Hospital profit margin improved 36.8 percent. In comparison, the other ten HCA North Texas division improved profitability or profit margin fell by 28.6 percent. Once again, while the author does not suggest that transformational leadership behavior did not exist in the other facilities, the dramatic improvement in profitability of Medical City Dallas Hospital is linked with the influence of transformational leadership behaviors.

In addition, the trended positive performance in each of the profitability categories indicated not only an improving profit margin but also an improvement in net income, net income per employee, and net revenue per employed staff (see table 29). The dynamic nature of the hospital industry is reflected in the variability of results. Nonetheless, Medical City Dallas Hospital demonstrated improving financial performance over the period studied.

From 2000 through 2007, net income improved 45 % annually. For several years, MCDH experienced significant improvement while in only one year (2004) did it experience

erosion in financial performance which was regained by 2007. During this year of financial erosion, two competing hospitals were built in the primary service area and the largest internal medicine group relocated to these competing campuses.

Net income per employee and net revenue per employee experienced annual variation as staffing levels or employed staff varied in response to growth in new and complex hospital services such as congenital heart, stem cell, and transplant services. Nonetheless, from 2000 to 2007 these profitability measures improved (see table 29) resulting in superior financial performance.

Although net revenue per employee increased from 2000 to 2007, eight percent at a compounding annual growth rate of 8.9%, the most dramatic increases occurred in the net income profitability measures. Net income is a function of increasing revenue and an improvement in operating costs. Medical City Dallas Hospital was able to achieve modest improvements in net revenue resulting in an annual improvement in net revenue per employee as outlined, however, net income per employed staff experienced even more significant increases. From 2000 to 2002, net income per employee increased an average of 102.8% per year. By 2005 through 2007, those increases had subsided to an average level of 8.9% per year.

Net income and net revenue results were also favorably compared to the other hospital categories. Medical City Dallas Hospital has emerged as the most profitable hospital of HCA. Internal HCA documents (HCA 2009) confirm that Medical City Dallas Hospital's net income is 167% higher than the average of all F-level hospitals. The twelve Level F hospitals have net revenues in excess of $330 million and are classified as the largest hospitals in the HCA portfolio.

In comparison to high performing facilities and North Texas division hospitals, Medical City Hospital's net income is 1,676% and 1,932% higher respectively. The dramatic difference in these figures was attributed to the smaller size and scope of services in these comparative groups.

In adjusting for size by comparing net income and net revenue per employee, the results were still significant. In 2007, net income per employee was 132% higher than the average for F-level hospitals, 565% higher than high performing hospitals, and 781% higher than North Texas division hospitals. Net revenue per employee was also compared to these other hospital groupings. Medical City Dallas Hospital was 12% higher than the average of F-level hospitals, 26% higher than high performing hospitals, and 19% higher than the other North Texas division hospitals.

Based on the figures, it was clear that while net revenue per employee in comparison to the three comparative groupings was less dramatic, Medical City Dallas Hospital was able to generate superior net income per employee through improved productivity and cost management resulting in significant net income per employee comparisons. In effect, the employees at Medical City Dallas Hospital were realizing superior financial results in both the aggregate but also per employee in comparison to similar-sized level F HCA hospitals, recognized high performing HCA facilities throughout the nation, and HCA sister hospitals throughout the North Texas region.

Productivity

Transformational leadership theory stated that these type of leaders "develop in their subordinates an expectation of high performance rather than merely spending time praising or reprimanding them" (Bass 1990, 54). In assessing productivity, four indicators were

selected that reflected the organization's ability to manage human resources. These included employees per occupied bed and changes in salaries, wages, and benefits per employee and net revenues (see table 30).

Employees per occupied bed (EPOB) was a productivity measure utilized extensively throughout HCA. This productivity indicator allowed leadership to measure personnel resources based on fluctuating inpatient activity. By reducing the number of employees caring for occupied in-patient beds, productivity and financial performance would improve. This indicator did not account for increasing complexity or acuity of patients. For example, medical/surgical staffing ratios call for one nurse for three to four in-patients. In the intensive care unit, it was typical to staff one nurse per patient. While staffing ratios change from floor to floor, shift to shift, and diagnosis to diagnosis, EPOB was considered an effective aggregate measurement of staffing effectiveness.

Medical City Dallas Hospital reduced employees per occupied bed from 4.96 to 4.63 during the period researched or .33 basis points, a reduction of 6.65% over seven years. In comparison, the Medical City Dallas Hospital EPOB was .53% lower than comparative level F hospitals, 13.62% lower than high performing hospitals, and .8% lower than North Texas division hospitals. Fluctuating performance in this measurement is attributed to several factors. Increased acuity in the congenital heart surgery and transplant programs required increased staffing per occupied bed. In addition, improved productivity and personnel performance allowed for reductions in staffing.

Year over year expenses in salaries, wages, and benefits (SWB) experienced consistent annual increases. According to the chief financial officer (Burroughs 2008), annual merit increases from 2003-2007 were budgeted at three percent. Combining salary

increases with the benefits category, which included education and training, SWB increased per employee six percent annually from 2000 to 2007. The difference in these growth rates was attributed to merit increases in excess of budgeted figures and increased education and training.

In evaluating productivity, SWB was compared to activity measures, namely net revenue. SWB as a percentage of net revenue declined an average of one percent per year from 2000 through 2007, decreasing from 38.9% in 2000 to 31.8% in 2007. Important to note is that personnel costs, while increasing per employee six percent per year, declined in comparison to net revenue. As both net revenue and SWB increased over the period studied, net revenue grew at nine percent compounded annual growth rate and SWB increased at six percent compounded annual growth rate per year. The resulting impact was an improvement in net revenue and net income per employee as previously described.

In comparing additional productivity results, in 2007, Medical City Dallas Hospital SWB per employee was two percent higher than F-level hospitals and 15% higher than high performing hospitals and five percent higher than North Texas Division hospitals. However, comparatives of salary, wages, and benefits as a percentage of net revenues demonstrated that Medical City Dallas Hospital operated with lower personnel costs as a percentage of net revenue. Salaries, wages, and benefits as a percentage of net revenue were 35.1% for level F hospitals. This statistic was significant because level F hospitals provided higher acuity and more sophisticated health care services. High performing hospitals had salaries, wages, and benefits as a percentage of net revenue at 35.6% and north Texas division hospitals averaged 36.4% in the same geographical area. Accounting for size (level F), performance (high

performing), and geographical location (north Texas), Medical City Dallas Hospital demonstrated superior performance in productivity.

Cost Management

Personnel costs represented 43% of total costs and were an important element in total cost management. Other areas affecting the category of total operating expenses included supplies, contract services, professional services, legal and accounting, marketing and advertising, postage and transportation, travel and entertainment, and dues and subscriptions.

Cost management was analyzed utilizing total operating expenses and total operating expenses minus bad debt in comparison to adjusted admissions. Adjusted admissions included total in-patient admissions and an adjustment factor based on net revenue to account for outpatient activity. Recognized as an industry standard, adjusted admissions provided a broader review of cost management in comparison to overall hospital activity.

Since 2000, Medical City Dallas Hospital total operating expenses per adjusted admission increased seven percent annually (see table A31). Adding the impact of bad debt, total operating costs increased six percent annually during this same period. Increasing operating expenses was associated with increases in costs for supplies, contract services, and professional services. The other categories represented insignificant costs.

Additional Quantitative Results

In assessing organizational performance, five additional indicators for nursing services were selected to highlight the impact of transformational leadership. The American Nursing Credentialing Center (ANCC) monitored these five indicators and required on-going status reports on organizational performance in these areas. Staff retention and educational advancement reflected an on-going commitment of the organization to human resources.

Further, comparatives were provided with other hospitals recognized for nursing excellence through their attainment of Magnet designation.

Nursing vacancy rate is a nationally recognized standard to evaluate staffing availability of nursing units. Medical City Dallas Hospital demonstrated significant improvement in staffing areas, increasing from a staffing rate of 81% to greater than 96% on all shifts on all days. Magnet designated hospitals achieved similar results. Important to note was that nursing vacancies were usually filled through temporary contract nurses or by existing staff requesting additional shifts.

Table 32. Nursing Vacancy Rate 2002 – 2007

	2002	2003	2004	2005	2006	2007	Magnet Average
Certification Rate	19%	17%	12%	10%	7%	4%	3.9%

Medical City Dallas Hospital estimated that the training of a new nurse costs in excess of $11,000 per new employee (Rose 2008). From 2002 to 2007, nursing turnover rates declined from 29% to 10% in comparison to Magnet designated hospitals at 11.6 percent. Turnover was a reflection of staff dissatisfaction with working conditions, compensation, or other personal reasons or factors, such as external demographic issues, family relocations, and economic hardships. Nurse longevity of employment was also identified as a measure of organizational performance. Longer-tenured employees were believed to be more productive and capable, according to CNO Edmonson (2008). Medical City Dallas Hospital's nursing personnel demonstrated an improving length of tenure up to 8.8 years.

Table 33. Nursing Turnover Rate Trend 2002 – 2007

	2002	2003	2004	2005	2006	2007	Magnet Average
Turnover Rate	29%	18%	15%	14%	12%	10%	11.6%

Table 34. Years Average Length of Employment Trend for Nurses 2002 – 2008

	2002	2003	2004	2005	2006	2007	2008	Magnet Average
Years	7.5	7.9	8.3	8.1	8.5	8.8	8.8	9.7

Certification and advanced degrees were also identified as measures of improved nursing performance. The American Nursing Credentialing Center (ANCC) determined that the attainment of certifications in nursing specific areas (intensive care, oncology, perinatal) ensured excellence in nursing care. Medical City Dallas Hospital achieved 22% certification rate for nursing. In addition, nurses attaining bachelor's degrees in nursing expanded from 33% in 2002 to 52% in 2008. The addition of an on-campus nursing school and an advancement of the nursing program from associate to bachelor, fully funded by Medical City Dallas Hospital, was expected to improve these indicators.

Table 35. Certification Rate Trend for Nurses 2002 – 2008

	2002	2003	2004	2005	2006	2007	2008	Magnet Average
Certification Rate	14%	16%	17%	20%	20%	25%	22%	21.8%

Table 36. Registered Nurses with a Bachelors in Nursing Trend 2002 – 2008

	2002	2003	2004	2005	2006	2007	2008	Magnet Average
BSN	33%	48%	48%	41%	47%	52%	52%	46.1%

Conclusions

Medical City Dallas Hospital has demonstrated not only the presence of a leadership system based on transformational leadership theory, but has also achieved superior outcome performance and results. The study conducted by HCA to identify high performing facilities (HCA 2005) recognized seven unique characteristics. These characteristics or behaviors aligned with contemporary literature on the theory of transformational leadership. The strategic planning process aligned these behaviors with leadership activities. The existence of a transformational leadership system based on theory at Medical City Dallas Hospital resulted in significant and superior organizational performance. In evaluating performance outcomes with three other comparative groups, it is not suggested that transformational leadership behaviors were not present in the other comparative groups; however, the performance of Medical City Dallas Hospital confirmed the influence of transformational leadership on strategic planning and on superior comparative organizational performance.

The presence of the seven behaviors aligned with transformational leadership theory was evident through the employee survey and leadership team questionnaire. Open-ended questions completed by members of the leadership team confirmed the presence of transformational leadership. These results were substantiated by an audit conducted by the Baird Borling Associates that confirmed the presence of transformational leaders. An

application and accompanying evaluation conducted by the Malcolm Baldrige National Quality Program also supported these conclusions.

In comparing organizational outcomes, Medical City Dallas Hospital was challenged to obtain comparative data from the health care industry. In response, the researcher utilized internal and confidential comparative data regarding profitability, productivity, and cost management. Efforts were taken to retain confidentiality through this analysis while still confirming comparative analysis on outcome performance. The report published by Goldman Sachs Research provided a public profitability comparative.

More importantly, Medical City Dallas Hospital was compared against the ten North Texas HCA hospitals located throughout the Dallas-Fort Worth Metroplex. The twelve level F-Hospitals owned and operated by HCA throughout the United States were also utilized to compare facilities with net revenues in excess of $330 million. Lastly, an internal HCA study of high performing hospitals which included eleven HCA hospitals from throughout the United States with varying degrees of size and complexity provided a third comparative data set.

The results of this research confirmed that performance outcomes improved significantly from 2000 through 2008, and these results were superior at Medical City Dallas Hospital in comparison to the other three groups and other public and private for-profit hospitals nationwide. Although the personnel costs per employee were greater than the comparative groups, the productivity of MCDH employees resulted in superior profitability. The Medical City Dallas Hospital achieved year over year improvement in profitability and productivity. Not only did profitability increase year over year, but also correspondingly, the data confirmed that employee productivity was superior and improved dramatically during

the period studied. Bernard Bass (1985, 32) was correct when he suggested that transformational leadership would account for a greater share of the variance in performance outcomes when compared with more traditional transactional styles of leadership. Medical City Dallas Hospital provided quantifiable confirmation of this theory.

CHAPTER 7

CONCLUSIONS

Health care is a complex and dynamic segment of our society. Annually, almost $2 trillion is invested in health care products and services. Hospitals represent 30 percent of all health care spending. In addition to the sheer size of the investment Americans make in hospitals, hospital care is interwoven into every aspect of our environment and community, encompassing government services, private enterprises, and non-profit organizations.

The hospital industry has called for health care professionals to enrich academic research with real life experiences to enhance organizational performance and thereby, improve the quality of health care provided to society. Nevertheless, hospitals function in unique environments with significant external influences and stakeholders, such as community agencies, third party insurers, government agencies, and regulatory agencies at the state and federal levels. Internal stakeholders are also influential and include patients, board of trustees, medical executive committees, medical staff department chairs, medical staff members, executive team members, leadership team members, supervisors, employees, volunteers, and corporate personnel. Clearly, hospital care is complex and dynamic.

Action research is a new form of investigational study. Researchers engage in intimate study that bridges the chasm between objective, analytical research and personal, experiential learning. Action researchers possess unique perspectives and experiential portfolios that make their observations valid and important. Researchers note changes within the organization in which they work and diligently attempt to create understanding and new

knowledge by exploring the nature of these changes. Combining action research with case study methodology provides unique insights into organizational performance and is beneficial in understanding a complex and dynamic environment such as health care.

This researcher is the president and chief executive officer of Medical City Dallas Hospital, a 705-bed acute care hospital located in the Dallas/Fort Worth metroplex. The transformation of this organization from mediocrity to excellence is the subject of this research. The hypothesis is that hospital performance improves when transformational leadership is utilized in strategic planning.

The research chronicles the organization's transformational journey over the past eight years, including the creation of the Medical City Dallas Leadership System (MCDLS) placed within a strategic planning framework. In defining transformational leadership, the researcher categorized the results into seven attributes which were identified by an internal HCA study on high performing facilities. These attributes are defined as visionary leadership, consistent and effective communication, selection for fit and on-going staff development, agile and open culture, service is job one, constant recognition and community outreach, and hospital-physician leadership.

The strategic planning was categorized into seven phases which included: plan, input, analyze, prioritize, establish, deploy, and review. The evolution of the planning process at Medical City Dallas Hospital moved from annual business cycles to a comprehensive multi-year strategic planning process and was described in the context of the transformational leadership behaviors previously identified. The creation of mission, vision, and value statements was foundational to this work and provided clarity of organizational purpose and direction.

Medical City Dallas Hospital developed five key indicators of success or the Five Keys to measure organizational performance against strategic planning structures and efforts. The creation and establishment of these elements is explained. The five key indicators are as follows: employee pride, physician engagement, patient loyalty, fiscal performance, and community involvement.

In accord with the academic literature, transformational leadership behaviors were evident at Medical City Dallas Hospital. In addition to describing the behaviors and activities aligned with transformational leadership theory, a survey of the leadership team combined with the results of the employee engagement survey confirmed the presence of transformational leadership within the organization. In addition, the research confirmed a progressive improvement in results from 2000 through 2008 and demonstrated superior performance in comparison to other HCA large facilities, HCA high performing facilities, and HCA North Texas hospitals.

