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US Army Medical Department Center and School
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14. ABSTRACT

The DeWitt Health Care Network, per the Base Realignment and Closure law, is endeavoring to evolve from a 44-bed community hospital with minimal specialty capabilities into a world class, state-of-the-art 120-bed hospital that will be one of the two primary military medical treatment facilities in the National Capital Area Medical Joint Task Force (JTF CAPMED). The command team sought to change the culture of the facility. The Command questioned whether an actual culture change emerged or if the improvements in the current metrics were a product of mere compliance. The purpose of this work is threefold: 1) introduce the Organizational Culture Assessment Instrument as the best possible tool for measuring and assessing the current culture and development of the Culture of Excellence; 2) measure and assess the current culture in the Family Health Center as a preliminary example and baseline; and 3) delineate a plan for the implementation of the strategic objective of inculcating a Culture of Excellence in time for the moving into the new hospital in September 2011. The Organizational Culture Assessment Instrument, administered to the Family Health Center at the DeWitt Army Community Hospital, revealed a current (*now*) culture profile of *Hierarchy* and a future (*preferred*) culture profile of *Clan*. The recommendation is that the Culture of Excellence be predominated by the *Clan* profile tempered with some aspects of the *Hierarchy* and *Market* profiles. The transition period will also include *Adhocracy* profile traits which will allow for adoption of new ways without creating internal conflict.

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Abstract

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The Organizational Culture Assessment Instrument, administered to the Family Health Center at the DeWitt Army Community Hospital, revealed a current (*now*) culture profile of *Hierarchy* and a future (*preferred*) culture profile of *Clan*. The recommendation is that the Culture of Excellence be predominated by the *Clan* profile tempered with some aspects of the *Hierarchy* and *Market* profiles. The transition period will also include *Adhocracy* profile traits which will allow for adoption of new ways without creating internal conflict.

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Preface

"The only constant in our business is that everything is changing. We have to take advantage of change and not let it take advantage of us. We have to be ahead of the game."

Michael Dell, Founder Dell Computer Corporation

When the world around us evolves at an increasingly rapid pace, the ability of the military hospital organization to evolve at the same pace is quintessential to fulfilling the purpose and mission for which it exists. The Department of Defense (DoD) is transforming, shedding the skin of industrialized sluggishness with the intent of growing into a lithe, nimble, quick responder. The Army, Air Force, Navy, Marines, and Coast Guard have embarked on their own evolution in the same direction. The Military Health System (MHS) is likewise seeking the same goal. The MHS may have an advantage as its unique correlation to the civilian marketplace has spurred evolution earlier and sometimes faster than the rest of the DoD. As part of the MHS, the DeWitt Health Care Network (DHCN) has been at the forefront of this evolution. In 1994, the DHCN invested in training and infrastructure to support Total Quality Management (TQM) (Goodwin, 1994). The culture was studied at that time in an effort to ensure full adoption of the principles of TQM by everyone who worked in or for the organization. Since, the DHCN has actively sought to improve the quality of care and the service to the patients of the DHCN with numerous initiatives and strategic efforts. Among these were the application of service principles to the organization; developing plans for a hospital facility renewal project; restructuring of the organization hierarchy; refocus to patient centered care, and open access.

Situation

DeWitt Health Care Network

Mission/Vision/Values

Mission: Safely provide our patients with quality primary and specialty care; to sustain our legacy of leadership in medical education, clinical research, and professional development; to meet any contingency at home or abroad.

Vision: Team Dewitt equals an enduring tradition of family centered healthcare, learning, and readiness for our community and our nation.

Values: Investing in people; Meeting any contingency; providing health and healing.

History

Originally built as a five-story 250-bed facility, DeWitt Army Community Hospital (DACH) took its name from Brigadier Wallace DeWitt, a Medical Corps officer who served 45 years in the Army. Dedicated on June 26, 1957, DACH is one of several hospitals built with congressionally designated Fiscal Year (FY) 1953 funds following the Korean War. The 191,000 square-foot hospital featured nine wards and 53 semi-private rooms and boasted a daily census of over 200 patients. In the late 1960's DACH built a one-story clinic addition, increasing the overall size to approximately 260,000 square feet.

Place in MEDCOM hierarchy

The Military Healthcare System (MHS) has a unique dual mission: ensuring readiness and delivering care to eligible populations. The National Capital Region (NCR) system in particular is extremely complex because it consists of 11 medical treatment facility (MTF) locations, 3.7 million outpatient visits, 40,000 admissions, and 66 Graduate Medical Education

programs, many one-of-a-kind military clinical programs, and is multi-service with numerous organizational cultures.

The U.S. Army Medical Command (MEDCOM) consists of six Regional Medical Commands (RMC), and is responsible for the care provided to soldiers, family members and retirees and all other beneficiaries, worldwide. The RMC commanders are responsible for strategic long-term planning to include health facility master planning for their respective regions. A key strategic development has been the alignment of all DoD medical care under the Military Health System (MHS) and Tricare.

Headquartered in Washington, DC, the North Atlantic Regional Medical Command (NARMC) is one of the six major subordinate commands of the MEDCOM. NARMC is responsible for the operation of 11 medical treatment facilities located at the Pentagon, and throughout 10 Army posts and 21 states in the northeastern United States.

DeWitt Army Community Hospital (DACH) is part of the DeWitt Health Care Network (DHCN) and located at Fort Belvoir, Virginia. It falls under the command of the Walter Reed Health Care System (WRHCS), an integrated health care delivery system offering access to quality and comprehensive care to military families in and around the NCR. The WRHCS also includes Kimbrough Ambulatory Care Center at Fort Meade, Maryland and Walter Reed Army Medical Center (WRAMC) in Washington, D.C. The hospitals and clinics within the WRHCS belong to the North Atlantic Regional Medical Command, the northeast subordinate command of the U.S. Army Medical Command.

The DACH grew into the DHCN through reorganization and expansion. The DHCN consists of a network of community-based clinics in Northern Virginia, including the Family Health Center of Fort Belvoir, the Family Health Center of Fairfax, the Family Health Center of

Woodbridge, and the Andrew Rader U.S. Army Health Clinic at Fort Myer, Virginia. The clinics at Woodbridge and Fairfax are unique in the AMEDD as civilian owned and operated contract clinics that serve only Tricare beneficiaries. The DeWitt Family Health Center (FHC) located within the DACH on Ft Belvoir, includes Family Practice, Internal Medicine, and Pediatrics. It provides primary care service to include outpatient procedures. The FHC is also the center of the Family Practice Residency and functions as a troop medical clinic (TMC).

DACH is the only military inpatient military medical facility in northern Virginia and operates four main inpatient areas: Medical/Surgical/Pediatric Unit, Mother-Baby Nursery Unit, Labor/Delivery Unit, and Intensive Care Unit. DACH also provides three operating rooms, an emergency department, a same-day surgery center, and a large primary care center comprised of Internal Medicine, Pediatrics, and Primary Care clinics. In addition to its 44-bed inpatient capability, DACH is the home of a nationally renowned family medicine residency-training program, a sports medicine fellowship and undergraduate nurse training programs. The hospital and its subordinate clinics provide the primary medical support for several major commands across service lines, including providing obstetric and orthopedic services, to Marines and their family members at the U.S. Navy clinic at Quantico.

Uniqueness of Civilian Contract Clinics

A historical overview of Dewitt's community-based experience with civilian contract care provides additional context. DHCN's community based experience with civilian contract care extends over 25 years. It has greatly evolved over time. In 1985 DACH established two direct-care clinics entirely owned and operated by contractors in an initial effort to provide community-based healthcare. This effort was less than successful due to insufficient command and medical oversight, inadequate cost controls, and cultural mismatch. Then from the mid to

late 1990's, PRIMUS clinics transformed to family health care centers (FHC) staffed with joint military and contract leadership and a majority of civilian contract providers and support staff to deliver primary care services. In 2001, Woodbridge and Fairfax clinics expanded to increase capacity for primary care at both sites and at Woodbridge, to add OB/GYN, Ortho, and PT/OT specialty care services. In 2007 a new five-year contract rebid changed to a performance-based contract for FHC Woodbridge and Fairfax. This included provisions for mental health capabilities, pay for performance, patient and provider satisfaction incentives, and increasing contractor responsibilities. DHCN maintains joint oversight, onsite military leadership and periodic review. The primary consequence of BRAC on these facilities is an increase in overall beneficiary enrollment, thus an increase in requirements for access to care. New process and protocols for patient transfers from the outlying clinics will be adopted upon the opening of the new hospital on Ft Belvoir.

The contract clinic experience has not been without some lessons learned. DHCN's experience with the PRIMUS civilian contractor owned/operated healthcare validated the need for enhanced medical quality oversight, military community identification, cost controls, and utilization management. Military/civilian hybrid partnerships offer the best value for the government—stability in the face of deployments, continuity (long-term civilian staff) and flexibility at a competitive cost (contractor staff/government oversight). The evolution towards performance–based, as opposed to historical workload, contracting must be sustained and requires close monitoring/ surveillance by MTF leadership. The preponderance of military backgrounds among Woodbridge and Fairfax civilian contract personnel provides for a degree of loyalty, commitment, and cultural congruence lacking in civilian populations at large. DACH's

network of military and contract support facilities offers exceptional adaptive capacity to respond to major deployments of the Global War on Terrorism since September 11, 2001.

Base Realignment and Closure Law

The 2005 Base Realignment and Closure law (BRAC) is ushering in the most comprehensive changes to the MHS in a generation. The BRAC recommendations will improve use and distribution of MHS facilities nationwide, and affect health care delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust platforms to support Graduate Medical Education. In some areas, it can be expected to significantly enhance care by providing services closer to where beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities will cease to provide inpatient services, and instead, focus on the delivery of high-quality ambulatory care.

Impact on NCR

No region in the country has been more significantly impacted by the 2005 BRAC law than the Washington D.C. National Capital Region (NCR) and in particular, Fort Belvoir and the DeWitt Army Community Hospital (DACH). Congressional adoption of the most recent BRAC Commission report in November 2005 represented the fifth military major base realignment effort since 1988. Most of the past four BRAC efforts involved closing major facilities, but only a few of those included realignments that moved significant personnel from one location to another. The planned NCR moves are unique in that the large majority of the organizations affected by realignment are being relocated from off-base leased space to on-base facilities. These moves have a relatively minimal impact on the workers because the moves are still within

reasonable commuting range of the workers' current homes. These BRAC-related moves are all scheduled to occur by September 15, 2011 according to current Congressional mandate.

The NCR military medical community is restructuring to comply with the BRAC by implementing the National Capital Area Medical Joint Task Force (JTF CAPMED). The Walter Reed Army Medical Center, the National Naval Medical Center at Bethesda and the DeWitt Army Community Hospital will restructure. DeWitt will expand (explained in detail in following sections), and Walter Reed Army Medical Center and the National Naval Medical Center will combine to form the Walter Reed National Military Medical Center at Bethesda. The NCR restructure involves facilities, personnel resources, beneficiaries, and multiple services. The catchment area for all NCR medical assets will be divided into two regions, North, and South. The North will be serviced by the new NMMC and the South by the new hospital on Ft Belvoir. The overall eligible population will remain relatively stable as will the enrolled population.

National Naval Medical Center (NNMC) in Bethesda is a 257-bed facility in Maryland, northwest of Washington D.C. NNMC, the Navy's flagship medical institution, is its third-largest health care delivery system and provides more than 12,500 ambulatory surgeries and almost 8,000 inpatient admissions each year. As the headquarters for the regional Health Care System, NNMC encompasses facilities in five states and the District of Columbia. NNMC also provides care to the President and Vice President, members of Congress and Justices of the Supreme Court. These resources will combine with the present day Walter Reed and form a world-class 345 bed medical center in the north. There is to be no loss of capability during transition.

Impact on Ft Belvoir

The 2005 BRAC report recommends nearly 23,470 military, federal civilian, and private embedded contractor jobs to be relocated to Fort Belvoir. These BRAC-related moves are all scheduled to occur by September 15, 2011 according to current Congressional mandate. With the expectation of thousands of new personnel moving to Fort Belvoir by 2011, the post will need to add to its available facilities substantially to support the new workforce. Approximately 6.2 million square feet of newly built office space and 7 million square feet of parking will be constructed at Fort Belvoir in the next four years.

Impact on DHCN

The BRAC law provided for the construction of new 120-bed, 1.1 million square feet community hospital on Ft Belvoir to eventually replace DeWitt Army Community Hospital. The new facility does not just replace the current hospital, it also adds to the capabilities of the hospital and the level of care available to beneficiaries with 55 primary and specialty clinics. The new facility will be completed in 2010 with move-in scheduled for 2011 using evidenced based design principles and a design/build model for construction. The hospital will grow from approximately 1100 staff to about 3200 staff. Enrollment will grow as the catchment area grows to include approximately 44% of the total NCR enrollees. The new facility will include increased specialty care, an Intensive Care Unit, 30% increase in med/surge capacity, 120% increase in Behavioral health, 56% increase in OB care, 83% increase in nursery capacity, and 70% increase in Operating Room Capacity. The new building and 2000 new staff will expect to provide an increased quantity of healthcare more efficiently.