While these results are impressive, additional quantitative outcomes and performance results including profitability, productivity, and cost management were studied. Authors and researchers on transformational leadership theory suggest that organizational performance outcomes would be enhanced in the presence of these leadership behaviors. In the case of Medical City Dallas Hospital, several measures demonstrated superior performance in trended results and comparative analysis.

Reporting on profitability, productivity, and cost management proved difficult in light of proprietary expectations of confidentiality. In response, the researcher provided trended and comparative data to demonstrate organizational improvements in the aforementioned

areas. Based on a publicly published report, Medical City Dallas Hospital was identified as the most profitable for-profit hospital nationwide.

Due to the dynamic nature of health care, the average profit margin during a three year average from 1997-1999 was compared to 2005-2007. The researcher determined that the average profit margin improved 36.8 percent. In comparison, the North Texas Division group of ten hospitals experienced a decline in average profit margin of 28.6 percent.

Utilizing contemporary measures of organizational profitability, net revenue per employee achieved a compounding annual growth rate of 8.9% from 2000 through 2007. In contrast, net income per employed staff grew by an average of 102.8% per year from 2000 to 2002. From 2005 through 2007, those increases had subsided to an average level of 8.9% per year. In comparing these results with the identified other HCA groupings, Medical City Dallas Hospital demonstrated superior profitability performance.

Productivity measures were also studied because employee performance aligned with the tenets of transformational leadership that suggested that engaged employees outperform disengaged employees. In the case of Medical City Dallas Hospital, productivity measures were determined by improvements in employees per occupied (EPOB), salaries, wages, and benefits per employee and net revenue. All experienced improved results. Despite the increasing acuity of services and programs during the period studied, Medical City Dallas Hospital reduced employee staffing (EPOB) measures by .33 basis points or seven percent.

In the other areas of productivity, Medical City Dallas Hospital achieved declining salaries, wages, and benefits as a percentage of net revenue. Despite increasing annual human resources expenses of six percent, the leadership team at Medical City Dallas Hospital demonstrated the ability to minimize growing expenses in this area.

The third area of study was cost management. During the time period studied, operating expenses per adjusted admission (including and excluding bad debt) increased annually six and seven percent respectfully. Effectively, Medical City Dallas Hospital maintained a consistent cost structure despite the increase in clinically complicated and sophisticated services, such as congenital heart surgery, stem cell transplants, and solid organ transplantations.

Additional quantitative results included measures aligned with transformational leadership theory. These results focused on nursing services and were trended and compared with other Magnet-designated hospitals throughout the nation. Significant improvements in nursing vacancy rates, turnover rates, length of employment, and educational status were reported.

This research supports the hypothesis that transformational leadership behaviors present in hospital strategic planning will improve organizational performance as previously described. Unfortunately, quantifying these results was challenging and comparative data was elusive. Therefore, future researchers would be well-served in considering the Medical City Dallas Hospital case study and explore if similar behaviors would yield similar results. Further, the creation of contemporary profitability and productivity measures in hospitals would provide a comparative construct for future research.

APPENDIX

Table A2. Leadership Teams and Committee Structure Descriptions with Purpose of Team and Frequency of Meeting

Team Name	Membership of Team	Purpose of Meeting	Frequency of Meeting
Hospital Board of Trustees	Community and Physician members, Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Operating Officer	Medical Structure/Oversight, Performance Improvement, Risk, Safety / Disaster	Monthly
Executive Team	Executives and Vice Presidents	Strategic direction, values, 5 Keys	Weekly
Leadership Team	Executive Team, Directors and Managers	Day-to-day operations, 5 Keys, leader development	Monthly
Ethics & Compliance Committee	Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Vice President Human Resources, Ethics and Compliance Officer	Track and report ethics / compliance issues	Quarterly
Medical Executive Committee	Presidents, Medical Department Chairs	Medical staff structure and credentials, medical oversight, performance improvement efforts	Monthly
Physician Leadership Teams	Medical Executive Committee members, designated physician leaders, designated Executive and Leadership Team members	Day-to-day operations, policies, rules / regulations, strategic direction	Monthly/ Quarterly
Section Chiefs	Section Chiefs	Day-to-day operations, coordination with Staff	Daily
Privileges and Credentialing Committee	Medical staff and past president, Chief Executive Officer, Quality Manager	Appointment and re-appointment of medical staff, track performance data	Monthly

Table A2 continued

Team Name	Membership of Team	Purpose of Meeting	Frequency of Meeting
Performance Improvement /Patient Safety Council	Section Chiefs, Board of Trustees, President-elect, Director of Patient Safety, Pharmacy Risk, Chief Nursing Officer , Quality Manager	Quality assessment, performance improvement progress, patient safety, education on clinical quality indicators	Monthly
Team Name	Membership of Team	Purpose of Meeting	Frequency of Meeting
Patient Care / Performance Improvement Committee *	Physician leaders as designated, executive and leadership team members as designated, Quality Director	Oversight and corrective action in patient satisfaction, safety, and performance improvement	Monthly
Other Committees	Various medical & hospital staff members	Oversight of assigned functions and activities	Monthly / Quarterly
Medical Staff Performance Improvement Committee	Department medical staff and their hospital teams	Oversight of performance in specialty areas	Monthly / Quarterly
Peer Review	Section and department medical staff	Medical staff performance for accountability	Monthly / Quarterly

*Includes Safety Committees, Medicine and Blood Usage, Utilization Review, Infection Ctrl., Environment of Care, Cancer Committee, Lab Science, etc.

Table A3. Medical City Accreditation, Regulatory, Legal, and Ethical Requirements, Practices, Measures, and Goals

Regulatory Area	Agency	Compliance Practices	Measure	Goal
Accreditation	The Joint Commission	Tracking standards covering all aspects of operations	Joint Commission Certification	Certification
	Board of Medical Examiners	Medical staff license tracking	Meet Requirements	100%
	College of American Pathologists	Lab Accreditation Process	CAP Score	0
	Mammography Quality Standards Act	Mammography quality standards	MQSA Score	0
	American College of Surgeons on Cancer	Oncology Program Certification	American College of Surgeons on Cancer Score	Certification
	Foundation for the Accreditation of Cellular Therapy	Stem Cell Transplant Program Certification	Foundation for the Accreditation of Cellular Therapy Score	Certification
Environment	Environmental Protection Agency	Environment pollution abatement – clean water and air	Agency Standards	0
	Department of Transportation	Biohazard mgmt practices and medical waste disposal	Comply certification	0
	Nuclear Regulatory Commission	Radiation Control & Safety (Radiology, Nuclear Medicine)	Reportable incident	0
	Texas Department of State Health Services	Radiation Control & Safety (Radiology, Nuclear Medicine)	Reportable incident	0

Table A3 continued

Regulatory Area	Agency	Compliance Practices	Measure	Goal
Patient	Drug Enforcement Agency	Laws for dispensing and administration of medication	Reportable Incident	0
	Centers for Disease Control and Prevention	Infection control standards and practices	Reportable Incident	0
	Department of Health	Infection control reportable diseases	Reportable Incident	0
	Texas Department of State Health Services	Enforce CMS Conditions of Participation	Reportable Incident	0
Patient Rights	Texas Department of State Health Services	Understand and participate in personal healthcare decisions	Signed Consent	100%
	Centers for Medicare and Medicaid Services	Understand and participate in personal healthcare decisions	Signed Consent	100%
Patient Privacy	Health Insurance Portability and Accountability Act	Protected health care information privacy, security	Meet Requirement	0
Diversity	Equal Employment Opportunity Commission	Employee diversity and equitable opportunity	Lawsuits	0
Workplace Health /Safety	Occupational Safety & Health Administration	Staff and contractor workplace safety -- infectious disease prevention, fire, hazardous chemical, hazard protection, etc.	Reportable Incident	0

Table A5. Comparative Data Measures and Uses by Clinical and Non Clinical Data

Clinical	
Source	Measures, Data, and Uses
Joint Commission, Centers for Medicare and Medicaid	Acute Myocardial Infarction, Heart Failure, Pneumonia, Surgical Care Improvement Project ,Child Asthma Care
American College of Cardiology	American College of Cardiology Outcomes
Society for Thoracic Surgery	Society for Thoracic Outcomes
National Data for Nursing Quality Improvement (NDNQI)	Nursing Care Hours; Patient Safety (pressure ulcers and patient falls)
Hospital Corporation of America (HCA)	Morbidity, Mortality, Clinical Outcomes, Length of Stay, Charge/Case, Centers for Medicare and Medicaid Core Measures
Clinical Data Systems (HCA)	Cardiology Process Medical./Intervention Outcomes
Cardiovascular Quality Committee	HCA North Texas Division
"Get with the Guidelines" AHA	Acute Myocardial Infarction process and outcomes
National Nosocomial Infection Surveillance System	Surgical procedures for infection risk factors; healthcare associated infection
National Healthcare Safety Network	Healthcare associated infections
THCIC - Texas Healthcare Information Council	Volumes & Outcomes, Morbidity and Mortality
Reduced Perinatal Risk HCA	Perinatal Process, Outcomes
Solucient	Clinical Outcomes, Financial Data
Cognos	Market Demographic Data
Dallas Fort Worth Hospital Council (market)	Procedure Volume, Clinical Outcomes
MedWatch	Equipment Defects or Malfunctions
UNOS (national)	Transplant Survival Rates
Corporate Decision Support System	Demographic Market Data Procedures Volume, Clinical Outcomes

Table A5 continued

Non-Clinical	
Source	Measures, Data, and Uses
Gallup Corporation	Patient Loyalty
Gallup Corporation	Physician Engagement
Foresight	Employee Pride
Corporate IT&S	Help Desk Response Time
Corporate FNS	Room Service Times
Corporate Human Resources	Market Salary and Wage data
Navicare	Patient flow
Plus Productivity	Internal Daily Basis by Pay Period
Corporate Staff Health/Safety	Lost Time, Days, & Expenses
Medical Staff databases	Physician./Allied Health Reports

Table A6. Organizational Dashboard – Layer 1 Rollup (Big Blue Report)

LAYER 1 ROLLUP – March 2008				
	Monthly Performance		Target	Prior Month
1) Patient Loyalty Levers	89.09%	Yellow	100%	83.66%
2) Employee Pride Levers	89.19%	Yellow	100%	83.60%
3) Physician Engagement Levers	91.81%	Green	100%	92.73%
4) Fiscal Excellence Levers	94.36%	Green	100%	92.29%
5) Community Awareness Levers	99.04%	Green	100%	100%

Table A7. Organizational Dashboard – Layer 2 Rollup (Big Blue Report)

LAYER 2 ROLLUP				
	Monthly Performance		Target	Prior Month
1) Patient Loyalty Levers	89.09%	Yellow	100%	83.66%
1.1 Caring Model (Gallup)	98.82%	Green	100%	98.77%
1.2 Staffing Turnover	100%	Blue	100%	100%
1.3 Cycle Time	47.04%	Red	100%	56.88%
1.4 Complaints	100%	Blue	100%	63.32%
1.5 Patient Loyalty	99.57%	Green	100%	99.35%
2) Employee Pride Levers	89.19%	Yellow	100%	83.60%
2.1 Employee Perception	100%	Blue	100%	99.44%
2.2 Scanning Rates Supplies	94.44%	Green	100%	88.89%
2.3 Equipment Available / Maintained	95.11%	Green	100%	95.26%
2.4 Staffing Effectiveness	67.21%	Yellow	100%	50.82%
3) Physician Engagement Levers	91.81%	Green	100%	92.73%
3.1 Physician Monthly Input	98.98%	Green	100%	100%
3.2 Cycle Time	77.50%	Red	100%	80.00%
3.3 Percent Self Pay / Charity	98.42%	Green	100%	98.54%
3.4 Quality Roll-up	92.34%	Green	100%	92.37%
4) Fiscal Excellence Levers	94.36%	Green	100%	92.29%
4.1 Volume Growth	96.67%	Green	100%	95.33%
4.2 Key Performance	86.23%	Yellow	100%	97.49%
4.3 Spending	100%	Blue	100%	77.21%
4.4 Payer Mix	88.89%	Yellow	100%	93.41%
4.5 Staffing Effectiveness (EPOB)	100%	Blue	100%	98.03%
5) Community Awareness Levers	99.04%	Green	100%	100%
5.1 Marketing Effectiveness	99.56%	Green	100%	100%
5.2 Community Events	96.59%	Green	100%	100%
5.3 Community Partnerships	100%	Blue	100%	100%
5.4 Physician Outreach	100%	Blue	100%	100%

Table A8. Performance Reviews and Measures with Participants and Frequency

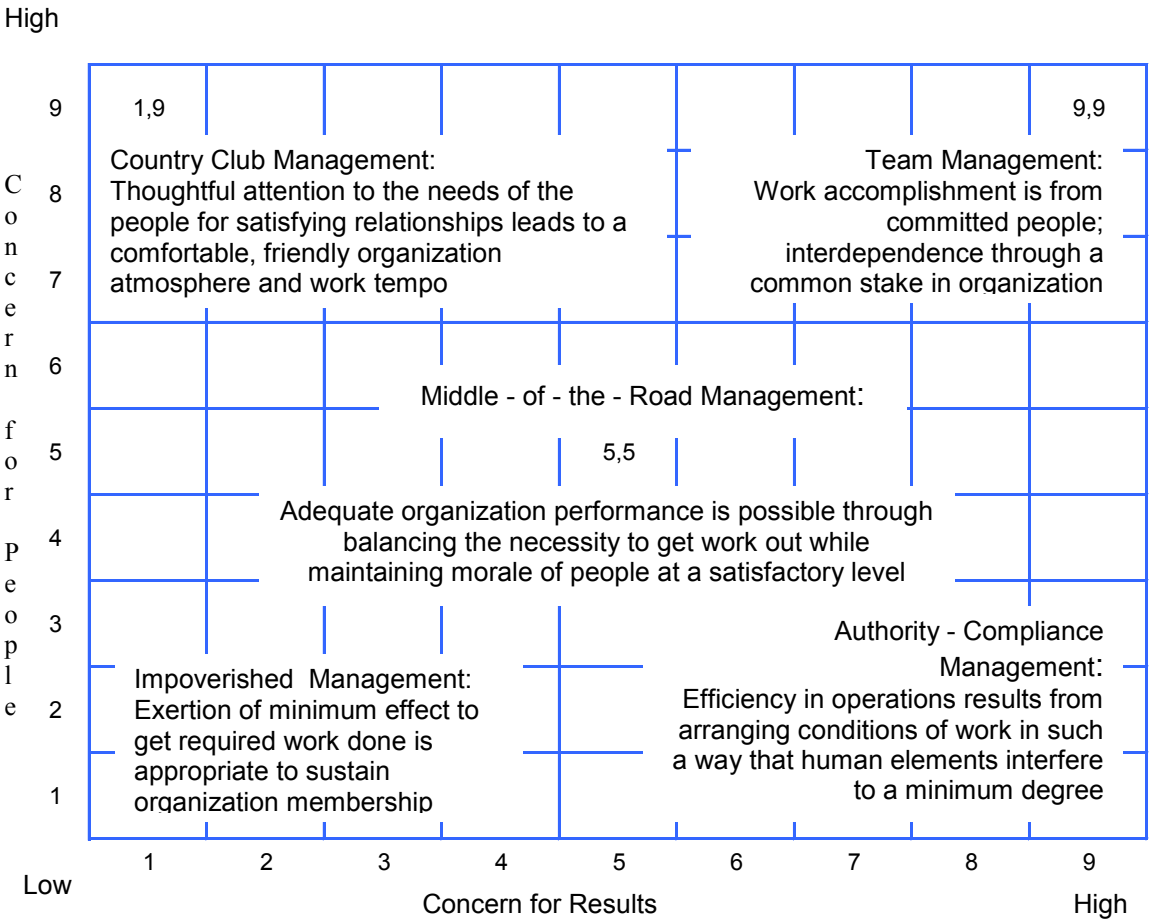
Review Meeting	Frequency	Participants	Focus/Measures
Executive Team	Monthly	Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Financial Officer, All Vice Presidents	Review indicators on Dashboard
Strategic Planning Committee	Annually	Executive Team, Invited others	Review action plans and measures from Strategic Planning Process
Staffing Advisory Council	Quarterly	Chief Nursing Officer, Quality Manager, Patient Flow Director, Staff nurses	National Database Nursing Quality Indicators, Comparative data, Staffing indicators / results
Revenue Integrity	Monthly	Chief Financial Officer, Health Information Management, Case Management, Admissions, Radiology, Laboratory, Finance	Billing Measures, Status
Capital Advisory Committee	Monthly	Chief Financial Officer, Finance, Executive Team members	Capital requests
Facilities Security Committee	Monthly	Ethics Compliance Manager, Health Information Manager, Quality Manager, MSO, Information Technology Department	Patient Information Access
Product Committee	Monthly	Materials, Finance., Organizational Development Department	New product selection
Survey Readiness	Monthly	Regulatory Accreditation Coordinator, Vice President Quality, Chief Nursing Officer, Safety, Infection Control	Joint Commission readiness

Table A8 continued

Review Meeting	Frequency	Participants	Focus/Measures
Policy and Procedure Committee	Monthly	Regulatory Accreditation Coordinator, Infection Control, Organizational Development, Patient Flow Director, Health Information Management, Clinical staff representatives	Inter-professional policies and procedures
Electronic Medication Administration Record	Monthly	Pharmacy Information Technology & Services, Nursing	Electronic Medication Administration Record Implementation and success
Medical Safety Team	Monthly	Pharmacy, Risk Management, Quality Management, Nurse Department & Representatives	Medical Errors Improvements
Infection Control Committee	Monthly	Medical Staff, Infection Control, Quality Manager, Nursing, Lab, Employee Health Nurse	Prevention and control of infection, Regulatory Compliance, Education
Environment of Care Committee (Safety)	Monthly	Safety Officer, Chief Operating Officer, Quality Manager, Infection Control, Organizational Development, Facilities Management, Employee Health & Safety, Biomedical	Safe work environment; reviews Performance Improvement data related to 7 safety management plans, emergency preparation
Critical Care Committee	Monthly	Medical Staff, Nursing Leadership, Radiation Therapy	Code Blue, Performance Improvement data, operational policy and process
Anesthesia Section	Quarterly	Medical, Surgery, Pediatrics, Lab Sciences	Sedation (operative/invasive)
Radiology and Emergency Department	Quarterly	Lab Sciences, Emergency Department Medical Staff	Radiology Over reads

Table A8 continued

Review Meeting	Frequency	Participants	Focus/Measures
Pharmaceutical & Therapeutic Committee	Monthly	Medical , Surgery, Obstetrics / Gynecology, Pediatrics, Lab Sciences	Medical Usage/ Evaluations / Safety / Pharmaceutical and Therapeutic
Tissue & Transplant Committee	Monthly	Medical, Surgery, Obstetrics / Gynecology, Pediatrics, Lab Sciences	Blood Usage Evaluation (comparative), Operative/Invasive (tissue review)
Medical Records / Utilization Review Committee	Monthly	Medical, Surgery, Obstetrics / Gynecology, Pediatrics, Lab Sciences	Medical Record Delinquency Record Review & Utilization Review, Emergency transfer (acute-acute non-Emergency Department)
Pharmaceutical & Therapeutic; Performance Improvement Council	Monthly	Medical, Surgery, Obstetrics/ Gynecology, Pediatrics, Lab Sciences	Risk Management (falls and medical errors)
Emergency Department Performance Improvement Committee	Monthly	Various Inter-professional - Nursing, Lab, Diagnostic, etc, Emergency Department Medical Staff	Emergency Transfer (acute to acute Emergency Department), Operational Performance Improvement



Reference: Northouse, Peter. 2007. *Leadership Theory and Practice.* Thousand Oaks, California: Sage.

Figure A1. Leadership Grid

Table A29. Profitability Measures 2000 – 2007

	2000	2001	2002	2003	2004	2005	2006	2007
Net Income Percent Change	.7%	138.4%	174.9%	22.9%	-6.9%	5.3%	1%	23.7%
Net Income / Employee Percent Change	-6.8%	142.5%	172.7%	23.8%	-5.2%	8.6%	-2.4%	20.5%
Net Revenue / Employee Percent Change	-1.7%	16.1%	24.1%	8.8%	7%	3.2%	7.8%	-2.8%
Return on Assets	6.1%	14.6%	39.9%	45.3%	38.7%	38.7%	39.1%	48.1%

Table A30. Productivity Measures 2000 – 2007

	2000	2001	2002	2003	2004	2005	2006	2007
Employee / Occupied Bed	4.96	4.64	4.58	4.63	4.6	4.48	4.63	4.63
Employee / Occupied Bed Percent Change	6.9%	-6.5%	-1.3%	1.1%	-.6%	-2.6%	3.3%	0%
Salary, Wages, and Benefits / Employee Percent Change	4.6%	10.9%	8.8%	4.3%	5.5%	5.2%	7.9%	-1.6%
Salary, Wages, and Benefits / Net Revenue Percent Change	6.4%	-4.5%	-12 %	-4 %	-1.4%	2%	0.1%	1.3%

Table A31. Cost Management Measures 2000 – 2007

	2000	2001	2002	2003	2004	2005	2006	2007
Total Operating Expense / Adjusted Admissions Percent Change	5.9%	7.8%	9.9%	5.8%	11.5%	0.7%	8.9%	5.2%
Total Operating Expense – Bad Debt / Adjusted Admissions Percent Change	6.1%	9.9%	7.2%	4.4%	8.2%	5%	8.9%	1.6%

SOURCES CONSULTED

ACHE Division of Research and Development. *Key Industry Facts.* Supplement, Healthcare Executive, Chicago: American College of Healthcare Executive, 2006.

Adams, J.S. *Inequity in Social Exchange.* Vol. 2, in *Advances in Experimental Social Psychology*, edited by L. Berkowitz, 267-296. New York: Academic Press, 1965.

Aiken, L.H., D.S. Havens, and D.M. Sloane. "The Magnet Nursing Services Recognition Program: A Comparison of Two Groups of Magnet Hospitals." *American Journal of Nursing* 100, no. 3 (2000): 26-36.

Alexander, Jeffrey A., and Marry L. Fennell. "Patterns of Decision Making in Multihospital Systems." *Journal of Health and Social Behavior* 27 (March 1986): 14-27.

Alexander, Jeffrey A., Laura L. Morlock, and Blair D. Gifford. "The Effects of Corporate Restructuring on Hospital Policymaking." *Health Services Research* 23, no. 2 (June 1988): 311-337.

Alexander, Jeffrey A., Mary L. Fennell, and Michael T. Halpern. "Leadership Instability in Hospitals: The Influence of Board-CEO Relations and Organizational Growth and Decline." *Administrative Science Quarterly* 38 (March 1993): 74-99.

Amercian Nurses Credentialing Center. 2008. http://www.nursecredentialing.org/Magnet/Programoverview.aspx (accessed October 7, 2008).

American Alliance of Healthcare Providers. January 2009. www.aahcp.com/directory.php (accessed January 11, 2009).

American Nurses Credentialing Center. 2007. http://nursecredentialing.org/ (accessed January 1, 2007).

Anderson, Ron J. "Building Hospital-Physician Relationships Through Servant Leadership." *Frontiers of Health Services Management* 20, no. 2: 43-47.

Annunzio, Susan Lucia. *Contagious Success.* New York: Penguin Group (USA) Inc., 2004.

Antonakis, John, and Robert J. House. *The Full-Range Leadership Theory: The Way Forward.* Vol. 2, in *Transformational and Charismatic Leadership: The Road Ahead*, edited by Bruce J. Avolio and Francis J. Yammarino, 3-33. Oxford: Elsevier Sience, Ltd., 2002.

Antonakis, John, Anna T. Cianciolo, and Robert J. Sternberg. "Leadership - Past, Present, and Future." Chap. 1 in *The Nature of Leadership*, edited by John Antonakis, Anna T. Cianciolo and Robert J. Sternberg, 3-15. Thousand Oaks: Sage Publications, Inc., 2004.

Argyris, Chris. *Flawed Advice and the Management Trap.* New York: Oxford Univesity Press, 2000.

Argyris, Chris. "Teaching Smart People How to Learn." *Harvard Business Review*, May-June 1991: 99-109.

Arndt, Margarete. "Hospital Administration in the Early 1900's: Visions for the Future and the Reality of Daily Practice." *Journal of Healthcare Management* 52, no. 1 (January/February 2007): 35-44.

Arndt, Margarete, and Barbara Bigelow. "The Transfer of Business Practices into Hospitals: History and Implications." *Advances in Health Care Management*, 2000: 339-368.

Ashmos, Donde P., and Reuben R. McDaniel. "Physician Participation in Hospital Strategic Decision Making: The Effect of Hospital Strategy and Decision Content." *Health Services Research* 26, no. 3 (August 1991): 375-401.

Atchison, Thomas A. "Exposing the Myths of Employee Satisfaction." *Healthcare Executive*, May/June 2003: 20-26.

—. *Leadership's Deeper Dimensions.* Chicago: Health Administration Press, 2006.

Atchison, Thomas A. "Striking a Balance." *Trustee*, July/August 2001: 28-29.

Atchison, Thomas A. "The Myths of Employee Satisfaction." *Healthcare Executive*, March/April 1999: 18-23.

—. *Turning Health Care Leadership Around.* San Francisco: Jossey-Bass Inc., Publishers, 1990.

Atchison, Thomas A. "What is Corporate Culture?" *Trustee*, April 2002: 11.

Atchison, Thomas A., and Joseph S. Bujak. *Leading Transformational Change.* Chicago: Health Administration Press, 2001.

—. *Leading Transformational Change.* Chicago: Health Administration Press, 2001.

Atkinson, Mark, interview by Britt Berrett. *Consultant - Medical City Dallas Hospital* (October 15, 2008).

Austin, Nancy, and Tom Peters. *A Passion for Excellence.* New York: Random House, Inc., 1985.

Avolio, Bruce J., and Francis J. Yammarino. *Introduction To, and Overview Of, Transformational and Charismatic Leadership.* Vol. 2, in *Transformational and Charismatic Leadership: The Road Ahead*, edited by Bruce J. Avolio and Francis J. Yammarino, xvii - xxiii. Oxford: Elsevier Science Ltd., 2002.

Avolio, Bruce J., and Francis J. Yammarino, . *Transformational and Charistmatic Leadership: The Road Ahead.* Vol. II. II vols. Oxford: Elsevier Science Ltd., 2002.

Ayman, Roya. "Situational and Contingency Approaches to Leadership." In *The Nature of Leadership*, edited by John Antonakis, Anna T. Cianciolo and Robert J. Sternberg, 148-170. Thousand Oaks: Sage Publications, 2004.

Baird Borling Associates. "Medical City of Dallas Employee Relations Assessment." July 2008.

Ball State University Institute . *Reforming the Health Care System.* Muncie: Miller College of Business - Ball State University, 2005.

Bartling, Ann C. "25 Pitfalls of Strategic Planning." *Healthcare Executive*, 1997: 20-23.

Barton, Phoebe Lindsey. *Understanding the U.S. Health Services System 3 ed.* Chicago: Health Administration Press, 2007.

Bass, Bernard. *Leadership and Performance Beyond Expectations.* New York: Free Press, 1985.

Bass, Bernard M. *Bass & Stogdill's Handbook of Leadership Theory, Research, and Managerial Applications.* 3rd Edition. New York: The Free Press, 1990.

Bass, Bernard M. "Concepts of Leadership: The Beginnings." Chap. 9 in *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 49-52. New York: The Free Press, 1995.

Bass, Bernard M. "The Meaning of Leadership." Chap. 7 in *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 37-38. New York: The Free Press, 1995.

Bass, Bernard. *Transformational Leadership: Industrial, Military, and Educational Impact.* Mahwah, New Jersey: Lawrence Erlbaum Associates, 1998.

Bassi, Laurie, and Daniel McMurrer. "Maximizing Your Return on People." *Harvard Business Review*, March 2007: 115-123.

Bays, Carson W. "Patterns of Hospital Growth - The Case of Profit Hospitals." *Medical Care* 21, no. 9 (1983): 850-857.

Bazerman, Max H. *Judgment in Managerial Decision Making.* Hoboken: John Wiley & Sons, Inc., 2006.

Beckham, J. Daniel. "Strategy: What It Is, How It Works, Why It Fails." *Health Forum Journal*, November/December 2000: 55-59.

Beekun, Rafik I., and Yvonne Stedham. "Board Characteristics, Managerial Controls and Corporate Strategy: A Study of U.S. Hospitals." *Journal of Management*, 1998: 3-19.

Beeson, Stephen C. *Practicing Excellence.* Gulf Breeze: Fire Starter Publishing, 2006.

Begun, James W., and Amer A. Kaissi. "Uncertainty in Health Care Environments: Myth or Reality." *Health Care Management Review*, January-March 2004: 31-39.

Begun, James W., Brenda Zimmerman, and Kevin J. Dooley. "Health Care Organizations as Complex Adaptive Systems." Chap. 10 in *Advances in Health Care Organizations*, edited by S.S. Mick and M.E. Wyttenback, 253-288. San Francisco: Jossey-Bass, 2003.

Begun, James W., James A. Hamilton, and Amer A. Kaissi. "An Exploratory Study of Healthcare Strategic Planning in Two Metropolitan Areas." *Journal of Healthcare Management* 50, no. 4 (July/August 2005): 264-275.

Begun, Jim, and Kathleen B. Heatwole. "Strategic Cycling: Shaking Complacency in Healthcare Strategic Planning." *Journal of Healthcare Management* 44, no. 5 (September/October 1999).

Bellido, Bob, interview by Britt Berrett. *Director of Environmental Services, Medical City Dallas Hospital* (November 23, 2008).

Bennis, Warren. "Leadership Theory and Administrative Behavior: The Probem of Authority." *Administrative Science Quarterly* 4 (1959): 259-260.

Bennis, Warren. "Leading Change: The Leader as the Chief Transformation Officer." In *Leadership in a New Era Vsionary Approaches to the Biggest Crisis of Our Time*, edited by John Renesch, 103-110. San Francisco: New Leaders Press, 1994.

Bennis, Warren. "The Four Competencies of Leadership." *Training and Development Journal* 38, no. 8 (1984): 14-19.

Bennis, Warren, and Burt Nanus. *Leaders.* New York: Harper & Row, 1985.

Berrett, Britt. "Survey of Executive Leadership Team of Medical City." Dallas, Texas, July 14, 2008.

—. "Survey of Leadership Team of Medical City Dallas Hospital." *The Influence of Transformational Leadership in Strategic Planning at Medical City Dallas Hospital.* Dallas, November 21, 2008.

Berrett, Britt, Tom Browning, Delawnia Hagans, and Gerell Oyun. "Increasing Physician Engagement at Medical City." Richardson, Texas, April 5, 2007.

Bersin & Associates. "Changing the Way Top Talent is Managed in Healthcare." February 2007. 1-41.

Berwick, Donald. "The Importance and Paucity of Trust in Today's Health Care System." *Trustee*, April 2005: 32-34.

Biebuyck, Julie F., and James T. Ziegenfuss. "How Physicians Can Create Their Future." *Physician Executive* 18, no. 4 (July-August 1992): 31-36.

Blake, Robert R., and Jane S. Mouton. *The Managerial Grid.* Houston: Gulf Publishing Group, 1965.

Blake, Robert R., and Jane Srygley Mouton. "Theory and Research for Developing a Science of Leadership." *The Journal of Applied Behavioral Science* 18, no. 3 (1982): 275-291.

Blanchard, David, interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (May 28, 2008).

Blanchard, Kenneth, Jr., William Onchen, and Hal Burrows. *The One Minute Manager Meets the Monkey.* New York: William Morrow and Company, Inc., 1989.