As the three medical organizations restructure and realign, the people that comprise these organizations must learn how to work in new environments with new personnel in the sense that

each organization by virtue of its service affiliation, size, historical relevance, proximity to political organizations and healthcare for politicians, has its own unique organizational culture. Assimilating persons from these three cultures becomes a strategic imperative, and, as asserted by this work, a priority purpose of the newly evolved organizations.

Statement of the problem

In 2006, the new DHCN Commander wanted to change the culture of customer satisfaction. The initial emphasis was simply on improving satisfaction scores on existing measures that would reflect increased access, quality, and patient satisfaction. Many changes were made that did indeed improve access, quality, and patient satisfaction. However, the commander, while executing management by walking around, had a startling realization. Despite impressive improvements, to include earning the distinction of the best MTF in the AMEDD and earning monetary awards for meeting productivity and HEDIS goals, the culture did not seem to have changed. That is to say, the motivation for such performance seemed to be because of the emphasis on these things from the commander and not from the employee's internal desire for excellence.

The DHCN commander wanted to have some way to discern the culture, to know what could be done to change it, and then, to have some way to know whether or not it had changed. If the culture did not change, find out why and what can be done to change it in a direction beneficial to the DHCN. The problem then is to find a measure or measures that will allow the command team to discern the culture, determine which way to take it, determine whether it is actually changing and, if so, in what way it is changing.

DHCN Strategic Plan

An agency's strategic plan is one of three main elements required by the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). The basic requirements for strategic plans appear in the Office of Management and Budget (OMB) Circular No. A-11, Part 6, Section 210. According to the OMB, an agency's strategic plan keys on those programs and activities that carry out the agency's mission and will provide the overarching framework for an agency's performance budget.

An Isis curve is a curve that starts up while a previous curve is starting down. In business, a successful company will begin a new initiative before the previous successful efforts begin to lag. The DHCN has been recognized for many successes. Before the momentum from these achievements can begin to lag, a new movement needs to begin.

The critical concept that MHS leaders share is simple: never be satisfied with our accomplishments. The people we serve (the front line commanders, service members, military families, civilian leadership, and the representatives of the American people in the Congress) expect us to accomplish even more, and to build upon our successes. DHCN was recognized by the MHS as the number one hospital in the AMEDD. However, many opportunities for improvement still exist. The metrics are hitting green on the red/ amber/ green/ scale, without being 100% green. Furthermore, being the best hospital in the AMEDD does not necessarily translate to a cultural shift.

Many people in many places have very high expectations for this country's military health system. "[The MHS'] responsibility in the coming years is to continue to exceed these expectations. [The MHS'] obligations are to those who follow us: today's sergeants and corporals, lieutenants and captains, and civilians now rising through the system" (Cassells,

2007). With the assured support from every level of leadership, the DHCN remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future.

The MHS Strategic Plan's purpose is "Keeping Warfighters Ready for Life". The MHS' goal is excellence in clinical care (including prevention and protection), teaching, and research. The MHS has shaped its strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), BRAC reports, the six task forces and independent review groups that have reported to the MHS, and several MHS strategic offsite meetings in 2007 and 2008. The strategic priorities for the MHS include a fit, healthy and protected force; superior follow-up care, and seamless transition with the Department of Veterans Affairs (VA); medical advancement through education and research opportunities; satisfied beneficiaries; support the creation of healthy communities; support deployment taskings; and effective management of health care costs.

The MHS will focus on combat care, humanitarian assistance, and disaster readiness, especially in those areas where others cannot operate. The MHS will strive to foster communication and jointness among the Military Services, key government agencies, such as the Departments of Health and Human Services (HHS), Homeland Security and State, nongovernmental organizations, and international organizations. The DHCN overarching objective of inculcating a COE is directly in line with the MHS goal of excellence in clinical care.

Healthy and productive individuals, families, and communities are the foundation of the nation's present and future security and prosperity. Although DHCN has made great progress, it must continue its current efforts to sustain positive outcomes and augment them with new,

innovative strategies to continue to improve the health and well-being of all its patients. The strategic plan provides direction for DHCN efforts to improve the health and well-being of its assigned population. The strategic plans goals and objectives direct DHCN efforts to improve health care, promote and protect the public's health, enhance services and advance the education and research. The plan addresses the strengths and weaknesses of the DHCN as well as potential opportunities and possible threats for its continued pursuit of mission accomplishment. The strategic plan encompasses the major areas of focus for the DHCN at the goal level and lays out the primary strategies for achieving these goals. However, it does not include all actions, metrics, measures, and initiatives that the DHCN might take to achieve any one objective. Given the size, the breadth of the DHCN it would be impractical to provide in this work a comprehensive list of all DHCN supported strategic endeavors and activities. Strategic objectives are not intended herein to be a catalog of all potential implementation plans; they merely indicate the priorities and general direction the DHCN intends to take.

DHCN Balanced Score Card

The critical concept that MHS leaders share is simple. They can never be satisfied with accomplishments. The people they serve, the line commanders and civilian leadership, the service members and military families, and the representatives of the American people in the Congress, expect the MHS to accomplish even more, and to build upon historic successes.
The Army Medical Command's balanced scorecard published in April of 2008 states that the mission of Army Medicine is to promote, sustain and enhance soldier health, train and develop an agile medical force that supports the full spectrum of operations, deliver leading edge healthcare resources to our warriors, military families, and to maximize outcomes. The scorecard begins with the resources section with the objectives of optimizing resources and values,

optimizing lifecycle management of facilities and infrastructure, and maximizing human capital. Next, under the learning and growth section, the BSC identifies objectives to improve recruiting and retention of AMEDD personnel, improve training and development, promoting and fostering a culture of innovation, and improve knowledge management. Four internal processes are involved in the support of the Army family covenant: maximizing physical and psychological health, improving quality outcomes with focused care and services, improving access and continuity of care, and the implementation of best practices.

The end-state for all of the aforementioned is improved healthy and protected families, beneficiaries and civilians, optimized care and transition of wounded, ill and injured warriors, improved healthy and protected warriors, response of battlefield metal force, improve patient and customer satisfaction, and to inspire trust in Army medicine.

Therefore, the Dewitt Healthcare Network focuses on acquiring new money for increased workload and for exceeding standards, and efficient use of resources. To foster learning and growth, they are leveraging science and technology while striving to recruit and retain quality staff and enhance employee satisfaction. Employee satisfaction is a key goal for internal processes that will maximize primary care throughout the DHCN, capture increased workload, market the Dewitt Healthcare Network as the site of choice for healthcare, and maintain accreditation standards at all times. They will implement the Army Medical Action Plan (AMAP) to include the Warriors in Transition unit. This plan will also transition to the new Dewitt Hospital when construction is completed in 2010. In 2011, the new DeWitt Hospital will open to serve beneficiaries. Starting now, the DHCN must begin to prepare the staff with the systems and processes that will make the new hospital truly a success. This will lead to improving access to care for beneficiaries. Beneficiaries will be happy with the care received

equating to patient satisfaction which is the primary focus of the hospital commander and the senior mission commanders.

Warriors will be able to get the care they need in order to recover from their conditions and transition quickly, effectively, and safely to their next role in life, whether it be continued service or to the civilian life. The Army at large is striving to provide healthy and protected Soldiers and seeking to transition the warriors not just the troops within a troop command. The Army strives to ensure that the all warriors are healthy and protected including all of those the DHCN helps to deploy. Dewitt Healthcare Network's vision is to be the destination of choice for patients because of its focus on quality health care delivery. This will be invaluable to the National Capital Area's Military Health System to enhance services and capacity. This vision is going to change slightly even in the near future as the DHCN is working to adopt the idea of a Culture of Excellence.

A negative perception of the fifty year-old hospital facility is understandable; however, the quality of care within its walls is unmistakable. Though DHCN is recognized as being best among its peers, internally the DHCN staff, commander, and cadre are fully aware that there are many opportunities for improvement. The command team, realizing the necessity to ensure quality care and that it depended upon accountability and reward, made the focus of their plan patient satisfaction and access to care.

DHCN is going to observe multiple metrics and focus on performance improvement initiatives to ensure constant improvement, with the strategic intent to generate improved patient satisfaction and ever-greater access. Moreover, incremental moves in provider schedules, provider templates, clinic hours, scripting of responses to patients questions and training are some of the methods managers have utilized to improve patient satisfaction and improve access.

One strategic goal is *open access* which allows the beneficiary to have the same day appointment almost any day that the clinic is open without compromising care for any other scheduled patient. Another performance improvement measure was to improve online appointment scheduling. Some new technology and special operator training would facilitate cooperation between the clinic and the operators for available open appointments. The providers of a given clinic could depend upon the call center to schedule patients appropriately and obtain sufficient information beforehand for the patient to be treated effectively during the visit. As part of the *access to care* agenda, the commander emphasized the *book-or-refer* protocol. The *book or refer* protocol refers to the options a beneficiary has for obtaining an appointment through the call center. If an appointment is not available for the beneficiary in the direct care network during the prescribed time-frame, the patient should be referred to the civilian network for the earliest possible appointment.

The internal improvement requires two phases. The first phase is contraction through retrenchment. The second phase is pursuing opportunity through enhancement. The DHCN will retrench through an internal focus involving integration and increasing flexibility with family and patient centered care. The DHCN will enhance its present facility with additional provider exam rooms, signage, and patient-friendly processes. The DHCN will address internal weaknesses and present opportunities in order to turn its competitive disadvantage (the aging facility) into a competitive advantage. The DHCN's overarching strategic objective for maximizing internal strengths and minimizing external threats is the inculcation of a Culture of Excellence. The DHCN will also develop better classes and training sessions for all incoming and current personnel reinforce the culture of excellence. The most noticeable long-term

competitive advantage for the DHCN is the construction of a new hospital with increased capacity and capabilities.

The DHCN has culled its BSC from the MEDCOM BSC. In the Means section of the BSC, the strategic objectives are to recapture resources by acquiring new money for the new workload, using resources efficiently, and providing incentives for exceeding standards. Each of the aforementioned foundational strategic objectives provides the resources for the culture of excellence. The learning and growth objectives include leveraging science and technology, recruit and retain quality staff, and enhance job satisfaction. The Culture of Excellence will be both a way to recruit personnel and a reason personnel will stay. The Culture of Excellence is also a factor in enhancing job satisfaction. The section of the BSC that is both critical to success and the subject of this work is *the Ways*, the internal Process.

The Culture of Excellence is a strategic objective bubble within the Transform column of the four columns: Sustain Prepare, Reset, and Transform. However, unique to the Culture of Excellence is that it connects to all four internal process columns and connects every other strategic objective. The Culture of Excellence is the lynchpin that will enable accomplishment of the ends. Sustain encompasses every way to keep what is going, going and this is summarized in the strategic objective of accurately capturing every piece of workload. The prepare column includes Increasing primary care capacity, maximizing access to care, and efficient use of inpatient capacity. The Reset column of the internal process includes Maintain accreditation standards at all times. The *at all times* is the aspect that the Culture of Excellence will influence most directly. The Warrior in Transition Unit (WTU) is the result of executing the Army Medical Action Plan (AMAP). The WTU replaces the Medical Hold units as an activity that strives to ensure optimum care and a timely, effective transition for every warrior.

The Culture of Excellence would propel these efforts to the best possible outcome. The Culture of Excellence transcends every strategic objective in the *means* section of the BSC and is essential for the strategic goal of Transition to DHCN 2010. The Culture of Excellence timeline is of being fully established by the time we move to the new hospital. The transition to the new hospital is a *sine qua non* of the DHCN. The Culture of Excellence will empower the DHCN to make the transition from 1500 to approximately 3200 personnel a success only if the culture of the few can translate to the culture of the many. The Culture of Excellence must be so ingrained that even the disruption of location and all new processes does not affect the culture. The climate might fluctuate, but the culture must remain stable.

Culture of Excellence: A strategic objective

Donabedian's (1966) Structure-Process-Outcome model describes *the what* of an organization quite effectively, but it does not discuss *the how*. Access to care, customer satisfaction, reputation, clinical excellence, geographical convenience and an efficient use of resources are key critical success factors for the DHCN. To focus its direction, DHCN has refined its vision and goals based upon the fundamental quest for a Culture of Excellence. Two previous studies have investigated the structure (organizational structure and facility) and process (Ferguson, 2000; Patterson, 2005). Perhaps, then, another nuance or approach is viable. Instead of a formal wire diagram of the structure, culture could be the context or structure. The culture of the organization will facilitate the process and the outcomes (Studer, 2003; Cameron and Quinn, 1999; Stubbelfield 2005; Scotti et al., 1997; Deal and Kennedy, 2001). As the culture begins to evolve into a Culture of Excellence the strategic initiative process will have fertile ground in which to thrive.