Blanchard, Kenneth, Sheldon Bowles, Don Carew, Eunice Parisi-Carew, and Sheldon. *High Five.* New York: HarperCollins Publishers Inc., 2001.

Blanchard, Kenneth, Thad Lacinak, Chuck Tompkins, and Jim Ballard. *Whale Done.* New York: Simon and Schuster, Inc., 2002.

Blum, M.L., and J.C. Naylor. *Industrial Psychology: Its Theoretical and Social Foundation.* New York: Harper & Row, 1956.

Boris, Elizabeth T., and C. Eugene Steuerle. "Scope and Dimensions of the Nonprofit Sector." In *The Non-Profit Sector Handbook*, edited by Walter W. Powell and Richard Steinberg, 66-85. New Haven, Connecticut: Yale University Press, 2006.

Bossidy, Larry, and Ram Charan. *Execution.* New York: Crown Business, 2002.

Bourgeois, L., I. Duhaime, and J. Stimpert. *Strategic Mangement: Concepts for Managers.* 2nd Edition. Fort Worth: Dryden Press, 1999.

Boyd, Bryan K. "Strategic Planning and Financial Performance: a Meta-Analytic Review." *Journal of Management Studies* 28, no. 4 (1991): 353-374.

Bracker, J. "The Historical Development of the Strategic Management Concept." *Academy of Management Review* 5, no. 2 (1980): 219-224.

Bracker, Jeffrey. "The Historical Development of the Strategic Management Concept." *Academy of Management Review* 5, no. 2 (1980): 219-229.

Brady-Schwartz, Daine C. "Further Evidence on the Magnet Recognition Program." *Journal of Nursing Administration* 35, no. 9 (2005): 397-403.

Brannick, Teresa, and David Coghlan. "In Defense of Being "Native" The Case for Insider Academic Research." *Organizational Research Methods* (Sage Publications) 10, no. 1 (January 2007): 59-74.

Briles, Judith. *Zapping Conflict in the Health Care Workplace.* Aurora: Mile High Press, 2003.

Brockner, J., P.A. Siegel, J.P. Daly, T. Tyler, and C. Daly. "When Trust Matters: The Moderating Effect of Outcome Favorability." *Administrative Science Quarterly*, September 1997: 558.

Brooks, Arthur C. "Can Nonprofit Management Help Answer Public Management's "Big Questions"?" *Public Administration Review* 62, no. 3 (2002): 259-266.

Brown, Adalsteinn D., L. Miln Alikhan, and Guillermo A. Sandoval. "Acute Care Hospital Strategic Priorities: Perceptions of Challenges, Control, Competition and Collaboration in Ontario's Evolving Healthcare System." *Healthcare Quarterly* 8, no. 3 (2005): 36-47.

Brown, Eleanor, and Al Slivinski. "Nonprofit Organizations and the Market." Chap. 6 in *The Nonprofit Sector: A Research Handbook*, edited by Walter W. Powell and Richard Steinberg, 140-158. New Haven: Yale University Press, 2006.

Brown, Pat, interview by Brit Berrett. *Leasing and Marketing Director, Medical City Limited* (December 12, 2007).

Bruch, Heike, and Sumantra Ghoshal. "Unleasing Organizational Energy." *MIT Sloan Management Review* 45, no. 1 (Fall 2003): 45-51.

Bruton, Gary D., Benjamin M. Oviatt, and Luanne Kallas-Bruton. "Strategic Planning in Hospitals: A Review and Proposal." *Health Care Management Review* 20, no. 3 (1995): 16-25.

Bryan, Lowell. "The New Metrics of Corporate Performance: Profit per Employee." *The McKinsey Quarterly* 1 (2007): 57-65.

Bujak, Joseph S. "Culture in Chaos: The Need for Leadership and Followership in Medicine." *Physician Executive* 25, no. 3 (May/June 1999): 17-23.

Burns, James MacGregor. *Leadership.* New York: Harper & Row, 1978.

Burns, James MacGregor. "The Crisis of Leadership." Chap. 2 in *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 8-10. New York: The Free Press, 1995.

Burns, James MacGregor. "Transactional and Transforming Leadership." Chap. 20 in *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 100-101. New York: The Free Press, 1995.

—. *Transforming Leadership.* New York: Grove Press, 2003.

Burns, Lawton R. *Clinical Technology: Confronting the Technological Imperative.* Fuuturescan - Healthcare Trends and Implications 2007-2012, Society for Healthcare Strategy and Market Development, Chicago: Health Administration Press, 2007.

Burroughs, Tim, interview by Britt Berrett. *Chief Financial Officer, Medical City Dallas Hospital* (October 7, 2008).

Burroughs, Timothy. "North Texas Division Budget Guidelines." HCA, 2000-2008.

Byham, William C. "Taking Your Succession Management Plan into the 21st Century." *White Paper.* DDI, 2008. 1-17.

—. *Zapp! Empowerment in Health Care.* New York: Random House, Inc., 1993.

Calhoun, Geoffrey S., John R. Griffith, and Marie E. Sinioris. "The Foundation of Leadership in Baldrige Winning Organizations." *Bulletin of the National Center for Healthcare Leadership*, December 2007: 9-19.

Calvert, Melissa. "Medical City Dallas Hospital Inpatient Admissions 1997-2006." Dallas, December 12, 2007.

Carnegie, Dale. *How To Win Friends And Influence People.* New York: Simon & Schuster Inc., 1936.

Carter, Herbert K., and Charles A. Porter. "Bookkeeping for Small Hospitals and Allied Institutions." *The Modern Hospital*, 1918: 182-189.

Carty, Jay, and John Wooden. *Coach Wooden's Pyramid of Success.* Ventura: Regal Books, 2005.

Champy, James, and Michael Hammer. *Reengineering the Corporation.* New York: HarperCollins Publishers Inc., 1993.

Chemers, Martin M. "Contemporary Leadership Theory." Chap. 18 in *The Leader's Companion- Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 83-99. New York: The Free Press, 1995.

Chilingerian, Jon A., and H. David Sherman. "Managing Physician Efficiency and Effectiveness in Providing Hospital Services." *Health Serices Management Research* 3, no. 1 (1990): 3-15.

Christensen, Clayton M., and M.E. Raynor. "Why Hard-Nosed Executives Should Care About Management Theory." *Harvard Business Review*, no. 81 (2003): 66-74.

Chustz, Mark H., and James S. Larson. "Implementing Change on the Front Lines: A Management Case Study of West Feliciana Parish Hospital." *Public Administration Review*, September/October 2006: 725-729.

Cialdini, Robert B. *Influence Science and Practice.* Needham Heights, Massachusettes: Allyn & Bacon, 2001.

Clair Schwendeman, M.D., interview by Britt Berrett. *President of the Medical Staff - 2005, Medical City Dallas Hospital* (July 9, 2008).

Clark, Don. "Instructional System Design Concept Map." December 1, 1999. http://nwlink.com/~donclark/hrd/ahold/isd.html (accessed October 26, 2007).

—. *nwlink.* January 22, 2000. http://www.nwlink.com/~donclark/hrd/history/history.html (accessed October 24, 2007).

Clarke, Fred "Buddy", interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (June 2008).

Cleverly, William O., James O. Cleverley, and Joanna M. LaFortune. *State of the Hospital Industry 2006 Edition.* Worthington, Ohio: Cleverly & Associates, 2006.

Clifton, Donald O., and Tom Rath. *How Full Is Your Bucket.* New York: Gallup Press, 2004.

Coffman, Curt, interview by Gallup Management Journal. "The High Cost of Disengaged Employees." *There are "cave dwellers" in your ranks, and they're hurting your company.* New York: The Gallup Management Journal, (April 15, 2002).

Coffman, Curt, and Gabriel Gonzalez-Molina. *Follow This Path.* New York: Warner Books, Inc., 2002.

Coffman, Curt, and Marcus Buckingham. *First Break All the Rules.* New York: Simon & Schuster, 1999.

Coghlan, David. "Action Research." *Presentation to Graduate Class of St. Benedectine College.* 2007.

Coghlan, David, and Teresa Brannick. *Doing Action Research in Your Own Organization.* 2 nd Edition. London: Sage Publications, 2005.

Cohn, Kenneth H. *Collaborate for Success!* Chicago: Health Administration Press, 2007.

Colan, Lee J. *7 Moments... That Define Excellent Leaders.* Dallas: CornerStone Leadership Institute, 2006.

Collins, C. James, and Jerry Porras. *Built to Last.* New York: HarperCollins Publishers, Inc., 1994.

Collins, Jim. *Good to Great.* New York: HarperCollins Publishers Inc., 2001.

Conger, Jay A., and Douglas A. Ready. "Rethinking Leadership Competencies." *Leader to Leader*, Spring 2004: 41-47.

Conger, Jay A., and Rabindra N. Kanungo. *Charismatic Leadership in Organizations.* Thousand Oaks: Sage Publications, 1998.

Conger, Jay A., and Rabindra N. Kanungo. "Toward a Behavioral Theory of Charismatic Leadership in Organizational Settings." *Academy of Management Review* 12, no. 4 (October 1987): 637-647.

Conger, Jay A., Rabindra N. Kanungo, and Sanjay T. Menon. "Charismatic Leadership and Follower Effects." *Journal of Organizational Behavior* 21 (2000): 747-767.

Connors, Rogers, Tom Smith, and Craig Hickman. *The Oz Principle.* New York: Penguin Group (USA) Inc., 2004.

Corbeil, Stephen E. "Celebrating 25 Years." *The History of Medical City Dallas Hospital.* Dallas, October 1999. 1-56.

Couto, Richard A. "The Transformation of Transforming Leadership." Chap. 20 in *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 102-107. New York: The Free Press, 1995.

Covey, Stephen R. *Spiritual Roots of Human Relations.* Salt Lake City: Deseret Book Company, 1970.

—. *The 7 Habits of Highly Effective People.* New York: Simon & Schuster, 1989.

—. *The 8th Habit.* New York: Simon & Schuster, 2004.

Covey, Stephen R., Roger A. Merrill, and Rebecca R. Merrill. *First Things First.* New York: Simon & Schuster, 1994.

Coye, Molly Joel. "No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patients' Needs." *Health Affairs* 20, no. 6 (November/December 2001): 44-56.

Crittenden, William F., Vicky L. Crittenden, and Tammy G. Hunt. "Planning and Stakeholder Satisfaction in Religious Organizations." *Journal of Voluntary Action Research* 17 (1988): 60-73.

Cross, Rob, Wayne Baker, and Andrew Parker. "What Creates Energy in Organizations?" *MIT Sloan Management Review* 44, no. 4 (Summer 2003): 51-56.

Dallas Business Journal. "2004 Best Places to Work in Dallas-Fort Worth." *Dallas Business Journal.* Biz Journals, April 23-29, 2004.

—. "Largest Metroplex Hospitals Ranked by Number of Licensed Beds in 2006." *Book of Lists 2008.* Compiled by Jerry Gunter. Dallas: Dallas Business Journal, May 25, 2007.

Daniels, Norman, and James Sabin. "The Ethics of Accountability in Managed Care Reform." *Health Affairs* 17, no. 5 (1998): 50-64.

Darling v. Charleston Community Memorial Hospital. 33 Ill.2d 326, 211 N.E.2d 253 (Appellate Court for Circuit Court of Coles County 4th District, September 29, 1965).

David M. Stern et al., Plaintiffs v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries, et al., defendants. Civ. A. No. 267-73 (United States District Court, District of Columbia, 381 F. Supp. 1003 July 30, 1974).

Davidson, Donna. "Strategic Planning: Myth or Reality?" *Seminars for Nurse Managers* 8, no. 2 (June 2000): 66-69.

Davis, Karen. *Access to Care: Key to a High-Performance Health System.* Futurescan Healthcare Trends and Implications 2007-2012, Society for Healthcare Strategy and Market Development, Chicago: Health Administration Press, 2007.

Delbecq, Andre L., and Sandra L. Gill. "Developing Strategic Direction for Governing Boards." *Hospital and Health Services Administration* 33, no. 1 (Spring 1988): 25-35.

Dent, Stephen M. *Partnering Intelligence.* Palo Alto: Davies-Black Publishing, 2004.

Devitt, Rob, Wolf Klassen, and Julian Martalog. "Strategic Management System in a Healthcare Setting-Moving from Strategy to Results." *Healthcare Quarterly* 8, no. 4 (2005): 58-65.

Dobel, J. Patrick. *Public Integrity.* Baltimore: The Johns Hopkins University Press, 1999.

Downs, Alexis, Rita Durant, and Adrian N. Carr. "Emergent Strategy Development for Organizations." *Emergence* 5, no. 2 (2003): 5-28.

Drucker, Peter. "Judge Non-Profits by Their Perfomrance, Not Only by Their Good Intentions." *Chronical of Philanthropy* 24, no. 2 (1990): 32-33.

Dumdum, Uldarico Rex, Kevin B. Lowe, and Bruce J. Avolio. *A Meta-Analysis of Transformational and Transactional Leadership Correlates of Effectiveness and Satisfaction: An Update and Extension.* Vol. 2, in *Transformational and Charismatic Leadership: The Road Ahead*, edited by Bruce J. Avolio and Francis J. Yammarino, 35-66. Oxford: Elsevier Science Ltd., 2002.

Duncan, W.J., P.M. Ginter, and L.E. Swayne. *Strategic Management of Health Care Organizations.* 2nd Edition. Boston: Blackwell Publishing, 1995.

Dunn, Brian, interview by Britt Berrett. *Chief Development Officer - CHG Healthcare Services, Inc* (November 20, 2008).

Dye, Carson F. *Leadership in Healthcare.* Chicago: Health Administration Press, 2000.

—. "Leadership Values: Strategies to Enhance and Improve Leadership." *American College of Healthcare Executives.* Dallas: Health Administration Press, 2007. 1-60.

Edmans, Alex. "Does the Stock Market Fully Value Intangibles? Employee Satisfaction and Equity Prices." Paper, Wharton School of Business, University of Pennsylvania, Philadelphia, 2007, 1-31.

Edmonson, Cole, interview by Britt Berett. *Chief Nursing Executive* (October 7, 2008).

—. "Medical Executive Committee Presentation." *Magnet Recognition Program.* Dallas, December 8, 2008.

Edwards, Richard L., and Douglas C. Eadie. "Meeting the Change Challenge: Managing Growth in the Nonprofit and Public Human Services Sectors." *Administration in Social Work* 18, no. 2 (1994): 107-123.

Eikenberry, Angela M., and Jodie Drapal Kluver. "The Marketization of Nonprofit Sector: Civil Society at Risk?" *Public Administration Review* 64, no. 2 (2004): 132-140.

Eisenberg, FM. "The Medical Staff Structure - its role in the 21st century." *Annals of Health Law* 12, no. 2 (2003): 249-264.

Eisenstat, Russell A., Michael Beer, Nathaniel Foote, Tobias Fredberg, and Flemming Norrgren. "The Uncompromising Leader." *Harvard Business Review*, July-August 2008: 51-57.

Elton, Chester, and Adrian Gostick. *Managing with Carrots.* Layton: Gibbs Smith, Publisher, 2001.

—. *The 24-Carrot Manager.* Layton: Gibbs Smith, Publisher, 2002.

Engstrom, Kathryn, interview by Britt Berrett. *Chief Financial Officer1998-2003, Medical City Dallas Hospital* (July 12, 2008).

Ettinger, Walter H. "Six Sigma: Adapting GE's Lessons to Health Care." *Trustee*, September 2001: 10-15.

Everly, Sheila, interview by Britt Berrett. *Chief Nursing Officer, Medical City Dallas Hospital 1993-2006* (October 2008).

Everly, Sheila, interview by Britt Berrett. *Chief Nursing Officer, Medical City Dallas Hospital 1993-2006* (April 2001).

Fainter, Jill. "About HCA . . ." *Presentation to Medical City Dallas Hospital Medical Staff.* Dallas, October 2008.

Farson, Richard. *Management of the Absurd.* New York: Simon & Schuster, 1996.