DHCN has continually sought to improve service and capabilities. In 1990, the effort was through both training its entire staff and infusing its culture with the principles of total quality management. Facility upgrades and renewal projects included a mother baby ward complete remodel project and near completion of plans for a hospital renewal project, that was superseded by the 2005 BRAC law. The new facility is an opportunity to improve workflow processes, patient flow, environmental and safety issues, food service, administrative and technological systems and processes, and, perhaps most importantly, the culture of the DHCN. In order to ensure that care is not just available but delivered in the best possible way, the Culture of Excellence must be well established and then convey when the transition is made to the new hospital. Culture, unlike any other initiative, is transmitted across time and generations; cultural elements are transmitted to and through a variety of people, such as coworkers, colleagues, and family members, (Bohannan 1995). Ensuring the inculcation and eventual transference of the Culture of Excellence will be a critical success factor when the new hospital opens for business in 2011.

The DHCN's goal is to be the first choice of patients' and customers for their healthcare needs. The DHCN strives to accomplish this by exceeding customers' expectations, demonstrating exceptional clinical standards, displaying compassion in patient care, and being responsive and flexible. We don't try to outspend or compete with other facilities, but we do have a fixed budget and limited resources. By creating a cultural transformation within the organization, the employees can become engaged and inspired to perform at the highest levels. Their positive outlook can translate into a level of service and operational excellence that will become a national example.

The Culture of Excellence strategic objective transcends the other means categories. The *Means* section delineates the Culture of Excellence instruments and related projects as well as the *Ways* section since those aspects of the strategy must also be conducted within the Culture of Excellence. The Culture of Excellence is the umbrella objective. The process improvement projects and Lean Six Sigma initiatives will reside under the Culture of Excellence. Likewise, other studies or business case analysis can be placed under this objective. The Culture of Excellence leads to employee satisfaction, which leads to high performance work centers and increased quality of care, which leads to patient satisfaction and improved outcomes. Culture is the common link among all of the other objectives of the BSC.

Organizational Culture

Definition

The organizational culture construct defines the parameters for a particular avenue of research and application. The term “organizational culture” is a relatively recent addition to the U.S. academic literature having been introduced in 1979 with an article in the journal *Administrative Science Quarterly*. In the U.S. management literature, culture and climate have erroneously been used synonymously. Organizational culture has acquired a status similar to structure, strategy, and control and it may be argued that “culture" and "strategy" are partly overlapping constructs (Weick 1985). There is debate about its definition, but most authors will probably agree on the following characteristics of the organizational/corporate culture construct: it is holistic, historically determined, related to anthropological concepts, socially constructed, soft, and difficult to change.

The literature on organizational cultures consists of a remarkable collection of pep talks, war stories, and some insightful, in-depth case studies. Even as managers and researchers began to accept organizational culture as distinct from organizational climate, study of culture often did not measure culture directly, or culture surveys still more closely resembled climate surveys.

Organizational culture and organizational climate, though both oriented around an organization, are distinct both technically and experientially. The culture and climate differences can be divided into three separate levels: (a) the values and beliefs that underlie actions; (b) the patterns of behavior that reflect and reinforce those values; and (c) the set of conditions, created by these patterns of behavior, within which organizational members must function (Denison 1990). Whereas organizational culture could be defined as the norms, values, and basic

assumptions of a given organization, organizational climate is the employees' perception of the organizations policies, procedures, and reward systems (Gershon, Stone, Bakken, Larson, 2004).

Organizational culture is different from organizational climate. Organizational Climate refers to more temporary attitudes, feelings, and perceptions on the part of individuals. Culture is an enduring, slow changing core attribute of organizations; climate, because it is based on attitudes, can change quickly and dramatically. Culture refers to implicit, often indiscernible attributes of organizations. Culture includes core values and consensual interpretations about how things are; climate includes individualistic perspectives that are modified frequently as situations change and new information is encountered. A cultural assessment tool should assess how things are, rather than how someone *feels* about them (Cameron and Quinn, 2005).

A cultural system is an organization of phenomena so inter-related that the relation of part to whole determines the relation of part-to-part. Culture includes traditions that tell *what has worked* in the past. It also encompasses the way people have learned to look at their environment and themselves, and their unstated assumptions about the way the world is and the way people should act (Triandis, 1994).

Culture can be thought of as unstated assumptions, standard operating procedures, and ways of doing things that have been internalized to such an extent that people do not argue about them. Culture as a strategic objective is unlike any other initiative because culture is transmitted across time and generations. Cultural elements are transmitted to a variety of other people, such as, coworkers, colleagues, and family members (Bohannan, 1995). Some of the characteristics of an ideal work culture would be: open minded; enjoyable environment; strong work ethic; holistic approach; team attitude; open communication; honesty; friendly, safe, supportive, convenient,

rewarding, encouraging, organized, well supplied, open to change, stable, caring concern, diversity, and responsible for good leadership (Stubbelfield, 2005).

Organizational culture is perhaps the single most powerful force for cohesion in the modern organization. Culture is essentially a common way of thinking, which drives a common way of acting on the job or producing a product in a factory. Usually these shared assumptions, beliefs, and values are unspoken-implicit. Yet in their silence, they can make the difference for a company between success and failure; and for the individual, they can make the difference between commitment and disaffection, between joy on the job and drudgery. Culture, then, is about sustainability. No business strategy or program can or will succeed without the appropriate organizational culture in place. Even the most expensive and elegantly designed building cannot stand without a sound infrastructure of beams and girders; "organizational culture is that underlying [infrastructure]" (Goffee and Jones, 1998).

Another proposed definition of organizational culture includes that which is valued, the dominant leadership style, the language and symbols, the procedures and routines, and the definitions of success that characterizes an organization. Organizational culture represents the values, underlying assumptions, expectations, collective memories, and definitions present in an organization (Schein, 1992; Cameron & Quinn, 1999).

This present work defines organizational culture as a system of information composed of ideas, assumptions, values, beliefs, and norms that connect members of a group together. In the course of adapting to problems posed by the physical and social environments, culture is reflected in the persistent and patterned way of thinking about the central tasks of, and human relationships within, an organization. As such, culture serves as a set of standards that guide prescriptively and proscriptively the behavior of members of the organization.

Importance of organizational culture to strategic success

Culture drives the organization and its actions. It is somewhat like the operating system of the organization. It guides how employees think, act, and feel. It is dynamic and fluid, and it is never static (Hagberg and Heifetz, 2000). The Culture of Excellence would engage employees who ask, "What do I need to do to be the best?" and thus become change agents without needing specific guidance from leadership.

The central issue associated with organizational culture is its linkage with organizational performance. Connections between organizational culture and performance have been well established (Hofstede, Neuijen, Ohayv, Sanders, 1990; Briley & Aaker, 2006). An increasing body of evidence supports a linkage between an organization's culture and its business performance (Cameron & Quinn, 2005). In the business arena, literature has shown evidence of companies that put emphasis in key managerial components, such as customers, stakeholders, employees, and leadership, outperform those that do not have these cultural characteristics (Kotter & Heskett, 1992; Wagner & Spencer, 1996).

Not until the beginning of the 1980s did organizational scholars begin paying serious attention to the concept of culture (Deal & Kennedy, 1982). The reason organizational culture was ignored, as an important factor in accounting for organizational performance is that it refers to the assumed (i.e. taken for granted) values, underlying assumptions, expectations, collective memories, and definitions present in an organization. It reflects the usual way of doing one's job, or the way things are done "around here". It reflects the prevailing ideology that people carry inside their heads. It conveys a sense of identity to employees, provides unwritten and, often unspoken guidelines for how to get along in the organization, and enhances the stability of the social system that they experience. Managers and scholars ignored culture for so long because it

is undetectable most of the time. Unfortunately, people are unaware of their culture until it is challenged, until they experience a new culture, or until it is made overt and explicit through, for example, a framework, or model (Cameron and Quinn, 1990). Organizations can no longer ignore their culture.

The contention is that policy and protocol are not what makes the organization successful, rather it is the organizational culture. It is the implementation of these polices by the staff/employees, which then allows every individual employee to see that the good of the organization is in their hands and they go beyond the rote of the policy and the procedure by seeking to serve the customer and the organizational goals to the best of their abilities. They no longer iterate the mantra of "this isn't my job" or similar statements.

> Without another kind of fundamental change, namely a change in organizational culture, there is little hope of enduring improvement in organizational performance. Although the tools and techniques may be present and the change strategy implemented with vigor, many efforts to improve organizational performance fail because the fundamental culture of the organization remains the same; i.e., the values, the ways of thinking, the managerial styles, the paradigms, and approaches to problem solving. . . When the culture of organizations was an explicit target of change, so that the initiatives were embedded in an overall culture change effort, the initiatives were successful. Organizational effectiveness increased. Culture change was key (Cameron & Quinn, 1999, p. 9).

The father of modern management, Peter Drucker, concluded that, "We are in one of those great historical periods that occurs every 200 or 300 years when people don't understand the world anymore and the past is not sufficient to explain the future" (Childress & Senn, 1995 pg 22). Unremitting, unpredictable, and sometimes alarming change makes it difficult for any

organization or manger to stay current, to predict accurately the future, and to maintain constancy of direction. The failure rate of most planned organizational change initiatives is dramatic. It is well known, for example, that as many as three quarters of reengineering, Total Quality Management (TQM), strategic planning, and downsizing efforts have failed entirely or have created problems serious enough that the survival of the organization was threatened (Cameron, 1997). The reported reasons for not succeeding are what are most interesting about these failures. Several studies reported that the most frequently cited reason given for failure was a neglect of the organization's culture. In other words, failure to change the organization's culture doomed the other kinds of organizational changes that were initiated (CSC Index, 1994; Caldwell, 1994; Gross, Pascale, & Athos, 1993; Kotter & Heskett, 1992 as cited in Cameron & Quinn, 1999).

Paradoxically, organizational culture creates both stability and adaptability for organizations. It creates stability by being the glue that holds the organization together. Culture reinforces continuity and consistency in the organization through adherence to a clear set of consensual values. Culture also fosters adaptability by providing a clear set of principles to follow when designing strategies to cope with new circumstances (Hagbert and Heifetz, 2000) Core competence and strategic intent are prerequisites to organizational adaptability, and both are grounded squarely in the organization's unique culture (Prahalad and Hamel as cited by Cameron and Quinn, 1999).

The NCR serves as a prime example of a similar and perplexing issue facing every large corporation that must merge with another large organization. How can the MHS consolidate three major medical centers, a large community hospital, and numerous ambulatory health clinics without sacrificing the continuity of care, without decreasing the appropriate level of access, and

without decreasing the overall level of patient satisfaction? The answer: develop a culture that values excellence that transcends the plethora of situations and issues that confound every merger.

Application to Health Care Facilities

Evidence continues to accumulate that both organizational culture and climate are pivotal factors in organizational outcomes. Within healthcare organizations, these constructs have important effects on health services outcomes, including patient quality of care indicators (e.g., HEDIS). The more clearly the leadership articulates cultural aspects to employees, the more cohesive, and stable the workers' collective behavior will be. Likewise, if the organizational culture is not well communicated, the greater the inconsistency in the performance of work, (e.g., delivery of care, safe work practices and teamwork) (Gershon, Stone, Bakken, Larson, 2004). Structural change alone does not deliver improvements in quality and performance in health care. Therefore, cultural change must occur alongside structural change in order to deliver improvements in quality and performance. The United States Institute of Medicine and the United Kingdom's National Health Service both support cultural reform as a strategic objective (Scott, Mannion, Davies, Marshall, 2003).

Scott *et al.* (2003) made an effort to review the quantitative instruments available to health service researchers who want to measure culture and cultural change. They identified thirteen instruments that satisfied their inclusion criteria, of which nine had a record of application in studies involving health care organizations. Following the collection, the researchers posited some conclusions. A range of instruments with differing characteristics are available to researchers interested in organizational culture, all of which have limitations in terms of their scope, ease of use, or scientific properties. The leadership team's concept of

organizational culture, the purpose of the investigation, the intended use of the results, and the availability of resources determines the choice of instrument.

Measuring Organizational Culture

The DHCN command team recognized that the DHCN needed a change in culture in order to achieve its access, patient satisfaction, and quality goals. One critical aspect of any initiative is ascertaining the existence, the extent, and the direction of the change from before and after the initiative. The question remains about how the leadership can identify if the Culture of Excellence exists and to what extent. Discerning this measure is the intent of this paper.

In discerning an organizational measure, the literature addresses some assumptions. First, the command team can measure organizational cultures quantitatively based on answers of organizational members to written questions, rather than only being described qualitatively. In operational terms, the issue is that membership in one organization rather than another explains a significant share of the variance in members' answers to questions dealing with culture-related matters. Second, executable and independent dimensions can be used to measure the organizational culture, and these dimensions relate to what is known about organizations from existing theory and research. Third, unique features of the organization in question, such as its history, contribute to the measurable differences among the cultures of different organizations. It is also possible to determine the extent to which these unique features reflect other characteristics of the organization, like its structure and control systems, which in themselves may have been affected by culture. Hypothetically, nationality, industry, and task, predetermine, in part, organizational cultures. These factors should be visible in significant levels of culture dimension

scores. (Hofstede, Neuijen, Ohayv, Sanders, 1990) Within the hospital industry, professional affiliation also plays a role in the organizational culture and subcultures.

Just as groups go through a well-known sequence in their development, known as forming, storming, norming and performing, so do corporate cultures. Indeed, the development of behavioral norms is at the very heart of culture (Furnham and Gunter 1993). Cultural assessment can provide measurable data about the real organizational values and norms that can be used to get management's attention. It can dispel some of management's illusions about what really matters in the organization and will tell them how far off the mark things really are. Management may discover that it is not practicing what it preaches (Hagberg and Heifetz, 2000).

Cultural assessment can enable a company to analyze the gap between the current and desired culture. Developing a picture of the ideal and then taking a realistic look at the gaps is vital information that can be used to design interventions to close the gaps and bring specific elements of culture into line. Understanding and assessing the DHCN's organizational culture means the difference between success and failure in the healthcare environment. In reality, what management pays attention to and rewards is often the strongest indicator of the organization's culture. These actions must be congruent with the values it verbalizes or the ideals for which it strives. A thoughtful assessment of the culture can facilitate the alignment of values and strategic goals across subcultures (Hagbert and Heifetz, 2000),

Organizations need to measure important factors. Measurement is based on tracking and using indicators to evaluate the current results based on data; take action to improve results; closely monitor results; report on what works and what does not. When the leadership combines clear goals with consistent measurement and aligned behaviors, results start to come. What gets measured gets done (Studer, 2003; Stubbelfield, 2005). Measure often enough so the leaders can

reward and recognize promptly after behaviors occur. By measuring often, process improvement increases and the hospital becomes a better organization as evidenced by every measure of effectiveness.

The usefulness of a quantitative approach is that it makes an otherwise nebulous concept accessible. Organizational cultures are gestalts which can only be completely experienced by insiders and which demand empathy in order to be appreciated by outsiders. However, in a world of hardware and bottom-line figures, a framework allowing the description of the structure in these gestalts is an asset. Practitioners can use it to create awareness of cultural differences, for example, in cases of planned mergers of culturally different units (as is happening in the NCR with the JTF CAPMED). It also allows comparisons to be made with other organizations, it can suggest the cultural constraints that strategic planners will have to respect. It allows measurement of culture change over time. Organizational cultures reflect nationality, demographics of employees and managers, industry and market; they are related to organization structure and control systems; but all of these leave room for unique and idiosyncratic elements. (Hofstede, Neuijen, Ohayv, Sanders, 1990)

Proxy measures

The word *proxy* means in the stead of, or on someone's behalf. In this case, the word *proxy* is applied to a measurement tool. This work uses the term p*roxy measure* with the connotation that any measurement tool that the organization uses to gather data about some aspect of the organization's performance that is not a specific measure of the culture and cannot be said to be a culture measure, that measure could be correlated to some facet of the culture and *approximate* the existence and extent of said culture facet. Therefore, the aforementioned

measure is a *proxy measure* for culture. Since these *proxy measures* do not directly measure the culture, a measure that **does** directly measure culture is best suited as the metric for analysis of the organization's culture. However, such a specific measure does not discount the usefulness of a *proxy measure* in corroborating the culture and identifying effects of the culture on the organization's performance, which is the whole point of a cultural assessment.

For example, as the Army Provider Level Satisfaction Survey (APLSS) does not measure culture directly, it cannot be said to be a culture measure *per se*. However, since patient satisfaction is affected by the culture of the organization, analysis of patient satisfaction data might lead to assumptions about the organizational culture. Such assumptions would hold some validity because of the research that has affirmed the correlation. Therefore, the APLSS is an organizational culture *proxy measure*.

Every system and organization has inputs – a process – and then an output. These proxy measures are designed to measure the quality of the output. The culture is assessing the reality of the process based on those in, and a part of, the process. The other proxy measures are based on the employees or the customers' perception of the output. The strategic value of the Culture of Excellence is the impact culture will have on the outputs. As stated before, the outputs have changed significantly, but the observation of the commander is that the culture has not changed. As the Culture of Excellence is pursued, that is, the process is manipulated; the leadership monitors this change using both a measure of the process, and measures of the outcomes. Monitoring both sets of measures will enable full-spectrum deductive analysis.

Most of the proxy-measures, or the measures of the outcomes, are already in use by the DHCN (or its hierarchy) and will not be discontinued. These measures are valuable tools because they do measure well the things they are designed to measure. These measures provide an

abundance of strategically important data, none of which directly indicates anything about the culture. These measures reflect the culture's impact on the outputs. A direct measure of the culture, such as the OCAI, is not beneficial in and of itself. The culture may change, for example from a Hierarchy to a Marketrocracy, but that does not necessarily mean that the outputs have adjusted in a strategically advantageous way. The data from the process (culture) measure and the outcomes measures are best used collectively, and correlated, one to the other. Other measures may be beneficial to use in conjunction with OCAI in order to *best* account for the organizational culture. For these aforementioned reasons the proxy measures are discussed in this work, that is, 1) to identify the measure's usefulness in the strategic plan of the DHCN, and 2) to discuss why the measure is insufficient as a culture measure but is still an integral part of the culture analysis.

Culture assessment tools have been in use for over ten years within the DoD for assessing safety and the safety culture. The DoD wants safety to be instinctive with every member of the DoD. The culture of safety is not the same as a safety climate. Climate is a function of the employees' reaction to the leadership and its policies, whereas culture is a function of the employees' internalization of the spirit of the policies and the organizational values. The DoD is trying to ascertain to what level of the organization and its subordinate units, the safety message has permeated and if the message has become internalized by each individual within the organization. Each service utilizes a Safety Culture assessment. From these efforts then, it is logical to deduce that culture can be assessed and acted upon.

The AMEDD and the DoD have some other tools, already in use, that meet the recommended criteria. Each measure of the organization's performance can be analyzed for its potential of evaluation of changes in the culture of the organization. The AMEDD's Customer

Satisfaction Survey (CSS), the Army Provider Level Satisfaction Survey (APLSS), tracking of quality standard compliance i.e. Health Care Employer Data Information Set (HEDIS) and The Joint Commission's (TJC) Oryx measures, as well as comparison with other military, federal, and civilian institutions. Perhaps one of the already in use measures could be applied to the culture of the organization in order to show areas for improvement and track progress in pursuit of a Culture of Excellence.

The results will not be pure nor used exclusively to monitor culture but with comparison, can be evaluated in the light of the shift in culture and can be supportive evidence. The Baptist Healthcare System used a patient satisfaction survey that it developed with special attention to the culture of the organization (Stubbelfield, 2005). However, as it used this survey as a basis for employee evaluations and awards, they did not specify the survey questions or how exactly that displayed a culture shift. Instead, anecdotes of incidents that related a particular positive experience by a patient were used as evidence of the culture. In the case of the DHCN, a change in culture could potentially manifest as higher patient satisfaction scores, improved HEDIS or ORYX, and access. Using such measures alone to measure culture would yield a false positive, a type II error.

Measures of effectiveness and efficiency such as that used by the Agency for Healthcare Research and Quality's (AHRQ's) Consumer Assessment of Health Providers and Systems Hospital Survey (HCAHPS), (Schoen, 2006) could also be used as proxies of culture assuming that the scores improve as the Culture of Excellence becomes imbedded.

Patient Satisfaction

Patient satisfaction is primarily used by healthcare institutions as a key indicator for the quality of care delivered; however, it has become a widely used tool to determine patients' perceptions of the care they received. Patient satisfaction has also developed into a marketing tool in an effort to gain market share in an increasingly competitive business environment.

Patient satisfaction scores are commonly used as outcome measures for the quality of health care delivery. As such, satisfaction is typically assessed with the use of various attitude surveys, instruments, and inventories. Many satisfaction studies lack a solid theoretical framework that has limited the ability to explain variability in satisfaction and its determinants (Mangelsdorff and Finstuen, 2003)

Army Provider Level Satisfaction Survey

APLSS is a customer-based assessment of several areas of medical care, to include access, timeliness, attentive listening, understanding of problems, courtesy and respect, explanation of matters, quality of care and overall satisfaction of medical care and service. The Office of the Surgeon General (OTSG) mails APLSS surveys to a sample of Army patients throughout the world to ask how Army providers and facilities are meeting the needs of the patients they serve, related to a single outpatient appointment.

Both the CSS and the APLSS have two shortcomings. First, though the measure appears comprehensive, the phraseology does not incline itself to the dedication of the staff as it does with the outcome of the encounter. The second is based on the first. The surveys are self-reported by the patient, and the patient's expectations or perceptions of an event do not reflect, per se, the

efforts of the staff to ensure high quality, compassionate, safe, efficient, and effective care in a timely manner. In other words, these are measures of perception and not necessarily of reality.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. MEDCOM and MTFs use HEDIS results to see where they need to focus their improvement efforts. The goal is for each MTF in the AMEDD to exceed the 90th percentile on publicly reported HEDIS performance quality measures. MTFs that reach the 50th or 90th percentiles on any measure are rewarded quarterly under the Performance Based Adjustment Model (PBAM).

The seven HEDIS measures MEDCOM adopted are (a) the percent of eligible population with mammograms, (b) the percent of eligible population with asthma on long term controller medications (c) the percent of eligible population with diabetes with AIC testing, (d) the percent of eligible population with diabetes with AIC <9, (e) the percent of eligible population with Diabetes with LDL <100, (f) the percent of eligible population with cervical screening, and (g) the percent of eligible population with colo-rectal exam.

Tricare ORYX measures

The Joint Commission (TJC) worked with the Center for Medicare and Medicaid Services (CMS) to match its slate of ORYX measures with those compiled by the federal government and promoted by Medicare quality improvement organizations. The CMS-backed measures serve as performance guideposts for hospitals independent of the reporting initiative.

The ORYX initiative represents one of TJC's first steps in focusing the accreditation process on key patient care, treatment, and service issues. Using ORYX as a tool, TJC has been changing the accreditation process from one in which health care organizations take a *snapshot* of their performance every three years to one in which they have more of an ongoing picture of their performance from which to focus their quality improvement activities.

Effective with January 1, 2004, discharges, accredited hospitals with an average daily census of greater than ten must select three core measure sets from the listed performance measurement systems that meet TJC's requirements for inclusion in the accreditation process. If the hospital serves patient populations with conditions that correspond with only two core measure sets, the hospital must collect data on all of the applicable measures in the two core measure sets along with three non-core measures. A hospital that can only identify one core measure set related to its patient population must collect data on all the applicable measures in that core measure set along with six non-core measures. Both core and non-core data will be submitted via the selected measurement system. A hospital that cannot identify any applicable core measure sets will collect and transmit data on nine non-core measures via its selected measurement system.

Behavioral health care and home care (which DHCN provides to eligible beneficiaries) are encouraged to consider taking advantage of the option to participate in non-core measurement with a listed measurement system and submitting ORYX performance measure data to The Joint Commission, until such time that relevant core measures are identified and implemented by The Joint Commission. Participation in a listed performance measurement system will provide comparative data that may not otherwise be readily available and help facilitate ongoing compliance with performance measurement and improvement requirements.

Command Climate Survey

The Command Climate Survey is a mandatory survey conducted and maintained by the company level unit commander within 90 days of assuming command and at least yearly thereafter. The Command Climate Survey is a fully automated, self-contained, survey program. It is designed to assist the company (or equivalent-sized unit) commander in assessing and developing action plans for sustaining and improving his or her unit command climate, as required. The survey is brief, yet comprehensive, consisting of 24 basic questions on a variety of topics and 2 comment questions, which address 20 command climate areas. In addition, the unit commander can add up to 10 optional unit-specific questions.

Climate factors such as leadership, cohesion, morale, and the human relations environment have direct impact on the effectiveness of the organization. Military company commanders use a variety of mechanisms to assess the attitudes, opinions, and state of readiness of the soldiers within their command. These include everyday observations, one-on-one conversations, staff/unit meetings, sensing sessions, unit records, and surveys.

Two things limit the Command Climate Survey. First, it is geared toward the military personnel and the relationship with a command that has direct authority over them. Second, the command climate survey measures climate, which is not the same construct as culture. Altering the climate survey does not assess culture.

Nurse-provider relationship survey

Healthcare organizations have an industry unique professional dynamic in that the teamwork required by nurses and providers can significantly affect the quality of care (Gershon R., Stone P., Bakken S. & Larson E., 2004). In addition, the healthcare professional is sometimes

more loyal to the profession than to the organization and may behave contrary to the best interests of the organization if such behavior is beneficial to the individual professionally. Many surveys, such as the Nursing Work Index (Hafner, L.P. and Kramer M., 1989), exist to measure this dynamic though none are currently used by the DHCN.