Fiedler, F. E. *A Contingency Model of Leadership Effectiveness.* Vol. 1, in *Advances in Experimental Social Psychology*, edited by L. Berkowtiz, 149-190. New York: Academic Press, 1964.

Fiedler, Fred E. *A Theory of Leadership Effectiveness.* New York: McGraw-Hill , 1967.

Firstenberg, P.B. "Profitminded Management in the Nonprofit World." *Management Review* 68 (1979): 8-13.

Forbes, Daniel P. "Measuring the Unmeasurable: Empirical Studies of Nonprofit Organziation Effectivenes from 1977 to 1997." *Nonprofit and Voluntary Sector Quarterly* 27, no. 2 (1998): 183-202.

Ford, Robert C., and Myron D. Fottler. "Creating Customer-Focused Health Care Organizations." *Health Care Management Review* 25, no. 4 (Fall 2000): 18-33.

Fortune 500 Ranking of Largest Corporations in 2006. 2007. http://money.cnn/magazines/fortune/fortune500/snapshots/1636.html (accessed December 12, 2007).

Foster, Richard J. *Celebration of Discipline.* New York: HarperCollins Publishers Inc., 1998.

French, R. J., and B. Raven, . *The Bases of Social Power.* Ann Arbor: University of Michigan, Institute of Social Research, 1959.

Friedman, Stuart, and Andrew Draper. "Strategic Planning: Going Beyond the Basics." *Trustee*, February 2001: 17-20.

Fromm, Bill. *The Ten Commandments of Business & How to Break Them.* New York: G. P. Putnam's Sons, 1991.

Fuller, J. Bryan, Coleman E. P. Patterson, Kim Hester, and Donna Y. Stringer. "A Quantitative Review of Research on Charismatic Leaderhip." *Psychological Reports* 78 (1996): 271-287.

Galloro, Vince. "Reorganized, Re-energized." *Modern Healthcare* 36, no. 22 (May 2006).

Gallup. "Employee Engagement Survey -2000." *Employee Engagement Survey.* Gallup Organization, February 2001.

—. "Patient Satisfaction Survey - 2000." *Patient Satisfaction Survey.* Gallup Organization, 2000.

Gardner, Howard. *Changing Minds.* Boston: Harvard Business School Press, 2004.

Gautam, Kanak, and Jerry Goodstein. "Insiders and Business Directors on Hospital Boards and Strategic Change." *Hospital & Health Services Administration* 41, no. 4 (Winter 1996): 423-440.

Gavras, John, interview by Britt Berrett. *Executive Director - Dallas Fort Worth Hospital Council* (January 2007).

Gawande, Atul. *Complications.* New York: Picador, 2002.

Ghinsberg, Yossi. *Laws of the Jungle.* Austin: Boomerang New Media, 2007.

Ghiselli, E.E., and C.W. Brown. *Personnel and Industrial Psychology.* New York: McGraw-Hill, 1955.

Gibson, Jennifer L., Douglas K. Martin, and Peter A. Singer. "Evidence, Economics and Ethics: Resource Allocation in Health Services Organizations." *Healthcare Quarterly* 8, no. 2 (2005): 50-58.

Gibson, Jennifer L., Douglas K. Martin, and Peter A. Singer. *Setting Priorities in Health Care Organizations: Criteria, Processes, and Parameters of Success.* Debate, BioMed Central, Toronto: BMC Health Services Research, 2004.

Gill, Roger. "Change Mangement or Change Leadership." *Journal of Change Management* 3, no. 4 (2003): 307-318.

Gilmore, James H., and B. Joseph Pine II. *The Experience Economy.* Boston: Harvard Business School Press, 1999.

Gingrich, Newt. *Saving Lives & Saving Money.* Washington: The Alexis de Tocqueville Institution, 2003.

Ginter, Peter. M., Linda .E. Swayne, and W. Jack Duncan. *Strategic Management of Health Care Organizations.* 4th Edition. Boston: Blackwell Publishing, 2002.

Giuliani, Rudolph W. *Leadership.* New York: Hyperion, 2002.

Gladwell, Malcolm. *The Tipping Point.* Boston: Little, Brown and Company, 2000.

Gladwin, Mary E. "Superintendents of Small Hospitals." *American Journal of Nursing* 7 (1907): 622-23.

Gnall, Shelley, Erin Blum, Matthew Borsch, and Barbara Chang. *Americas: Healthcare Services: Hospitals - 2009 Hospitals Outlook: Buyer's market; be selective.* Global Investment Research, The Goldman Sachs Group, Inc., 2009, 1-57.

Goes, James B., and ChunLiu Zhan. "The Effects of Hospital-Physician Integration Strategies on Hospital Financial Performance." *Health Services Research* 30, no. 4 (October 1995): 507-530.

Goldsmith, Jeff. *Baby Boomers and the Health System: "It's the Workforce, Stupid!".* Futurescan - Healthcare Trends and Implications 2007-2012, Society for Healthcare Strategy and Market Development, Chicago: Health Administration Press, 2007.

Goldstein, Susan Meyer, and Sharon B. Schweikhart. "Empirical Support for the Baldrige Award Framework in U.S. Hospitals." *Health Care Management Review* 27, no. 1 (2002): 62-75.

Goldwater, S.S. "The Training of Hospital Superintendents." *The Modern Hospital*, 1920: 275-277.

Goleman, Daniel. "What Makes a Leader?" *Harvard Business Review*, November-December 1998: 93-102.

Goleman, Daniel, Richard Boyatzis, and Annie McKee. *Primal Leadership Learning to Lead with Emotional Intelligence.* Boston: Harvard Business School Press, 2002.

Golightly, B. "A Few Problems of Small Hospital Management." *The Modern Hospital*, 1916: 178-179.

Goodman, John C., Gerald L. Musgrave, and Devon M. Herrick. *Lives at Risk.* Lanham: Rowman & Littlefield Publishers, Inc., 2004.

Graen, G. B., and M. Uhl-Bien. "Reationship-Based Approach to Leadership: Development of Leader-Member Exchange (LMX) Theory of Leadership over 25 Years: Applying a Multi-Level, Multi-Domain Perspective." *Leadership Quarterly* 6, no. 2 (1995): 219-247.

Graen, George, and Steven Ginsburgh. "Job Resignation as a Function of Role Orientation and Leader Acceptance: A Longitudinal Investigation of Organizational Assimilation." *Organizational Behavior and Human Performance*, no. 19 (1977): 1-17.

Gray, Barbara, and Sonny S. Ariss. "Politics and Strategic Change Across Organizatinoal Life Cycles." *Academy of Management Review* 10, no. 4 (1985): 707-723.

Greenspan, Elizabeth, Susanna E. Krentz, and Molly K. O'Neill. "Strategic Service-Line Planning Building Competitve Advantage." *Healthcare Financial Management*, December 2003: 72-78.

Greenwood, Davydd J., and Morten Levin. *Introduction to Action Research.* 2nd Edition. Thousand Oaks: Sage Publications Ltd., 2007.

Griffith, John R., and Jeffrey A. Alexander. "Measuring Comparative Hospital Performance." *Journal of Healthcare Management* 47, no. 1 (January/February 2002): 41-57.

Grint, Keith. "Management or Leadership?" *Journal of Helath Services Research and Policy* 7, no. 4 (October 2002): 248-251.

Grobmyer, James E. "The Challenge of Financially Based Strategic Planning." *Trustee*, October 2001: 34-36.

Halachmi, Arie. "Strategic Planning and Management? Not Necessarily." *Public Productivity Review* 40 (1986): 35-50.

Hambrick, Donald C. "Environmental Scanning and Organizational Strategy." *Strategic Management Journal* 3, no. 2 (April-June 1982): 159-174.

Hambrick, Donald C. "Strategic Awareness Within Top Management Teams." *Strategic Management Journal* 2 (1981): 263-279.

Hansen, Richard D. "Strategic Planning: The Basics and Benefits." *MGM Journal*, May/June 1999: 28-35.

Hartman, Karen. "Smart Strategic Planning for Cardiovascular Services." *Healthcare Financial Management*, December 2005.

Hatcher, Ann, interview by Britt Berrett. *Vice President of Talent Management - HCA* (November 20, 2008).

Hater, John J., and Bernard M. Bass. "Superiors' Evaluations and Subordinates' Perceptions of Transformational and Transactional Leadership." *Journal of Applied Psychology* 73, no. 4 (1988): 695-702.

Hattori, Ruth Ann, and Todd Lapidus. "Collaboration, Trust and Innovative Change." *Journal of Change Management* 4, no. 2 (June 2004): 97-104.

Haugh, Richard. "Are You Looking for a Fresh Start with Your MDs?" *Hospitals & Health Networks*, May 2005: 36-42.

HCA. "The High Performance Facility Study." 2005.

HCA. “Financial Analysis – 2000-2007.” 2009.

HCA. "HCA Competency Directory." Internal Document, Nashville, 2007, 1-258.

HCA Healthcare Home Page. December 2007. http://www.healthcare.com/CPM/HCA2 (accessed December 12, 2007).

HCA. "Healthy Work Environment - Vulnerability." *Medical City Dallas Hospital - Dallas/Ft. Worth Market.* June 2008.

Herman, Robert D., and David O. Renz. "Theses on Nonprofit Organizational Effectiveness." *Nonprofit and Voluntary Sector Quarterly* 28, no. 2 (1999): 107-126.

Hersey, P., and K. H. Blanchard. "Life Cycle Theory of Leadership." *Training and Development Journal* 23 (1969): 26-34.

Hersey, Paul, and Kenneth H. Blanchard. "Behavioral Theories in Leadership." In *The Leader's Compaion - Insights on Leadership Through the Ages*, by J. Thomas Wren, 144-148. New York: The Free Press, 1995.

Hewitt Associates. "Growing Great Leaders Key to Double-Digit Growth." *Research Brief.* Hewitt Associates, March 2004. 1-11.

Hiebeler, Robert H. "Benchmarking Knowledge Management." *Strategy and Leadership*, March-April 1996: 22-29.

Higgs, Malcolm, and Deborah Rowland. "All Changes Great and Small: Exploring Approaches to Change and its Leadership." *Journal of Change Management* 5, no. 2 (2005): 121-151.

Hill, John, interview by Britt Berrett. *Chief Operating Officer 2002-2006, Medical City Dallas Hospital* (July 12, 2008).

Hill, Napoleon. *Think & Grow Rich.* New York: Random House Inc., 1960.

Hoffman, Susan M., and Mark K. Cassell. "Understanding Mission Expansion in the Federal Home Loan Banks: A Return to Behavioral-Choice Theory." *Public Administration Review* 65, no. 6 (November/December 2005): 700-712.

Hollander, E. P. *College and University Leadership from a Social and Psychological Perspective: A Transactional View.* Paper, Invitational Interdisciplinary Colloquium on Leadership in Higher Education, National Center for Postsecondary Governance and Finance, New York: Columbia University, 1987.

Hood, Christopher. "A Public Management for All Seasons?" *Journal of Public Administration* 69 (1991): 3-19.

Hopkins, Shelton M.D., interview by Britt Berrett. *President of the Medical Staff - 2007, Medical City Dallas Hospital* (July 7, 2008).

Horner, Maude. "Office Work in the Small Hospital." *The Trained Nurse and Hospital Review*, 1917: 139-141.

Hornsby, John A. "The Hospital Problem of Today - What Is It?" *The Modern Hospital*, 1917: 322-328.

House, R.J. "A Path-Goal Theory of Leader Effectiveness." *Administrative Quarterly* 16 (1971): 321-328.

House, Robert J. "A 1976 Theory of Charismatic Leadership." In *Leadership: The Cutting Edge*, edited by James g. Hunt and Lars L. Larson, 189-207. Carbondale: Southern Illinois University Press, 1977.

Howard, Chris. "Restructuring Hospital-Physician Relationships for Future Success." *Frontiers of Health Services Management* 20, no. 2: 23-30.

Howell, Jane M. "A Laboratory Study of Charismatic Leadership." *Organizational Behavior and Human Decision Processes* 43 (1989): 243-269.

Hughes, Richard L., Robert C. Ginnett, and Gordon J. Curphy. "Understanding and Influencing Follower Motivation." In *The Leader's Companion - Insights on Leadership Through the Ages*, edited by J. Thomas Wren, 327-338. New York: The Free Press, 1995.

Hunt, James G. (Jerry). "What is Leadership?" Chap. 2 in *The Nature of Leadership*, edited by John Antonakis, Anna T. Cianciolo and Robert J. Sternberg, 19-47. Thousand Oaks: Sage Publications, 2004.

Hunt, James G., and Lars L. Larson. *Leadership: The Cutting Edge.* Carbondale: Southern Illinois University Press, 1977.

ICMA. "Healthy Communities - Managers Can Help Local Governments Serve as Role Models in Wellness Trend." *ICMA Management Prespective*, October 2006: 1-4.

Institute of Medicine of the National Academies. "The Institute of Medicine." *Performance Measurement: Accelerating Performance.* September 1, 2005. http://www.iom.edu/CMS/3809/19805/31310.aspx (accessed July 21, 2007).

—. *To Err is Human.* Washington: National Academy Press, 2000.

Jack Welch, Suzy Welch. *Winning.* New York: HarperCollins Publishers, Inc., 2005.

Jackson, Bianca, interview by Britt Berrett. *Communications Coordinator of Medical City Dallas Hospital* (October 3, 2008).

Jeffrey A. Alexander, Yining Ye, Shoou-Yih D. Lee, Bryan J. Weiner. "The Effects of Governing Board Configuration on Profound Organizational Change in Hospitals." *Journal of Health and Social Behavior* 47 (September 2006): 291-308.

Jenster, Per V., and George A. Overstreet Jr. "Planning for a Non-profit Service: A Study of U.S. Credit Unions." *Long Range Planning* 15 (1990): 103-111.

Jesse, William. "Building a Bridge to Mutual Survival: Why Hospitals Must Actively Involve Physicians in Strategic Decsion-Making." *Modern Healthcare* 34, no. 40 (October 2004).

Johnson, Perry L. *Keeping Score.* New York: Ballinger Publishing Company, 1989.

Johnson, Spencer. *Who Moved My Cheese.* New York: G. P. Putnam's Sons, 1998.

Jones, Laurie Beth. *Jesus CEO.* New York: Hyperion, 1995.

Judge, Timothy A., and Ronald F. Piccolo. "Transformational and Transactional Leadership: A Meta-Analytic Test of Their Relative Validity." *Journal of Applied Psychology* 89, no. 5 (2004): 755-768.

Judge, William Q., and Carl P. Zeithaml. "An Empirical Comparison between the Board's Strategic Role in Nonprofit Hospitals and in For-Profit Industrial Firms." *Health Services Research* 27, no. 1 (April 1992): 47-64.

Julian, Larry. *God is my CEO.* Avon: Adams Media Corporation, 2001.

Kaboolian, Linda. "The New Public Management: Challenging the Boundaries of the Management vs. Administration Debate." *Public Administration Review* 58, no. 3 (1998): 189-193.

Kahneman, Daniel, and Jonathan Renshon. "Why Hawks Win." *Foreign Policy*, January/February 2007.

Kaissi, Amer. "Manager-Physician Relationships - An Organizational Theory Perspective." *The Health Care Manager* 24, no. 2 (2005): 165-176.

Kaleba, Richard. "Strategic Planning Getting from Here to There." *Healthcare Financial Management*, November 2006: 74-78.

Kalzuny, A., and J. Veney. "Who Influences Decisions in Hospitals?" *Modern Hospital*, December 1972.

Kaplan, Robert S. "Strategic Performance Measurement and Management in Nonprofit Organziations." *Nonprofit Management & Leadership* 11, no. 3 (2001): 353-370.

Kaplan, Robert S., and David P. Norton. "Strategy Maps." Chap. 2 in *Strategy Maps: Converting Intangible Assets into Tangible Outcomes*, by Robert S. Kaplan and David P. Norton, 1-28. Boston: Harvard Business School Press, 2004.