Employee satisfaction survey

A validated employee survey correlated with a validated patient satisfaction survey could be adequate measures of culture in an organization (Scotti, 2007). Literature has shown that satisfied employees perform at higher levels than those who are not. The satisfaction of the employee has been correlated to the organizational culture in that new employees will witness the culture and usually buy into it. Unsatisfied employees often act in their own best interests, whether or not it is complementary to the interests of the organization. In addition, the employee survey can be compared to patient satisfaction and quality measures. The cultural survey can then be compared to the employee satisfaction results to see how each varies per iteration over time.

By US federal statute, every agency of the Federal Government to include the AMEDD has conducted employee satisfaction surveys. These surveys have been shown to be reliable and valid. Federal law requires that certain federal organizations conduct an employee satisfaction survey at least once a year. These surveys can correlate to a positive or negative culture, or whether the employees like or do not like the current culture. These surveys offer neither specifics nor any predictive or actionable information other than their primary purpose of employee satisfaction. The organizational culture is a determinate of employee satisfaction.

Organizational Culture Assessment Instrument

Description

Cameron and Quinn (1999) developed the Organizational Culture Assessment Instrument (OCAI) that is used to identify the organizational culture profile based on the core values, assumptions, interpretations, and approaches that characterize organizations. The purpose of the OCAI is to assess six key dimensions of organizational culture. The instrument is most helpful for determining ways to change the culture.

The OCAI is built upon a theoretical model called the "Competing Values Framework."

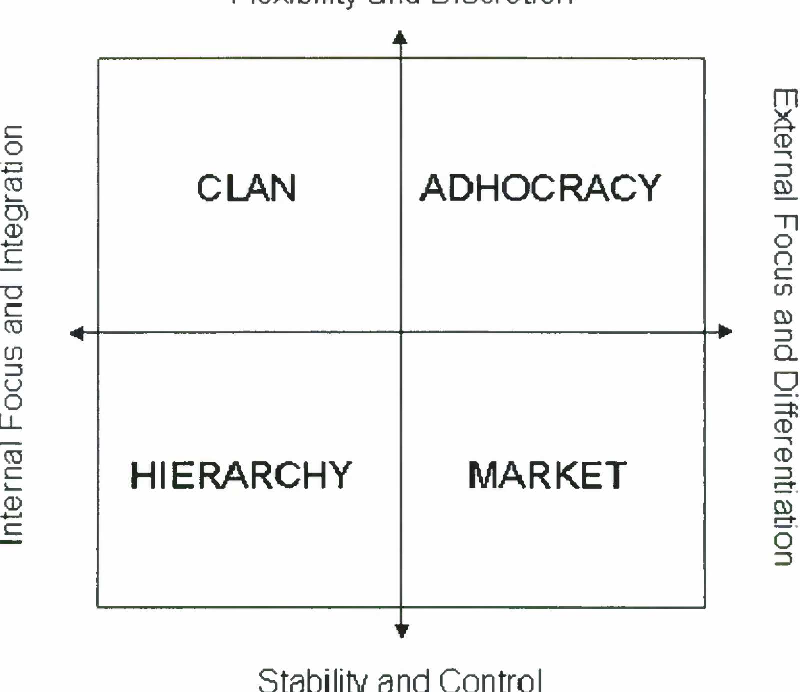

Figure 1. Illustration of the competing values framework depicting the four "types" with their associated characteristics. This figure shows the values that predominate and also that the values can overlap and be evidenced to varying degrees within an otherwise dominant type. This is the framework on which Cameron and Quinn base the culture profile.

Reference: Cameron, K. S, & Quinn. R. E. (1999) Diagnosing and Changing Organizational Culture. Addison-Wesley. Reading, HA

This framework refers to whether an organization has a predominant internal or external focus and whether it strives for flexibility and individuality or stability and control. The empirically derived Competing Values Framework has been found to have both face and empirical validity, and helps integrate many of the dimensions proposed by various authors. In brief, the Competing Values Framework has been found to have a high degree of congruence with well-known and well-accepted categorical schemes that organize the way people think, their values and assumptions, and the ways they process information. The competing values framework can be used in constructing an organizational culture profile. Using the OCAI and the competing values framework an organizational culture profile can be drawn by establishing the organization's dominant culture type characteristics. In this respect the overall culture profile of an organization can be identified.

The OCAI consists of six questions. Each question has four alternatives. The respondent is asked to divide 100 points among these four alternatives depending on the extent to which each alternative is similar to the respondent's own organization, giving a higher number of points to the alternative that is most similar to your organization. For example, in question one, if the respondent thinks alternative A is very similar to their organization, alternative B and C are somewhat similar, and alternative D is hardly similar at all, the respondent might give 55 points to A, 20 points to B and C, and five points to D. The total just has to equal 100 points for each question when the inventory is completed. The first pass through the six questions is labeled *Now.* This refers to the culture, as it exists today. After the respondent completes the *Now* portion, the questions repeat under a heading of *Preferred.* The respondent should base answers to these questions on how the respondent would like the organization to look five years from now (Cameron & Quinn, 1999).

The OCAI uses a type of scale called the *ipsative rating scale* in which respondents divide 100 points among 4 alternatives in 6 sections. The ipsative scale differs from a Likert scale in that the respondent is able to both tell the existence and the importance or prevalence of the particular item. Additionally, the respondent must consider the tradeoffs that exist in any organizational culture. Each answer in a section is dependent on the other three answers Many organizational culture studies have used the Likert scale. Generally, respondents either respond very high or very low. The ipsative rating scale allows the respondent more discretion in the response and still demands the respondent to make some determination on each choice. The respondent cannot answer all low, or all high. In addition, unlike open-ended questions where the respondent's answers may have little convergence, the ipsative rating scale allows the respondent to place value and express opinion more so than the Likert scale, and yet all answers are limited within the scale and thus must have some parameters and convergence.

The OCAI is easy to score using simple arithmetic. The administrator graphs the totals using a radar (spider web) graph. The graph, like a culture compass, points to the dominant culture type. The highest score is the most dominant culture type. Six comparisons can be made from the results of the OCAI. The first comparison is the type of organizational culture. The second is the discrepancies in the culture of levels of personnel and work centers. The third comparison is about the strength of the culture. The fourth comparison is congruence of the current and preferred culture with the organization's strategic ends. The fifth comparison is with the thousands of other organizations that have applied the OCAI to their respective organizations. The sixth comparison is with internal and external trends from 20 years data.

The culture framework is assembled into six organizational culture dimensions and four dominant culture types. The culture dimensions are (a) Dominant characteristics, (b)

Organizational Leadership, (c) Management of Employees, (d) Organizational Glue, (e) Strategic Emphases, and (f) Criteria for Success. The Four culture types are Clan, Hierarchy, Adhocracy, and Market.

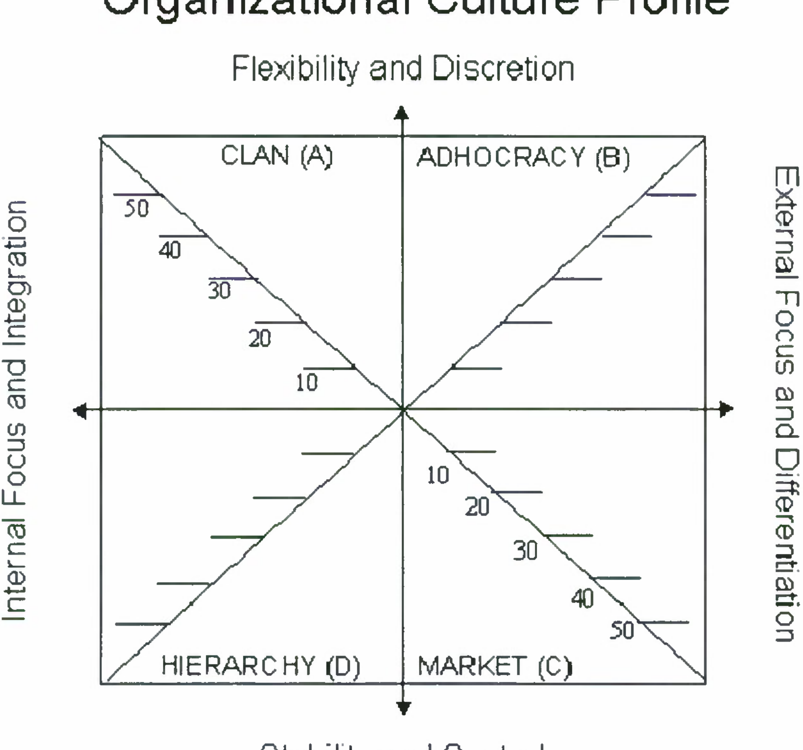

Figure 2. Illustration of Cameron and Quinn's (1999) culture profile matrix. The four primary culture profiles are founded on the competing values framework which provides each profile with its associated characteristics. Each profile has some characteristics that predominate and also characteristics that overlap and can be evidenced to varying degrees within an otherwise dominant type. The graph provides the method to determine an organization's culture type by observing the greatest peak in the resultant quadrangle.

Reference: Cameron, K. S, & Quinn, R. E. (1999) Diagnosing and Changing Organizational Culture. Addison-Wesley. Reading, HA

Dominant characteristics of the organization are what comprise the overall organizational culture profile. Organizational Leadership is the leadership style and approach that permeates the organization. Management of Employees is the style that characterizes how employees are treated and what the working environment is like. The organizational glue is the bonding mechanisms that hold the organization together. The strategic emphasis defines what areas of emphasis drive the organization's strategy. The criteria for success determine how victory is defined and what is rewarded and celebrated (Cameron and Quinn, 2005).

The Clan type is an organization that concentrates on internal maintenance with flexibility, concern for people, and sensitivity for customers. The Hierarchy type is an organization that focuses on internal maintenance with a need for stability and control. The Adhocracy type is an organization that concentrates on external positioning with a high degree of flexibility and individuality. The Market type is an organization that focuses on external maintenance with a need for stability and control (Cameron and Quinn, 2005).

Applicability

Almost all organizations develop a dominant type of organizational culture. They tend to emphasize one or more of the four culture types above others: Adhocracy, Clan, Hierarchy, or Market cultures. Particular types of cultures form because of certain values, assumptions, and priorities becoming dominant as the organization addresses challenges and adjusts to changes. These dominant cultures help the organization become more consistent and stable as well as more adaptable and flexible in dealing with its rapidly changing environment. Whereas these culture types tend to evolve in predictable ways over time, organizations face the need to change cultures in connection with many other forms of organizational changes (Cameron and Quinn,

1999). The strengths of the OCAI is that it is simple and quick to complete, has high face validity, has been used in several studies in health settings, has a strong theoretical basis, and assesses both congruence and strength of culture. It is also able to detect sub-cultures within the larger organization.

Reliability and Validity

The validity and reliability of the OCAI has been substantiated by use in a multitude of studies since its first appearance in 1996.

Reliability refers to the extent to which the instrument measures culture types consistently. No less than four studies in 1991 tested the reliability of the OCAI with more than 12,000 respondents in 1200 different public and private business and educational institutions. Chronbach's Alpha for the four types is .82 for Clan reliability, .83 for Adhocracy, .78 for Market, and .76 for Hierarchy. Sufficient evidence exists then that the OCAI meets or exceeds the reliability of other culture measurement instruments.

Validity refers to the extent to which phenomena that are supposed to be measured are actually measured. In other words, does the OCAI really measure the four types of organizational culture as it claims? Tests for convergent validity and discriminate validity were conducted using a multitrait-multimethod analysis and a multidimensional scaling analysis (Quinn and Spreitzer, 1991). All diagonal correlation coefficients were statistically different from zero ($p < .001$) Additional studies have been conducted and no contradictory disconfirmatory evidence has been produced (Cameron and Quinn, 2005).

Value added to DHCN – The Culture of Excellence Pyramid

The Culture of Excellence can be measured using the Organizational Culture Assessment Instrument. The value of using the OCAI is illustrated in the Culture Pyramid. The pyramid's levels build on each other however, they are neither mutually independent nor totally distinct from each other, are not independent of each other, and are not truly distinct one from the others. Each level relies on every other level, and feeds, as it were, from the others levels

Figure 3. Organizational Culture Pyramid

The Culture of Excellence forms the foundation because culture is formed from the values of the organization and of the people who work in and for the organization. The OCAI is

based on the Competing values framework. This assessment allows the command team to assess the culture directly.

Literature on organizational culture stresses the importance of employee satisfaction in the organization in order to achieve the organization's mission in accordance with its vision and goals (Scottie & Harmon, 2007; Stubblefield 2005; Studer 2003). Satisfied (i.e. happy/content) employees lead to better work performance. Satisfaction of the employees is an indicator of the culture and relative to assessing the quality of care given to patients and the quality of all other work performed for both internal and external customers in the hospital. An employee satisfaction measurement instrument would be a key collaborative accompaniment to the OCAI.

Assessment of the measures of quality of care can reveal how satisfied the employees are and can also help form a more complete picture of the underlying culture. The HEDIS measures, Clinical Practice Guideline compliance, and Tricare ORYX measures are valid, reliable and already in use. Comparing these measures with the employee satisfaction survey, and the OCAI, could provide the command team with insight into where the culture needs to go to achieve the other goals of the organization.

The Culture of Excellence supports employee satisfaction, which produces quality work performance, which leads to patient satisfaction. Patient satisfaction is one of the principle objectives of the DHCN. The command team seeks to change the culture not to just meet a measurement objective but to provide for those who come through the doors the best the DHCN has to offer. Measures of access to care, template management, appointment line statistics, APLSS and the customer satisfaction survey all provide indicators of the quality of medical care, but do not show the internal customer service picture, or the quality of the multitude of other interactions that visitors, patients, employees have with all the other employees and patients and

other visitors. These interactions are difficult to measure easily or accurately. However, the employee satisfaction measure and the OCAI both support how people will interact with each other. These measures then are sufficient independently, and collectively, help to form as near a complete picture as possible. Without the OCAI, the picture becomes many parts without a unifying aspect. With the OCAI, the statistical picture becomes whole.

First iteration of OCAI in FHC establishing baseline for COE

The publisher granted permission to use the instrument for research that was not intended to earn the organization a profit (appendix). The OCAI was distributed to the Family Health Center (FHC) at the DACH. The FHC includes the Internal Medicine clinic, the Pediatric Clinic and the Family Care Clinic (primary care). The instrument was delivered electronically through e-mail and in hard copies to all personnel who worked in and for the FHC at DACH. 140 hard copies were distributed. Respondents were given an e-mail address to return electronically completed surveys. For those surveys completed on paper, respondents were instructed to return them to a common area receptacle.

Results of OCAI

Results

Scores

The scoring of the OCAI is relatively simple. The survey scores are tabulated, and then the averages are computed for the overall A, B, C and D for now and preferred. These eight numbers are graphed on a radar chart. 45 surveys were returned. Averages were then graphed as directed

Table 1. *Overall OCAI results for the Now and Preferred culture profiles*

NOW AVERAGES				PREFERED AVERAGES			
A	B	C	D	A	B	C	D
28.95	16.07	25.29	29.80	36.61	21.42	18.83	23.21

The OCAI was supplemented with a demographic sheet asking the respondent what type of employee one was, where the respondent worked, how long the respondent had worked at DeWitt and what position the respondent worked in at the FHC. These demographics allowed the researcher to develop additional information from the survey.

The respondent's employment type could be a military member, a civilian, or a contract employee. Of the responses received, 20% were military, 20% were contract employees and 60% were civilian. The total employees in the FHC are split at about 33% each. The demographic sheet provided a list of 14 positions in the FHC. An "other" alternative was offered in case the respondent did not think their position was listed. Licensed Practical nurses had the highest number of responses with 9 surveys. Administrative Assistants, Administrators, and the other category were collected together in order to be able to provide a sub-culture profile.

Scores for each demographic were averaged and graphed. This was done to compare each demographic's perception of the culture with the overall culture, i.e. how each aligns with the other. This is what allows for sub-culture identification, comparison, and analysis.

Charts

The esteemed statistician John W. Tukey, known for his test for honestly significant differences, Edward Tufte, Professor and published author, and Cameron and Quinn authors of the OCAI, share a common philosophy. The most effective way to interpret numbers is to plot them, draw pictures with them, chart them, or graph them in an easily discernable manner

(Cameron and Quinn, 2005). This is why the OCAI does not end with computation of averages. Graphing these averages allows for a depiction of the culture profile that would otherwise be indiscernible.

Each item on the survey corresponds to one of the four culture profiles. All A items correspond to the Clan culture, B to the Adhocracy culture, C to the Market culture and D to the Hierarchy culture. The radar graph is thusly divided into quadrants so as the scores are plotted, a four sided figure is formed, usually in the shape of a kite, more or less. The dominant side of the quadrangle is indicative of the most dominant culture. The extent to which other culture profiles are represented indicates attributes of those culture profiles within the organization. By graphing each A, B, C or D independently, one is able to discern greater detail of each non-dominant culture profile. Such detail provides leadership with actionable information.

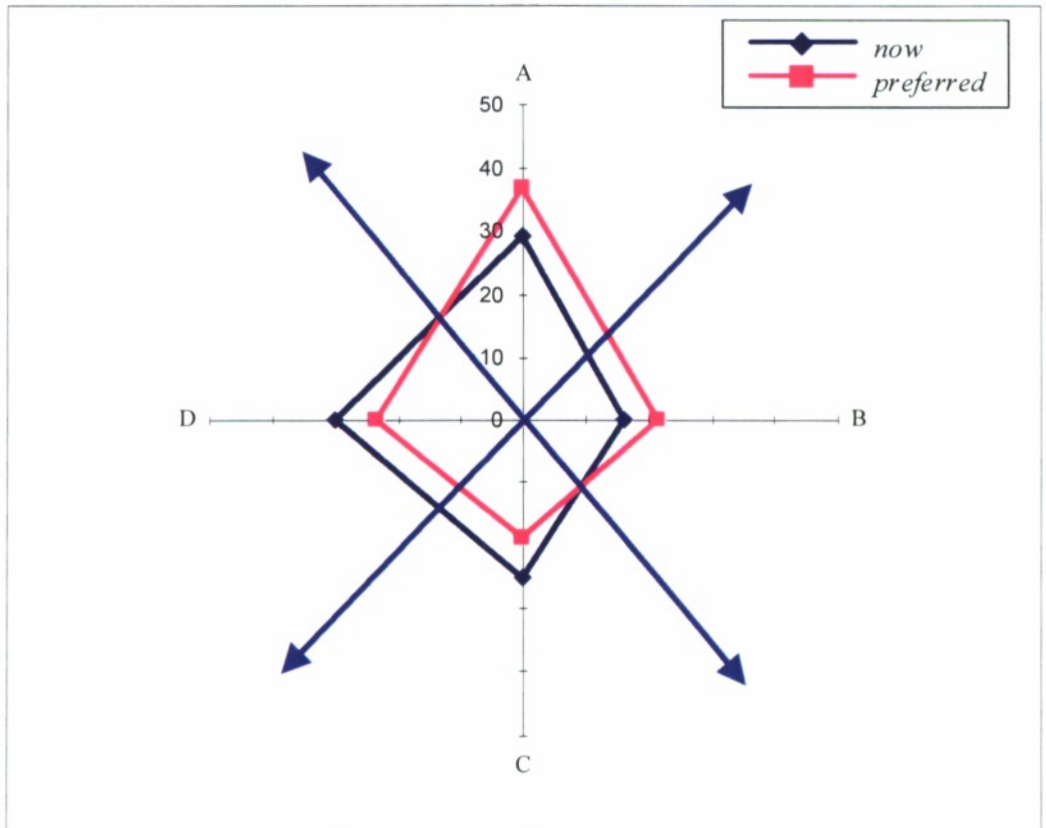

Figure 4. The overall results from all FHC respondents on all questions. The *now* culture profile is a Hierarchy, and the *preferred* culture profile is a definitive Clan. The overall *preferred* culture profile forms the kite shape that Cameron & Quinn identify as the ideal profile.

Culture type now and preferred

The researcher initially anticipated that the *now* culture would be either Hierarchy or Adhocracy and the *preferred* culture would be Clan. The final results, when graphed, depict that the current culture is a Hierarchy and the preferred culture is a Clan culture. The survey was only conducted in the FHC. So though the culture profile is accurate for the FHC, it may not be generalizable to the rest of the DHCN. The culture of the FHC may in fact be a subculture of the DHCN.

Profiles were computed for each of the following descriptors: years, work-center, duty position, and employment category. The sub-groups are illustrative of the FHC, but because of the small sample size, the profiles are not legitimately extrapolated to the rest of the DACH. Nonetheless, they do establish a baseline and indicate areas to change to bring about the Culture of Excellence.

Cameron and Quinn use a graph as described earlier to chart the results of the OCAI. In this project, the Microsoft program Excel was used to chart the results. Excel builds a radar graph in a diamond shape. The results chart the same as in Cameron and Quinn's chart, just turned 45 degrees clockwise (Table 2, figures 5 & 6). The excel graphs are more specific than could be created by hand, and thus, more reliable and valid. All subsequent graphs depicting the results were computed using the same process. Each graph is oriented the same and each is sized the same as the others for ease of comparison. For all graphs, a blue line with diamond markers represents the *now* culture profile and a pink line with square markers represents the *preferred* culture profile. The blue arrows approximate the vertical and horizontal sectional arrows as in the orientation of Cameron and Quinn's version.

Table 2. *Sample OCAI data used in the comparison graphs, Figures 5 and 6.*

Sample	Now	Preferred
A - Clan	27	31
B - Adhocracy	13	24
C - Marketocracy	30	23
D - Hierarchy	29	22

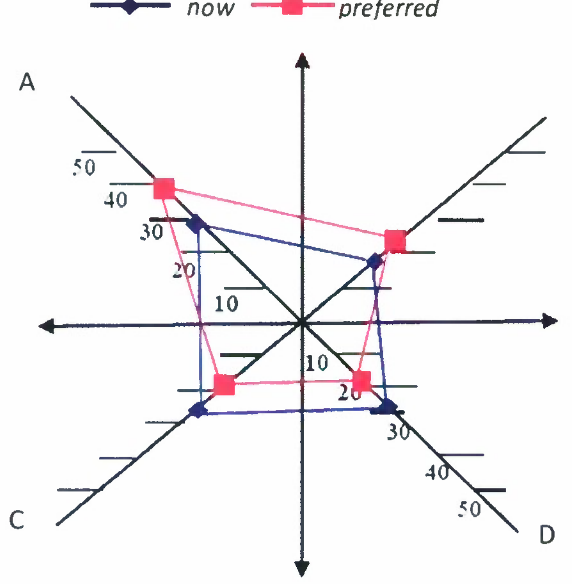

Figure 5. Using the same data as Figure 6 in a graph of OCAI data according to Cameron and Quinn. Line A-C and line B-D are the same length in each graph. This graph is intended as a comparison with the Microsoft Excel graph to demonstrate that the Excel graph is as good as the graph devised by Cameron and Quinn

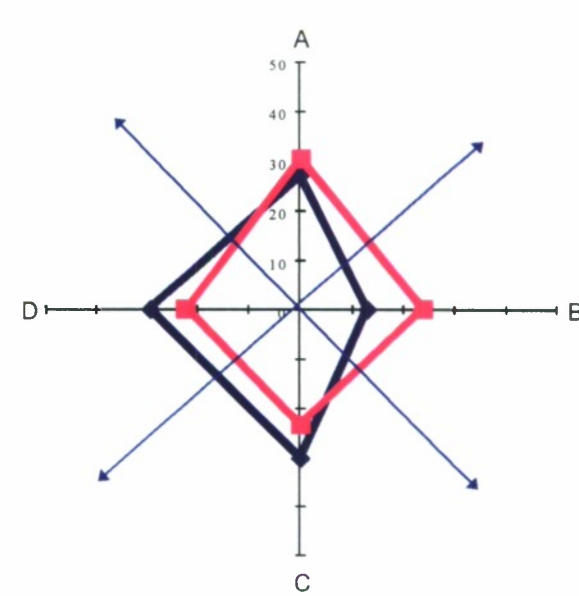

Figure 6. Uses the same data as Figure 5 in a radar graph constructed using Microsoft Excel. The line A-C and line B-D are the same length in each graph. This graph is intended as a comparison with the graph devised by Cameron and Quinn to demonstrate that the Excel graph is as good as the graph devised by Cameron and Quinn.

Table 3.

The OCAI results for results of all questions for all respondents and depicted in figure 7.

	Now	Preferred
A - Clan	29	37
B - Adhocracy	16	21
C - Marketocracy	25	19
D - Hierarchy	30	23

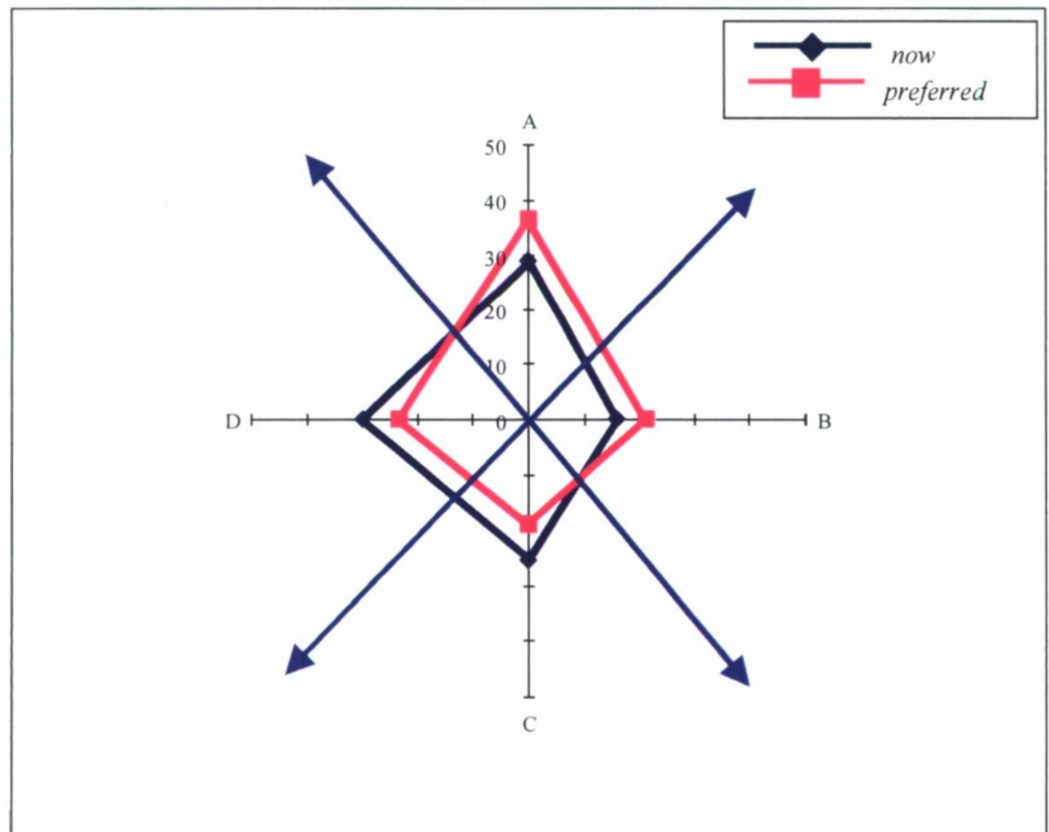

Figure 7. Depicts the *now* and the *preferred* culture profiles for the overall FHC on the total average of the OCAI. *The now* culture is a Hierarchy profile, and the *preferred* culture is a definitive Clan culture profile. This group of questions uses the *preferred* culture profile to clarify what future success looks like.