Katz, Gerald, Leslie Zavodnick, and Elaine Markezin. "Strategic Planning in a Restrictive and Competitive Environment." *HCM Review*, Fall 1983: 7-12.

Kearns, Kevin P., and Georgine Scarpino. "Strategic Planning Research Knowledge and Gaps." *Nonprofit Management & Leadership* (Jossey-Bass) 6, no. 4 (Summer 1996): 429-439.

Kenagy, John W., Donald M. Berwick, and Miles F. Shore. "Service Quality in Health Care." *Journal of the American Medical Association* 281, no. 7 (February 2007): 661-665.

Kersten, E. L. *The Art of Demotivation.* Austin, Texas: Despair, Inc., 2005.

Kettl, Donald F. "The Global Revolution in Public Management: Driving Themes, Missing Links." *Journal of Policy Analysis and Management* 16, no. 3 (1997): 446-462.

Khalsa, Mahan. *Let's Get Real or Let's Not Play.* Salt Lake City: Franklin Covey Co., 1999.

Knauft, E.B., R.A. Berger, and S.T. Gray. *Profiles of Excellence: Achieving Success in the Nonprofit Sector.* San Francisco: Jossey-Bass, 1991.

Knowledge @ Wharton. "How Investing in Intangibles Like Employee Satisfaction Translates into Financial Returns." *Knowledge @ Wharton.* January 9, 2008. http:/knowledge.wharton/upenn.edu/article.cfm?articleid=1873 (accessed January 14, 2008).

Korman, Ira, interview by Britt Berrett. *President of Medical City Dallas Hospital - 1984-1991* (October 23, 2007).

Kotter, John P. "Leading Change - Why Transformation Efforts Fail." *Harvard Business Review*, January 2007: 96-103.

—. *Leading Change.* Boston: Harvard Business School Press, 1996.

Kouzes, James M., and Barry Z. Posner. *The Leadership Challenge.* 3rd Edition. San Fransciso: Jossey-Bass, 2002.

Kramer, M., and C. Schmalenberg. "Essentials of a Magnetic Work Environment: Part 1." *Nursing* 34, no. 6 (2004): 50-54.

Krzyzewski, Mike, and Donald T. Phillips. *Five Point Play.* New York: Warner Books, Inc., 2001.

Kurt Lewin: groups, experiential learning and action research. Mark K. Smith; Michele Erina Doyle; Tony Jeffs. www.infed.org/thinkers/et-lewin.htm (accessed June 8, 2007).

Lagrone, Stephen, interview by Britt Berrett. *Director of Physician Services of Medical City Dallas Hospital* (December 11, 2007).

Lake, Timothy, Kelly Devers, Linda Brewster, and Lawrence Casalino. "Something Old, Something New: Recent Developments in Hospital-Physician Relationships." *Health Services Research* 38, no. 1 Part II (February 2003): 471-488.

Larkin, T.J., and Sandar Larkin. "Reaching and Changing Frontline Employees." *Harvard Business Review*, May-June 1996: 95-104.

Larson, Laurie. "Encouraging Physicians to Help Set the Strategic Plan - Balance of Power." *Trustee*, 2002: 13-17.

Laschinger, H.K.S., J. Shamian, and D.Thomson. "Impact of Magnet Hospital Characteristics on Nurses' Perception of Trust, Burnout, Quality of Care and Work Satisfaction." *Nurse Economist* 19, no. 5 (2001): 325-336.

Lawler, Edward E. *Treat People Right!* San Francisco: Jossey-Bass, 2003.

Leapfrog Group on Health. "Leapfrog Group." *Leapfrog Group Benchmarking.* 2007. https://leapfrog.medstat.com/pdf/final.pdf (accessed July 21, 2007).

Lee, Fred. *If Disney Ran Your Hospital.* Bozeman: Second River Healthcare Press, 2004.

Lemak, Christy Harris, and Elizabeth Goodrick. "Strategy as Simple Rules: Understanding Success in a Rural Clinic." *Health Care Management Review*, April-June 2003: 179-188.

Lenarsky, Carl M.D., interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (May 1, 2008).

Lencioni, Patrick. *The Five Dysfunctions of a Team.* San Francisco: Josey-Bass, 2002.

Levin, Ira M. "Vision Revisited: Telling the Story of the Future." *The Journal of Applied Behavioral Science* 36, no. 1 (March 2000): 93-107.

Lewin, Kurt. "Action Research and Minority Problems." *Journal of Social Issues* 2, no. 4 (1946): 34-46.

Lightspeed Research - The Foresight Group. "HCA 2008 Employee Survey." *Engagement Snapshot.* June 19, 2008.

—. "HCA 2008 Employee Survey Comment Report." *Medical City Dallas Hospital.* June 26, 2008.

Lines, Brian. "Effectiveness of the City Forums at Medical City." Internal Document, Dallas, 2008, 1-5.

Lines, Brian. "Leadership Team Affiliations." Internal Document, Dallas, 2009.

Lines, Rune, Marcus Selart, Bjarne Espedal, and Svein T. Johansen. "The Production of Trust During Organizational Change." *Journal of Change Management* 5, no. 2 (June 2005): 221-245.

Loder, Cornelius S. "Operating a Hospital Under the Budget System." *The Modern Hospital*, 1915: 411-412.

Loeher, James E. *Stress for Success.* New York: Three Rivers Press, 1997.

Lohmann, Roger. "Charity, Philanthropy, Public Service, or Enterprise: What are the Big Questions of Nonprofit Management Today?" *Public Administration Review*, May/June 2007: 437-444.

Lowe, Kevin B., and K. Galen Kroeck. "Effectiveness Correlates of Transformational and Transactional Leadership: A Meta-Analytic Review of the MLQ Literature." *Leadership Quarterly* 7, no. 3 (1996): 385-425.

Lucia, Alexander, and Eric Harvey. *Walking the Talk Together.* Dallas: Performance Systems Corporation, 1998.

Luke, Roice D., Stephen L. Walston, and Patrick Michael Plummer. *Healthcare Strategy in Pursuit of Competitive Advantage.* Chicago: Health Administration Press, 2004.

Lyons, Barrow B. "Maintaining Balance in Hospital Administration." *The Modern Hospital*, 1919: 166-168.

Machiavelli, Niccolo. *The Prince (1513).* Translated by N.H. Thomson. New York: P.F. Collier & Son, 1992.

Mackay, Harvey. *Beware The Naked Man Who Offers You His Shirt.* New York: Random House Inc., 1990.

Madden, Shannon, Douglas K. Martin, Sarah Downey, and Peter A. Singer. "Hospital Priority Setting with an Appeals Process: A Qualitative Case Study and Evaluation." *Health Policy* 73 (2005): 10-20.

Mahon, John F., and Edwin A. Murray. "Strategic Planning for Regulated Companies." *Strategic Management Journal* 2, no. 3 (July-September 1981): 251-262.

Martin, Charles. *Healing America.* Nashville: Thomas Nelson, Inc., 2004.

Martin, Doug, and Peter Singer. "A Strategy to Improve Priority Setting in Health Care Institutions." *Health Care Analysis* 11, no. 1 (March 2003): 59-68.

Martin, Douglas, Julia Abelson, and Peter Singer. "Participation in Health Care Priority-SettingThrough the Eyes of the Participants." *Journal of Health Services Research Policy* 7, no. 4 (October 2002): 222-229.

Martin, Douglas, Ken Shulman, Patricia Santiago-Sorrell, and Peter Singer. "Priority-Setting and Hospital Strategic Planning: A Qualitative Case Study." *Journal of Health Services Research & Policy* 8, no. 4 (October 2003): 197-201.

Martin, Lawrence L., and Peter M. Kettner. *Measuring the Performance of Human Service Programs.* Thousand Oaks: Sage Publications, 1996.

Masoti, I.P. "Business has a Role in Trustee Education." *Business and Health*, June 1984.

Maxwell, John C. *The 360 Degree Leader.* Nashville: Thomas Nelson, Inc., 2005.

May, David, ed. "By the Numbers: An Annual Resource Guide Filled with the Numbers, Rankings and Financial Figures that Shape Healthcare." *Modern Healthcare*, December 2006: 1-88.

May, David, ed. "By the Numbers: An Annual Resource Guide Filled with the Numbers, Rankings, and Financial Figures that Shape Healthcare ." *Modern Healthcare*, December 2007: 1-96.

May, Ellen Lanser. "Recruiting the Right Management Team for Organizational Transparency." *Healthcare Executive*, July/August 2005: 22-26.

McBain, Richard. "Why Do Change Efforts So Often Fail?" *Faculty of Finance and Management*, May 2006: 13-17.

McColl-Kennedy, Janet R., and Ronald D. Anderson. "Impact of Leadership Style and Emotions on Subordinate Performance." *Leadership Quarterly* 13 (2002): 545-559.

McConnell, Charles R. *Case Studies in Health Care Supervision.* Gaithersburg: Aspen Publishers, Inc., 1998.

McDonagh, Kathryn J. "Hospital Governing Boards; A Study of Their Effectiveness in Relation to Organizational Performance." *Journal of Healthcare Management* 51, no. 6 (2006): 377-389.

McGowan, Robert A. "Physicians Come on Board." *Healthcare Informatics*, April 2005.

McGowan, Robert, and Amy MacNulty. "Developing a Physician-Hospital Alignment Plan." *Trustee*, March 2007: 26-27.

McKee, Robert, interview by Harvard Business Review. *Storytelling that Moves People*Edited by Thomas A. Stewart. Harvard Business Review, (June 2003): 51-55.

McNiff, Jean, and Jack Whitehead. *All You Need to Know About Action Research.* London: Sage Publications, 2006.

Medical City Dallas Hospital. "2008 Strategic Plan - Planning Overview." January 2007.

—. "2009 Business Plan." Dallas, October 16, 2008.

—. "An Approach to Leadership Development." Dallas, September 3, 2008.

—. "Leadership Development and Acceleration Pool - Event Journal." Compiled by Virginia Rose. November 18, 2008.

—. "MCDU Leadership Development - Building a System That Builds Leaders." Dallas, October 1, 2007. 1-36.

Menefee, David. "Strategic Administration of Nonprofit Human Service Organizations: A Model for Executive Success in Turbulent Times." *Administration in Social Work* 21 (1997): 1-19.

Mento, Anthony J., Raymond M. Jones, and Walter Dirndorfer. "A Change Management Process: Grounded in Both Theory and Practice." *Journal of Change Management* 3, no. 1 (2002): 45-59.

Mick, Stephen S., et al. "Strategic Activity and Financial Performance of U.S. Rural Hospitals: A National Study 1983-1988." *The Journal of Rural Health* 10, no. 3 (Summer 1994): 150-167.

Middleton, Melissa. "The Nonprofit Sector: A Research Handbook." In *The Non-Profit Sector a Research Handbook*, edited by Walter W. Powell and Richard Steinberg, 141-153. New Haven: Yale University Press, 1987.

Mihm, J. Christopher. "Human Capital - Success Planning and Management is Critical Driver of Organizational Transformation." *Testimony before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform.* Washington, D.C.: United States General Accounting Office, October 1, 2003.

Minkoff, Debra C., and Walter W. Powell. "Nonprofit Mission: Constancy, Responsiveness, or Deflection:." Chap. 25 in *The Non-Profit Sector: A Research Handbook*, edited by Walter W. Powell: Richard Steinberg, 591-611. New Haven: Yale University Press, 2006.

Mintzberg, Henry. "Rethinking Strategic Planning Part II: New Roles for Planners." *Long Range Planning* 27, no. 3 (1994): 22-30.

Mintzburg, Henry. *The Nature of Managerial Work.* New York, New Jersey: Harper & Row, 1973.

Mitton, Craig, and Cam Donaldson. "Setting Priorities in Canadian Regional Health Authorities: A Survey of Key Decision Makers." *Health Policy* 60 (2002): 39-58.

Molinari, Carol, Laura Morlock, Jeffrey Alexander, and C. Alan Lyles. "Hospital Board Effectiveness: Relationships between Governing Board Composition and Hopsital Financial Viability." *Health Serivces Research* 28, no. 3 (August 1993): 357-377.

Montgomery, Cynthia A. "Putting Leadership Back Into Strategy." *Harvard Business Review*, January 2008: 54-60.

Moser, MaryAnn, interview by Britt Berrett. *Director of Food and Nutritional Services of Medical City Dallas Hospital* (November 15, 2008).

Mullins, Larry A. "Hospital-Physician Relationships: A Synergy that Must Work." *Frontiers of Health Services Management* 20, no. 2: 37-41.

Mumford, Michael D., and Jill M. Strange. *Vision and Mental Models: The Case of Charismatic and Ideological Leadership.* Vol. II, in *Transformational and Charismatic Leadership: The Road Ahead*, edited by Bruce J. Avolio and Francis J. Yammarino, 109-142. Oxford: Elsevier Science Ltd., 2002.

Musgrave, Gerald L., and John C. Goodman. *Patient Power.* Washington: Cato Institute, 1994.

Mycek, Shari. "Strategic Planning; Taking the Community's Pulse." *Trustee*, June 2004: 34-36.

National Center for Healthcare Leadership. "Health Leadership Competency Model." 2005.

National Institute of Standards and Technology. *Baldrige National Quality Program.* 2007. www.quality.nist.gov/ (accessed December 31, 2007).

National Institute of Standards and Technology. "Malcolm Baldrige National Quality Award -- Feedback Report - Medical City Dallas Hospital." 2006.

National Institute of Standards and Technology. "Malcolm Baldrige National Quality Award -- Feedback Report -- Medical City Dallas Hospital." 2008.

Nelson, Bob. *1001 Ways to Reward Employees.* New York: Workman Publishing Company, Inc., 1994.

Nelson, Paula, and Donald O. Clifton. *Soar With Your Strengths.* New York: Bantam Doubleday Dell Publishing Group, Inc., 1992.

Nielsen, Karen. "DBJ Healthcare Heroes." *Dallas Business Journal*, September 21-27, 2007: 14B.

Noonan, David. *Aesop & the CEO.* Nashville: Thomas Nelson, Inc., 2005.

Northouse, Peter G. *Leadership Theory and Practice.* 4th Edition. Thousand Oaks: Sage Publications, 2007.

O'Brien, Rory. *An Overview of the Methodological Approach of Action Research.* 1998. http://www.web.net/~robrien/papers/arfinal.html (accessed January 2, 2008).

Orr, Ronald E., and Sarah Smith. *Improving Leadership in Nonprofit Organisations.* San Francisco: Jossey-Bass, 2004.

Ostrom, Vincent. *The Intellectual Crisis in Amercian Public Administration.* 2nd edition. Tuscaloosa, Alabama: The University of Alabama Press, 1989.

Ostrower, Francie, and Melissa M. Stone. "Governance: Research Trends, Gaps, and Future Prospects." In *The Non-Profit Sector, 2d ed.*, by Walter W. Powell and Richard Steinberg, 612-628. New Haven: Yale, 2006.

Packard, David. *Speech given to HP's training group.* Hewlett-Packard Company Archives, March 8, 1960.

Palmer, Donald. *Looking at Philosophy - The Unbearable Heaviness of Philosophy Made Lighter.* 4th Edition. New York: McGraw Hill, 2006.

Palmer, Ian, Richard Dunford, and Gib Akin. *Managing Organizational Change.* New York: McGraw-Hill/Irwin, 2006.

Pascale, Richard, Mark Millemann, and Linda Gioja. "Changing the Way We Change." *Harvard Business Review*, November-December 1997: 126-139.

Paton, Huntley. "2003 Best Places To Work." *Dallas Business Journal.* Dallas: Dallas Biz Journals, April 18-24, 2003.

Patterson, Kerry, Joseph Grenny, David Maxfield, Ron McMillan, and Al Switzler. *Influencer - The Power to Change Anything.* New York: McGraw-Hill, 2008.

Patterson, Kerry, Joseph Grenny, Ron McMillan, and Al Switzler. *Crucial Confrontations.* McGraw-Hill: New York, 2005.

—. *Crucial Conversations.* New York: McGraw-Hill Companies, 2002.