Table 4.

The OCAI results for the sub-culture of military members on active duty (type M) and depicted in figure 8.

Type M	Now	Preferred
A - Clan	29	38
B - Adhocracy	16	21
C - Marketocracy	26	18
D - Hierarchy	29	22

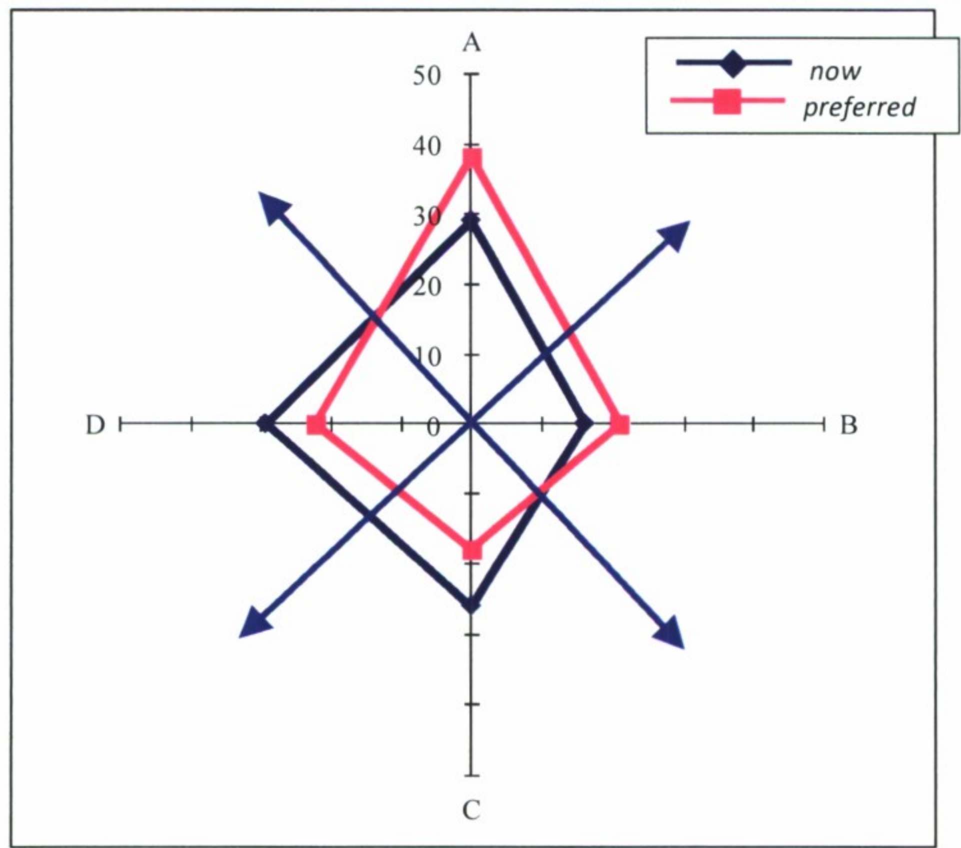

Figure 8. Depicts the *now* and the *preferred* culture profiles for the respondents identified as military members on active duty, coded M. The *now* culture is a Marketocracy with a strong Hierarchy profile, and the *preferred* culture is a Clan profile.

Table 5.

The OCAI results for the sub-culture of government civilians (type C) and depicted in figure 9.

Type C	Now	Preferred
A - Clan	*27*	31
B - Adhocracy	*13*	24
C - Marketocracy	*30*	23
D - Hierarchy	*29*	22

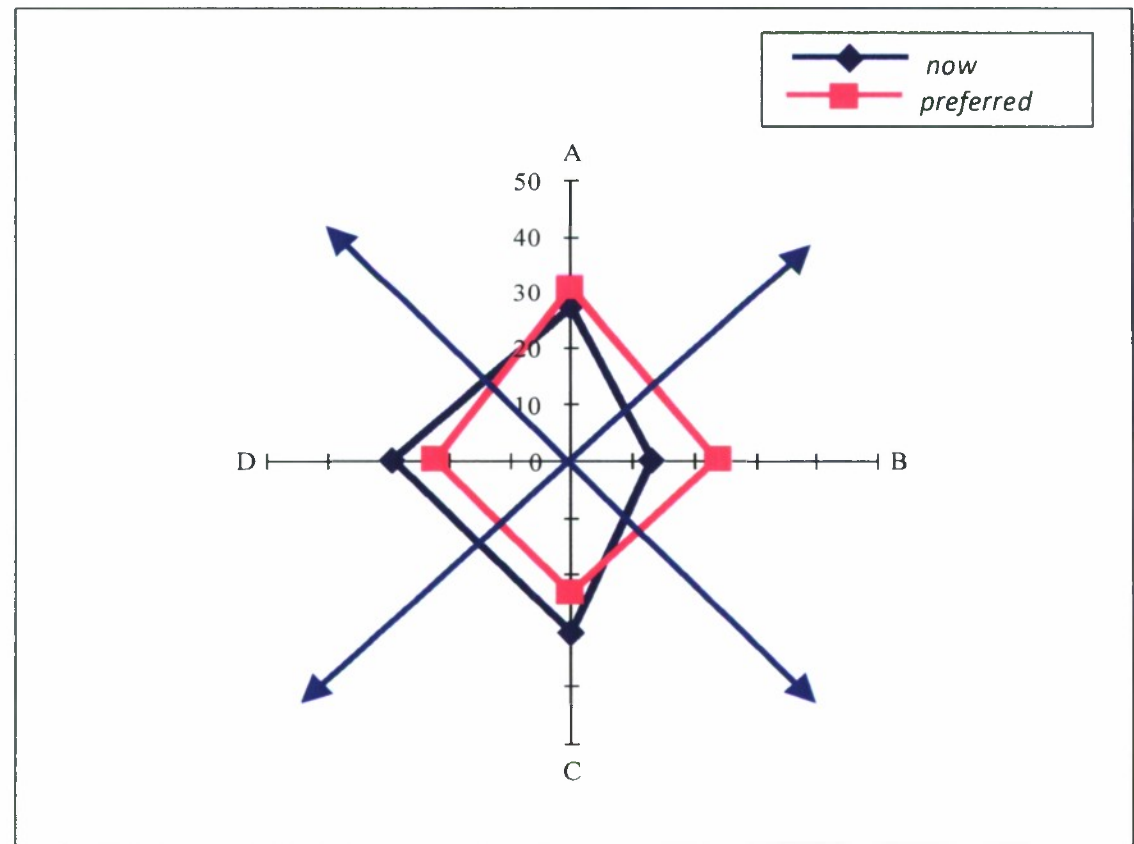

Figure 9. Depicts the *now* and the *preferred* culture profiles for the respondents identified as government civilian employees, coded C. The *now* culture is a Hierarchy profile with a very strong clan profile component, and the *preferred* culture is predominately a Clan profile.

Table 6.

The OCAI results for the sub-culture of contract personnel (type R) and depicted in figure 10.

Type R	Now	Preferred
A - Clan	31	38
B - Adhocracy	18	20
C - Marketocracy	20	16
D - Hierarchy	31	26

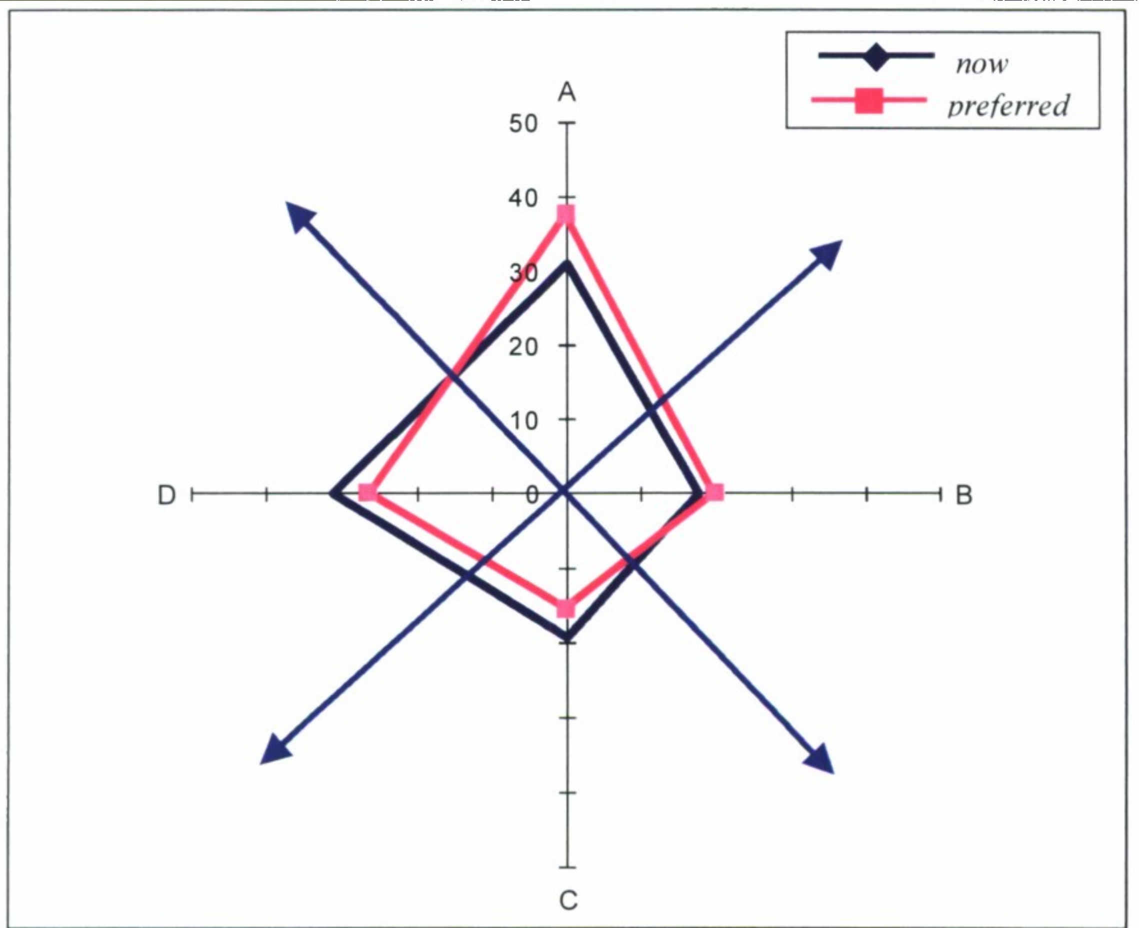

Figure 10. Depicts the *now* and the *preferred* culture profiles for the respondents identified as contract personnel coded R. The *now* culture is a mix of a Clan and Hierarchy profile, and the *preferred* culture is distinctively a Clan profile.

Table 7.

The OCAI results for the sub-culture of non-resident physicians (position A) and depicted in figure 11.