—. *The Balancing Act: Mastering the Competing Demands of Leadership.* Provo, Utah: Thompson Executive Press, 1999.

Peace, William H. "The Hard Work of Being a Soft Manager." *Havard Business Review*, December 2001: 7-12.

Pearce, Craig L., Youngjin Yoo, and Maryam Alavi. "Leadership, Social Work, and Virtual Teams - The Relative Influence of Vertical Versus Shared Leadership In the Nonprofit Sector." In *Improving Leadership in Nonprofit Organizations*, edited by Ronald E. Riggio and Sarah Smith Orr, 180-203. San Francisco: Jossey-Bass, 2004.

Pearson-Hormillosa, Sashana. "Business Philanthropy Award." *Dallas Business Journal.* Dallas, December 19-25, 2008. B3, B27.

Pepper, Alexander. "Leading Professionals: A Science, a Philosophy and a Way of Working." *Journal of Change Management* 3, no. 4 (2003): 349-360.

Perez, Christine. "Health Care Heroes." *Dallas Business Journal.* Dallas: Biz Journals, September 21-27, 2007.

Perlin, Martin S. "Current Practices in Long-Range Planning." *Journal of the American Hospital Association* 46 (September 1972): 62-65.

Perrott, Bruce. "Strategic Implications of Quality Management in Health Care." *Journal of Change Management* (Henry Stuart) 3, no. 2 (July 2002): 158-166.

Peters, Tom. *Thriving on Chaos.* New York: HarperCollins Publishers, Inc., 1987.

Pfeffer, Jeffrey, and John F. Veiga. "Putting People First for Organizational Success." *Academy of Management Executive*, May 1999: 37-48.

Phillips, Donald T. *The Founding Fathers on Leadership.* New York: Warner Books, Inc., 1997.

Pieper, Shannon K. "Reading the Right Signals: How to Strategically Manage with Scorecards." *Healthcare Executive*, May/June 2005: 8-14.

Podsakoff, Philip M., Scott B. MacKenzie, Robert H. Moorman, and Richard Fetter. "Transformational Leader Behaviors and Their Effects on Followers' Trust in Leader, Satisfaction, and Organizational Citizenship Behaviors." *Leadership Quarterly* 1, no. 2 (1990): 107-142.

Pontes, Manual C., and Nancy M.H. Pontes. "Variables that Influence Consumers' Inferences About Physicain Ability and Accountability." *Health Care Management Review* 22, no. 2 (Spring 197): 7-20.

Porter, Michael E. "The Five Competitive Forces that Shape Strategy." *Harvard Business Review*, January 2008: 78-93.

Porter, Michael. "What is Strategy?" *Harvard Business Review*, November- December 1996: 61-78.

Poscente, Vince. *Invinceable Principles.* Dallas: Invinceability Series, 1999.

—. *The Ant and the Elephant.* Dallas: CornerStone Leadership Institute, 2004.

Poteet, William, interview by Britt Berrett. *Division President - North Texas Division - HCA* (April 17, 2000).

Powell, Walter W., and Richard Steinberg. *The Nonprofit Sector.* 2nd. Edited by Walter W. Powell and Richard Steinberg. New Haven: Yale University Press, 2006.

Price Waterhouse Cooper. "Health Cast Tactics: A Blueprint for the Future." *The Healthcast 2010 Series*, 2002.

PriceWaterhouseCooper. "How Leadership Must Change to Meet the Future." 2008. http://www.pwc.com/us/advisory (accessed November 15, 2008).

Prosen, Bob. *Kiss Theory Good Bye.* Dallas: Gold Pen Publishing, 2006.

Purtell, Dennis J. "Medical Staff in Need of Change: Explore a Revolutionary Way to Reorganize Your Medical Staff." *The Physician Executive*, January/February 2002: 64-67.

Putnam, Robert D. *Bowling Alone.* New York: Touchstone, 2000.

Quality Texas Foundation. *Encouraging Excellence.* 2008. http://www.texas-quality.org (accessed October 10, 2008).

Quinn, Brian, interview by Britt Berrett. *Chaplain, Medical City Dallas Hospital* (July 1, 2008).

Rapoport, R.N. "Three Dilemmas in Action Research, with Special Reference to the Tavistock Experience." *Human Relations* 23, no. 6 (1970).

Reason, Peter, and H. Bradbury. *Handbook of Action Research.* London: Sage, 2001.

Redden, Candace Johnson. "Rationing Care in the Community: Engagin Citizens in Health Care Decision Making." *Journal of Health Politics, Policy and Law* 24, no. 6 (December 1999): 1363-1389.

Reeleder, David, Douglas K. Martin, Christian Keresztes, and Peter A. Singer. "What Do Hospital Decision-Makers in Ontario, Canada, Have to Say About the Fairness of Priority Setting in their Institutions?" *BMC Health Services Research*, January 2005.

Reeleder, David, Vivek Goel, Peter A. Singer, and Douglas K. Martin. "Leadership and Priority Setting: The Perspective of Hospital CEOs." *Health Policy* 79 (2006): 24-34.

Reeves, Terrie C., and Eric W. Ford. "Strategic Management and Performance Differences: Nonprofit versus For-Profit Health Organizations." *Health Care Management Review*, October/December 2004: 298-308.

Reeves, Terrie C., and Eric W. Ford. "Srategic Management and Performance Differences: Nonprofit versus For-Profit Health Organizations." *Health Care Management Review* 29, no. 4 (October/December 2004): 298-308.

Renz, David O., and Robert D. Herman. "The Changing Face of Nonprofit Effectiveness." http://www.bloch.umkc.edu/mwcnl/research/TheChangingFaceofNonprofitEffectiveness.pdf (accessed October 20, 2007).

Ring, P.S., and J.L. Perry. "Strategic Management in Public and Private Organizations: Implications of Distinctive Contexts and Constraints." *Academy of Management Review* 10 (1985): 276-286.

Who is Medical City? Directed by Kristen Rister. Produced by J & R Promotions. 2000.

Robertson, Peter J., and Sonal J. Seneviratne. "Outcomes of Planned Organizational Change in the Public Sector: A Meta-Analytic Comparison to the Private Sector." *Public Administration Review* 55, no. 6 (November/December 1995): 547-558.

Rose, Virginia, interview by Britt Berrett. *Vice President Strategic Communication and Development of Medical City Dallas Hospital* (July 10, 2008).

Rosenau, Pauline Vaillancourt, and Stephen H. Linder. "Two Decades of Research Comparing For-Profit and Nonprofit Health Provider Performance in the United States." *Social Science Quarterly*, May 19, 2003: 219-241.

Rovinsky, Michael. "Physician Input: A Critical Strategic Planning Tool." *Healthcare Financial Management*, January 2002: 36-38.

Rovinsky, Michael. "Physician Input: A Critical Strategic Planning Tool." *Healthcare Financial Management*, January 2002: 36-38.

Royer, Thomas C. *Physicians: A Stabilizing of the Social Contract with Hospitals.* Futurescan Healthcare Trends and Implications 2007-2012, Society for Healthcare Strategy and Market Development, Chicago: Health Administration Press, 2007.

Runy, Lee Ann. "Most-common Organizational Changes Could be the Riskiest." *AHA News*, October 4, 1999.

Rutherford, Charles M.D., interview by Britt Berrett. *President of the Medical Staff - 2002, Medical City Dallas Hospital* (July 10, 2008).

Saint-Onege, Hubert. "Tacit Knowledge: The Key to the Strategic Alignment of Intellectual Capital." *Strategy and Leadership*, March-April 1996: 10-16.

Santos, Ma Valle, and Ma Teresa Garcia. "Organizational Change: The Role of Managers' Mental Models." *Journal of Change Management* 6, no. 3 (September 2006): 305-320.

Sashkin, Marshall. "The Visionary Leader." In *Charismatic Leadership: The Elusive Factor in Organizational Effectiveness*, edited by J.A. Conger and R. N. Kanungo, 122-160. San Francisco: Jossey-Bass, 1988.

Sashkin, Marshall. "Transformational Leadership Approaches." Chap. 8 in *The Nature of Leadership*, by John Antonakis, Anna T. Cianciolo and Robert J. Sternberg, 171-196. Thousand Oaks: Sage Publications, Inc., 2004.

Sawhill, John C., and David Williamson. "Mission Impossible? Measuring Success in Nonnprofit Organizations." *Nonprofit Management & Leadership* 11, no. 3 (2001): 371-386.

Schendel, D., and C. Hoffer Schendel. *Strategic Management: A New View of Business Policy and Planning.* Boston: Little Brown and Company, 1979.

Schlesinger, Mark, and Bradford H. Gray. "Nonprofit Organizations and Health Care: Som Paradoxes of Persistent Scrutiny." In *The Non-Profit Sector: A Research Handbook*, edited by Walter W. Powell and Richard Steinberg, 378-405. New Haven: Yale University Press, 2006.

Schmidly, Scott, interview by Britt Berrett. *Chief Operating Officer of Medical City Dallas Hospital* (October 7, 2008).

Schoen, Cathy, Karen Davis, Sabrina K.H. How, and Stephen C. Schoenbaum. "U.S. Health System Performance: A National Scorecard." *Health Affairs*, September 2006: 457-474.

Schriesheim, Chester A., and Steven Kerr. "Theories and Measures of Leadership: A Critical Appraisal of Current and Future Directions." In *Leadership: The Cutting Edge*, edited by James G. Hunt and Lars L. Larson, 9-56. Carbondale: Southern Illinois University Press, 1976.

Schwartz, David J. *The Magic of Thinking Big.* New York: Simon & Schuster, Inc., 1965.

Schwartz, Michael, interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (June 4, 2008).

Schwartz, Richard W, and Kenneth H. Cohn. "The Necessity for Physician Involvement in Strategic Planning in Healthcdare Organizations." *The American Journal of Surgery* 184, no. Special Article (2002): 269-278.

Secord, P.F., and C.W. Backman. *Social Psychology.* 2nd Edition. New York: McGraw-Hill, 1974.

Seymour, Don. *FutureScan - Healthcare Trends and Implications 2007-2012.* Annual guide to healthcare trends, American College of Healthcare Executives, Chicago: Health Administration Press, 2007.

Shamir, Boas, Eliav Zakay, Esther Breinin, and Micha Popper. "Correlates of Charismatic Leader Behavior in Military Units: Subordinates' Attitudes, Unit Characteristics, and the Superiors' Appraisals of Leader Performance." *Academy of Management Journal* 41, no. 4 (August 1998): 387-409.

Shamir, Boas, Robert J. House, and Michael B. Arthur. "The Motivational Effects of Charismatic Leadership: A Self-Concept Based Theory." *Organizational Science* 4, no. 4 (November 1993): 577-594.

Shani, A.B. (Rami), and W.A. Pasmore. "Organization Inquiry: Towards a New Model of the Action Research Process." In *Contemporary Organization Development: Current Thinking and Applications*, by Scott Foresman, edited by D.D. Warrick, 438-448. Glenview, 1985.

Shell, Richard G., and Stephen K Klasko. "Biases Physicians Bring to the Table." *Physician Executive* 22, no. 12 (December 1996): 4.

Shortell, Stephen M. "New Directions in Hospital Governance." *Hospital & Health Services Administration* 34, no. 1 (Spring 1989): 7-23.

Shriberg, Arthur, David L. Shriberg, and Richard Kumari. *Practicing Leadership.* Hoboken: John Wiley & Sons, Inc., 2005.

Siciliano, Julie I. "The Relationship Between Formal Planning and Performance in Nonprofit Organizations." *Nonprofit Management & Leadership* 7, no. 4 (1993): 387-3999.

Simon, John, Harvey Dale, and Laura Chisolm. "The Federal Tax Treatment of Charitable Organizations." In *The Non-Profit Sector*, by Walter W. Powell and Richard Steinberg, 276-306. New Haven: Yale University Press, 2006.

Sinha, D. "The Contribution of Formal Planning to Decisions." *Strategic Management Journal* 11 (1990): 479-492.

Sloan, Frank A., Gabriel A. Picone, Donald H. Taylor, and Shin-Yi Chou. "Hospital Ownership and Cost and Quality of Care: Is There a Dime's Worth of Difference?" *Journal of Health Economics*, January 2001: 1-21.

Smith, Howard L., Neill F. Piland, and Michael J. Funk. "Strategic Planning in Rural Health Care Organizations." *Health Care Management Review*, 1992: 63-80.

Smith, Ken G., Terence R. Mitchell, and Charles E. Summer. "Top Level Management Priorities in Different Stages of the Organizational Life Cycle." *Academy of Management Journal* 28, no. 4 (1985): 799-820.

Smith, Scott, interview by Britt Berrett. *President, Medical City Limited* (December 12, 2007).

Smith, Steven Rathgeb, and Kirsten A. Gronbjerg. "Scope and Theory of Government-Nonprofit Relations." Chap. 10 in *The Non-Profit Sector*, by Walter W. Powell and Richard Steinberg, 221-242. New Haven: Yale University Press, 2006.

Smyth, J.Patrick, and J.Charles Cosovich. "Value-Based Strategic Planning for the Not-For-Profit Hospital." *Healthcare Strategic Management* 18, no. 9 (September 2000).

Snell, S., and J. Dean. "Integrated Manufacturing and Human Resource Managment: A Human Capital Perspective." *Academy of Management Journal* 35, no. 3 (1992): 467-504.

Snelson, EA. "Proposed Changes to the Hospital-Medical Staff Relationship to improve Quality of Care." *Annals of Health Law* 12, no. 2 (2003): 265-275.

Solucient. "Benchmarking." *Solucient.com.* 2007. http://www.solucient.com/publications/books/default.shtml#Benchmarking (accessed July 21, 2007).

Spaeth, RG, KC Pickering, and SM Webb. "Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures." *Annals of Health Law* 12, no. 2 (2003): 235-247.

Spath, Patrice L. *Leading Your Healthcare Organization to Excellence: A Guide to Using the Baldrige Criteria.* Chicago: Health Administration Press, 2005.

Spiegel, A.D., and H.H. Hyman. *Strategic Health Planning Methods and Techniques Applied to Marketing and Management.* Norwood, NJ: Ablex Publishing Corporation, 1991.

Starkweather, David. "Hospital Board Power." *Health Services Management Research* 1, no. 2 (July 1988): 74-86.

Starr, Paul. *The Social Transformation of American Medicine.* Basic Books, 1982.

Stayer, Ralph C., and James A. Belasco. *Flight of the Buffalo.* New York: Warner Books, Inc., 1993.

Steiner, J.R., G.M. Gross, M.C. Ruffolo, and J.J. Murray. "Strategic Planning in Non-Profits: Profit from It." *Administration in Social Work* 18, no. 2 (1994): 87.

Steiner, Joseph R., Gerald M. Gross, Mary C. Ruffolo, and John J. Murray. "Strategic Planning in Non-Profits: Profit from It." *Administration in Social Work* (18) 2 (1994): 87-106.

Stern, Andy, interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (June 27, 2008).

Stogdill, Ralph M. "Personal Factors Associated with Leadership: A Survey of the Literature." *Journal of Psychology* 25 (1948): 35-71.

Studer, Quint. *101 Answers to Questions Leaders Ask.* Gulf Breeze: Fire Starter Publishing, 2005.

—. *Hardwiring Excellence.* Gulf Breeze: Fire Starter Publishing, 2003.

Succi, Melissa J., and Jeffrey A. Alexander. "Physician Involvement in Management and Governance: The Moderating Effects of Staff Structure and Composition." *Health Care Management Review* 24, no. 1 (Winter 1999): 33-44.

Svara, James. *Ethics Primer for Public Administrators in Government and Nonprofit Organizations.* Sudbury, Massachusetts: Jones and Barlett, 2007.

Tanner, Lisa. "Medical City Dallas Cultivates Empployee Pride." *Dallas Business Journal*, April 23-29, 2004: 11B.

Tassie, Bill, Vic Murray, and James Cutt. "Evaluating Social Service Agencies: Fuzzy Pictures of Organizational Effectiveness." *Voluntas: Internatinal Journal of Voluntary and Nonprofit Organizations* 9, no. 1 (1998): 59-79.

Terry, Larry D. "Administrative Leadership, Neo-Managerialism, and the Public Management Movement." *Public Administration Review* 58, no. 3 (1998): 194-200.

Tertel, Jennifer, interview by Britt Berrett. *Director of Human Resources of Medical City Dallas Hospital* (November 17, 2008).

Texas Hospital Association. *Texas Hospital Association.* 2006. www.texashospitalsonline.org/index.asp (accessed January 1, 2007).

Texas Quality. 2007. www.texas-quality.org (accessed December 12, 2007).

The Beryl Institute. "High Performing Organizations: Culture as a Bottom-Line Issue." *A White Paper by the Beryl Institute.* November 2007.

The United States Department of Health and Human Services. "Measuring Health Care Quality." *Agency for Health Care Quality and Research.* 2007. http://www.ahrq.gov/qual/measurix.htm (accessed July 21, 2007).

Thomas, John Clayton. "Outcome Assessment and Program Evaluation." Chap. 16 in *The Jossey-Bass Handbook of Nonprofit Leadership & Management*, by Robert D. Herman & Associates, 391-416. 2005.

Thomas, Warner. "It's All in the Preparation." *Modern Healthcare* 35, no. 37 (September 2005).

Thompson, Paul, and Gene W. Dalton. *Novations.* Glenview: Scott, Foresman and Company, 1986.

Thompson, Richard E. *Keys to Winning Physician Support 2 ed.* Tampa, Florida: American College of Physician Executives, 1998.

Tipping, A.B. "Qualifications of the Modern Hospital Superintendent." *The Modern Hospital*, 1914: 98-99.

Tobias, Todd, and Randall Tobias. *Put the Moose on the Table.* Bloomington: Indiana University Press, 2003.

Tozzio, Mark G., Gary L. Rower, Robert R. Cook, and John R. Griffith. "Strategic Planning for a Turnaround." *Health Progress*, May/June 2003: 35-40.

Trinh, Hanh Q., and Stephen J. O'Connor. "Helpful or Harmful? The Impact of Strategic Change on the Performance of U.S. Urban Hospitals." *Health Services Research* 37, no. 1 (February 2002): 145-171.

Trottier, Tracey, Montgomery VanWart, and XiaoHu Wang. "Examining the Nature and Significance of Leadership in Government Organizations." *Public Administration Review*, March-April 2008: 321-331.

Trustee. "Strategic Planning? An Interview with Thomas C. Dolan, President and CEO of the American College of Healthcare Executives." *Trustee* (Trustee) 57, no. 9 (2004): 5-6.

Tuckman, Howard P., and Cyril F. Chang. "Commercial Activity, Technological Change, and Nonprofit Mission." Chap. 26 in *The Non-Profit Sector: A Research Handbook*, edited by Walter W. Powell and Richard Steinberg, 629-644. New Have: Yale University Press, 2006.

Tuckman, Howard P., and Cyril F. Chang. "Commercial Activity, Technological Chnage, and Nonprofit Mission." In *The Non-Profit Sector A Research Handbook*, by Walter W. Powell and Richard Steinberg, 629-644. New Haven: Yale University Press, 2006.

U.S. Department of Health and Human Services; Health Resources and Services Administration; Bureau of Health Professions;. "Preliminary Findings: 2004 National Sample Survey of Registered Nurses." 2006. http://bhpr.hrsa.gov/healthworkforce/reports/rnpopultation/preliminaryfindings.htm (accessed May 26, 2007).

Ulrich, David, Jack Zenger, and Norm Smallwood. *Results-Based Leadership.* Boston: Harvard Business School Press, 1999.

Unterman, I., and R. Davis. "From the Board Room: The Strategy Gap in Not-for-Profits." *Harvard Business Review* 60 (May-June 1982): 30-40.

Upeniekes, V. "Assessing Differences in Job Satisfaction of Nurses in Magnet and Non-Magnet Hospitals." *Journal of Nursing Administration* 32, no. 11 (2002): 564-576.

Van De Ven, Andrew H. "Central Problems in the Managment of Innovation." *Management Science* 32, no. 5 (May 1986): 590-607.

Van Maurik, John. *Writers on Leadership.* London: Penguin Group, 2001.

VanWart, Montgomery. *Dynamics of Leadership in Public Service.* Armonk, New York: M.E. Sharpe, Inc., 2005.

—. *Leadership in Public Organizations.* Armonk, New York: M.E. Sharpe, Inc., 2008.

Vernon, Kim M.D., interview by Britt Berrett. *President of the Medical Staff - 2001, Medical City Dallas Hospital* (July 15, 2008).

Vetter, Laurence P., Robert Carden, and David S. Wilkinson. "Strategic Planning in a Clinical Environment." *Clinical Leadership & Management Review*, 2001: 34-38.

Villarreal, Troy, interview by Britt Berrett. *Chief Operating Officer, Medical City Dallas Hospital 2000-2003* (October 2008).

Vizzard, William. "Transforming the FBI: A Challenge of Culture, Resources, and Mission." Edited by Nancy Roberts. *Public Administration Review*, September/October 2006: 764-766.

Vogel, Lynn Harold, and Irma Patterson. "Strategy and Structure: A Case Study of the Implications of Strategic Planning for Organizational Structure and Management Practice." *Administration in Social Work* 10 (1986): 53-66.

Waldheim, Aaron. "Increasing the Efficiencyof Hospital Administration." *The Modern Hospital*, 1920: 298-299.

Waldman, David A., and Mansour Javidan. "Charismatic Leadership at the Strategic Level: Taking a New Look at Upper Echelons Theory." In *Transformational and Charismatic Leadership: The Road Ahead*, edited by Bruce J. Avolio and Francis J. Yammarino, 173-199. Oxford: Elsevier Science Ltd., 2002.

Waldman, David A., Gabriel G. Ramirez, and Robert J. House. "Does Leadership Matter? CEO Leadership Attributes and Profitability Under Conditions of Perceived Environmental Uncertainty." *Academy of Management Journal* 44, no. 1 (2001): 134-143.

Waldman, David A., Mansour Javidan, and Paul Varella. "Charismatic Leadership at the Strategic Level: A New Application of Upper Echelons Theory." *Leadership Quarterly* 15 (2004): 355-380.

Walsh, William. "The Hospital Superintendent- Past, Present, and Future." *The Modern Hospital*, 1915: 19-23.

Walston, Stephen L., and Clint Chadwick. "Perceptions and Misperceptions of Major Organizational Changes in Hospitals: Do Change Efforts Fail Becuase of Inconsistent Organizational Perceptions of Restructuring and Reengineering?" *Inernational Journal of Public Administration* 26, no. 14 (2003): 1581-1605.

Walston, Stephen L., Peter Lazes, and Patricia Garcia Sullivan. "Improving Hospital Restructuring: Lessons Learned." *Health Care Management Review* 29, no. 4 (2004): 309-319.

Walston, Stephen Lee, Lawton Robert Burns, and John R. Kimberly. "Does Reengineering Really Work: An Examination of the Context and Outcomes of Hospital Reengineering Initiatives." *Health Services Research* 34, no. 6 (February 2000): 1363-1388.

Walters, Les M.D., interview by Britt Berrett. *President of the Medical Staff - 2008, Medical City Dallas Hospital* (June 4, 2008).

Ward Lane, M.D., interview by Britt Berrett. *President of the Medical Staff - 2004, Medical City Dallas Hospital* (August 1, 2008).

Watkins, Barbara, interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (May 2, 2008).

Weber, David Ollier. "Golden and R-E-S-P-E-C-T Encourage Employee Loyalty." *The Physician Executive*, July/August 2003: 6-11.

Weber, Laura, interview by Britt Berrett. *Director of Quality Improvement, Medical City Dallas Hospital* (December 11, 2008).

Weber, Max. *Max Weber on Charisma and Institutional Building.* Edited by S. N. Eisenstadt. Chicago: The University of Chicago Press, 1968.

Webster, J.L., W.R. Reif, and J.S. Bracker. "The Manager's Guide to Strategic Planning Tools and Techniques." *Planning Review* 17, no. 6 (1989): 5.

Webster, Stephen A., and Mary L. Wylie. "Strategic Planning in Competitive Environments." *Administration in Social Work* 12, no. 3 (1988): 25-42.

Weiner, Bryan J., and Jeffrey A. Alexander. "Corporate and Philanthropic Models of Hospital Governance: A Taxonomic Evaluation." *Health Services Research* 28, no. 3 (August 1993): 325-355.

Weinstein, Matt. *Managing To Have Fun.* New York: Fireside, 1996.

Weitekamp, Michael R., Luanne E. Thorndyke, and C. McCollister Evarts. "Strategic Planning for Academic Health Centers." *The American Journal of Medicine* 101 (September 1996): 309-315.

Weymes, Ed. "Relationships not Leadership Sustain Successful Organisations." *Journal of Change Management* 3, no. 4 (2003): 319-331.

Wiesendanger, B. "Profitable Pointers from Non-profits." *Journal of Business Strategy* 15, no. 4 (1994): 32-39.

Willingham, Ron. *Hey, I'm the Customer.* Paramus: Prentice Hall, 1992.

Winfred Parnell, M.D., interview by Britt Berrett. *Board of Trustees of Medical City Dallas Hospital* (June 2, 2008).

Wolf, Jason A. "Health Care, Heal Thyself! An Exploration of What Drives (and sustains) High Performance in Organizations Today." *Performance Improvement* 47, no. 5 (May/June 2008): 38-45.

—. "High Performance Facility Study 2005." *HCA Organizational Effectiveness.* Nashville, October 2006.

Wolf, Jason, interview by Britt Berrett. *Director of Organizational Development Eastern Group - HCA* (January 13, 2009).

Wren, J. Thomas, and Marc J. Swatez. "The Historical and Contemporary Contexts of Leadership: A Conceptual Model." In *The Leader's Companion - Insights on*

Leadership Through the Ages, edited by J. Thomas Wren, 245-252. New York: The Free Press, 1995.

Wright, Bob, interview by Britt Berrett. *General Managing Partner, Medical City Limited* (July 23, 2008).

Wright, Bradley E. "Public Service and Motivation: Does Mission Matter?" *Public Administration Review*, 2007: 54-64.

Yin, Robert K. *Case Study Research Design and Methods.* 3rd Edition. Vol. 5. Thousand Oaks: Sage Publications, 2003.

Young, Carole, interview by Britt Berrett. *Chairman, Board of Trustees of Medical City Dallas Hospital* (May 8, 2008).

Young, Gary, Rafik I. Beekun, and Gregory O. Ginn. "Governing Board Structure, Business Strategy, and Performance of Acute Care Hospitals: A Contingency Perspective." *Health Services Research* 27, no. 4 (October 1992): 543-564.

Yousuf, Faraaz, interview by Britt Berrett. *Director of Operations Finance - Planning, HCA* (October 26, 2008).

Yukl, Gary A. *Leadership in Organizations.* Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1981.

Zaccaro, Stephen J., Cary Kemp, and Paige Bader. "Leader Traits and Attributes." Chap. 5 in *The Nature of Leadership*, edited by John Antonakis, Anna T. Cianciolo and Robert J. Sternberg, 101-124. Thousand Oaks: Sage Publications, 2004.

Zuckerman, Alan M. *Healthcare Strategic Planning.* Chicago: Health Administration Press, 2005.

—. *Improve Your Competitive Strategy.* Chicago: Foundation of the American College of Healthcare Executive, 2002.

Zuckerman, Alan M. "Strategic Planning for a Financial Turnaround." *Health Progress*, September/October 2005: 54-57

VITA

Britt Berrett, son of Frank and Irene Berrett, was raised in Vancouver, British Columbia. Upon finishing high school in 1981, he enrolled at Brigham Young University. During his undergraduate studies, he served an LDS Mission in Lima, Peru from 1982-83. Prior to his marriage to Lori Ann Lake in 1986, he worked on the U.S. Senate Labor and Human Resources Committee, subcommittee on health, under the direction of Dr. David Sundwall.

In 1987, he completed his bachelor's degree in Finance from BYU and began his graduate work in health administration at the Washington University School of Medicine in St. Louis, Missouri. Throughout his educational experience, he participated in numerous civic and church organizations. In addition, he worked as an evening/night administrator at Barnes Hospital to fund his graduate schooling. Upon completing his graduate degree in 1989, he was selected by National Medical Enterprises as a President's Fellow and participated in a comprehensive health care administrative training program. His first administrative position was as the Assistant Administrator at Doctors' Hospital of Montclair and Ontario Community Hospital.

Since 1989, his professional career in hospital administration has included employment in San Bernardino, Los Angeles, Salt Lake City, and San Diego in both private and non-profit hospitals. In 2000, he was appointed president and chief executive officer of Medical City Dallas Hospital and Medical City Children's Hospital. During his tenure as the

senior executive, he enrolled in the doctoral program in public affairs at the University of Texas at Dallas.

Throughout his career, he has received numerous awards and recognitions and has actively participated as a board member on over 20 nonprofit organizations. He and his wife have three children (Kelsey, Brad, and Gracie) and reside in Fairview, Texas.

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PROFESSIONAL POSITIONS

President & Chief Executive Officer at Medical City Dallas Hospital and Medical City Children's Hospital, 2000 to present.

Chief Executive Officer at SHARP Chula Vista Medical Center, Chula Vista, California, 1996 to 2000.

Administrator/Chief Operating Officer at Daniel Freeman Memorial Hospital sponsored by the Sister's of St. Joseph of Carondelet, Los Angeles, California, 1995 – 1996.

Chief Executive Officer at Mission Bay Memorial Hospital, Mission Bay, California 1994-1995.

Associate Administrator at Pioneer Valley Hospital in West Valley, Utah, 1993-1994.

Associate Administrator at Encino Hospital, Encino, California 1992-1993.
Assistant Administrator at Doctors' Hospital of Montclair/Ontario Community Hospital, Montclair/Ontario, California 1989-1992.

EDUCATION

Candidate - Doctor of Philosophy (Ph.D.), Public Affairs, University of Texas at Dallas, Current.

Master of Health Administration (MHA), Washington University School of Medicine, 1989.

Bachelor of Science (BS), Finance, Brigham Young University, 1987.

Senate Intern, Labor and Human Resources Committee, Washington, D.C., 1986.

ARTICLES IN JOURNALS

Robinson, Scott, Britt Berrett, and Kelley Stone. "The Development of Collaborative Response to Hurricane Katrina in the Dallas Area. *Public Works Management & Policy* 10:4 (April 2006).

PROFESSIONAL SERVICE- Recent

ACHE Regent for North Texas, 2007-2010

Invited Speaker at 2007 & 2008 ACHE Congress in New Orleans

American College of Healthcare Executives – Fellow

Greater Dallas Chamber of Commerce, Executive Board Member

Dallas Medical Resources, Board Member

Labor and Human Resources Committee - GDCC, Chairman

Dallas/Fort Worth Hospital Council, Board Member

Health Industry Council – Dallas/Fort Worth, Board Member

Green Oaks Psychiatric Hospital – Dallas Texas, Board Member

Texas Business Education Coalition, Board Member

Ronald McDonald House, Advisory Board Member

City of Dallas Comprehensive Plan Advisory Committee Member

PERSONAL SERVICE & HONORS

LDS Mission to Lima, Peru – 1982-84

UTD Executive Education Advisory Board

SMU Executive MBA Scholarship Merit & Mentoring Program, Mentor

Allen Sports Association, Board of Directors, President

American Heart Association – Dallas Division, Board Member

40 Under 40 Award - Dallas Business Journal

South Bay Human Services Council, Chairman

1998 Modern Healthcare "Up & Comer"

American Heart Association – Chairman, San Diego South County Division

American Heart Association – Volunteer of the Year, South County Division

South Bay YMCA, Board Member

Burn Institute, Board Member

Marriott School of Management, BYU, Alumni Board Member

Seminary Teacher – Old & New Testament 1995, 1996, 2004, 2005