Position A	Now	Preferred
A – Clan	33	41
B – Adhocracy	11	21
C – Marketocracy	23	14
D – Hierarchy	33	24

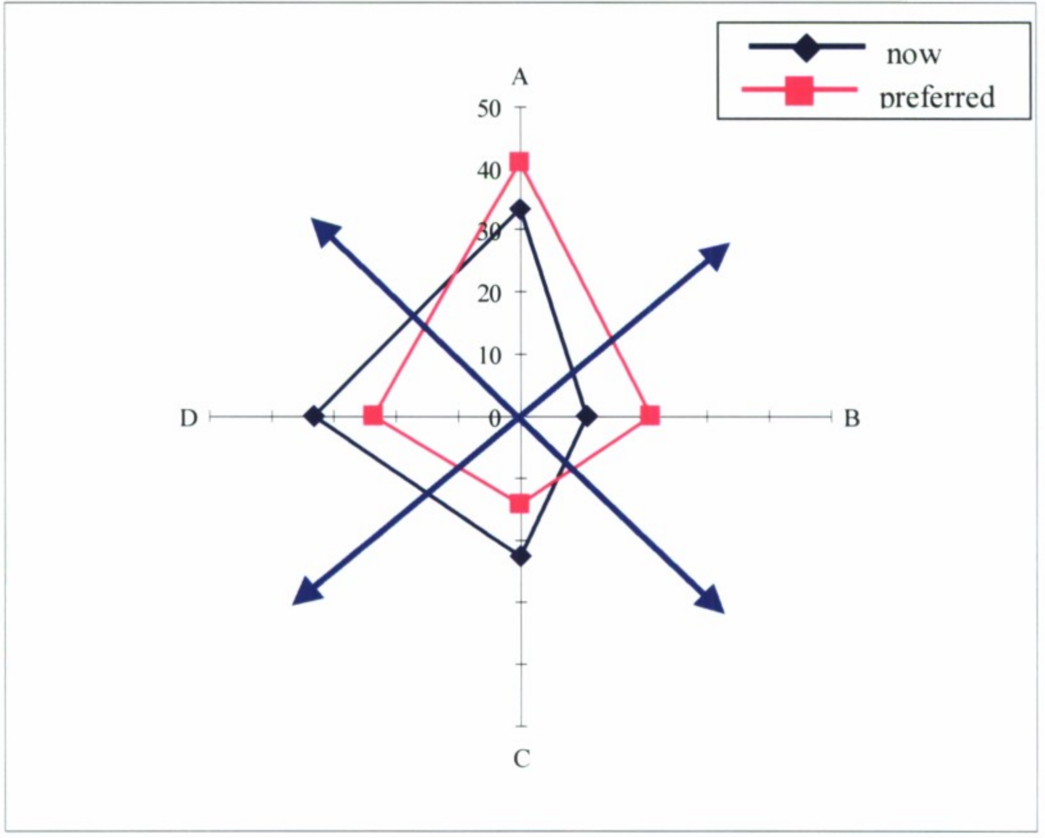

Figure 11. Depicts the *now* and the *preferred* culture profiles for the respondents identified as non-resident physicians, coded position A. The *now* culture is an even mix of Hierarchy and Clan profiles, and the *preferred* culture is a strong Clan profile.+

Table 8.

The OCAI results for the sub-culture of registered nurses (position B) and depicted in figure 12.

Position B	Now	Preferred
A – Clan	22	38
B – Adhocracy	16	22
C – Marketocracy	28	19
D – Hierarchy	34	21

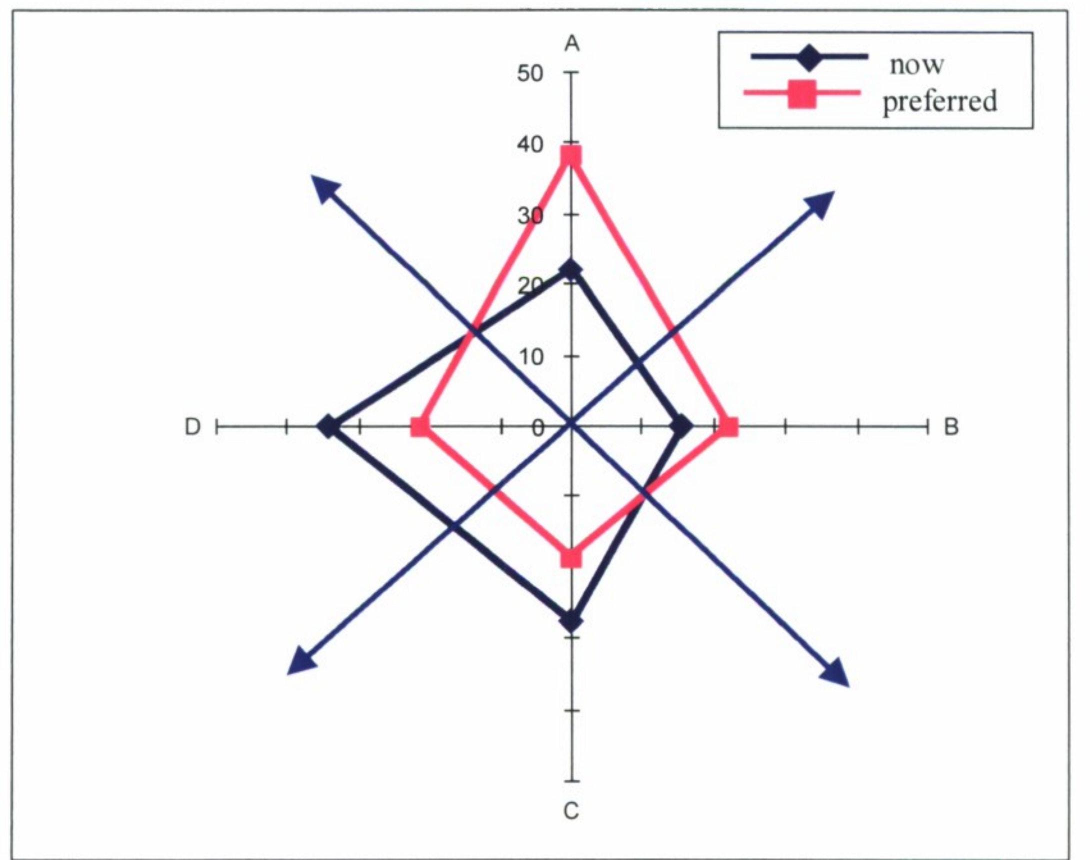

Figure 12. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified registered nurses, coded position B. The *now* culture is a distinct hierarchy profile, and the *preferred* culture is a strong clan profile.

Table 9.

The OCAI results for the sub-culture of licensed practical nurses (position C) and depicted in figure 13.

Position C	Now	Preferred
A - Clan	32	35
B - Adhocracy	17	20
C - Marketocracy	20	19
D - Hierarchy	31	26

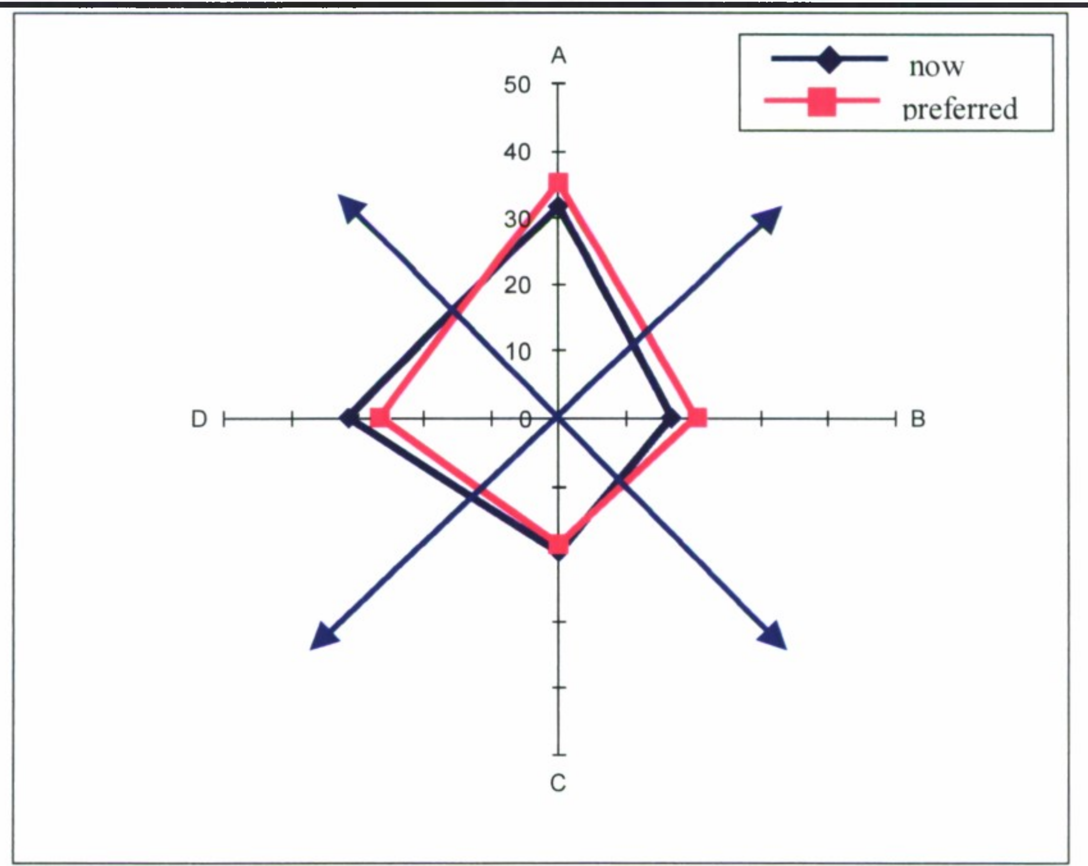

Figure 13. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as licensed practical nurses, coded position C. The *now* culture is a Clan profile with an almost equally strong Hierarchy attributes, and the *preferred* culture is a strong Clan profile.

Table 10.

The OCAI results for the sub-culture of medical assistants (position D) and depicted in figure 14.

Position D	Now	Preferred
A - Clan	30	30
B - Adhocracy	22	21
C - Marketocracy	20	19
D - Hierarchy	28	29

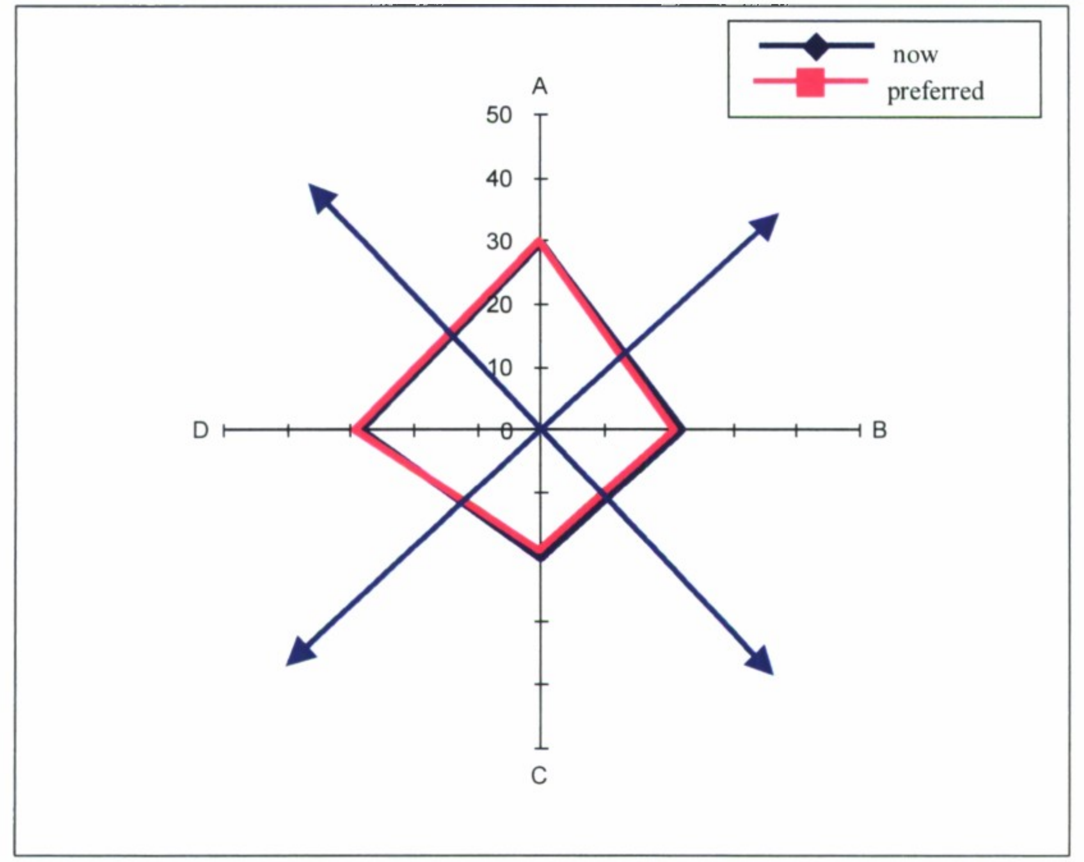

Figure 14. Depicts the *now* and the *preferred* culture profiles for the respondents identified as medical assistants, coded position D. The *now* culture is combination of Hierarchy and Clan profiles, and the *preferred* culture is a combination of Clan and Hierarchy profiles.

Table 11.

The OCAI results for the sub-culture of medical residents, fellows, and interns (position G) and depicted in figure 15.

Position G	Now	Preferred
A - Clan	28	33
B - Adhocracy	12	24
C - Marketocracy	35	24
D - Hierarchy	25	20

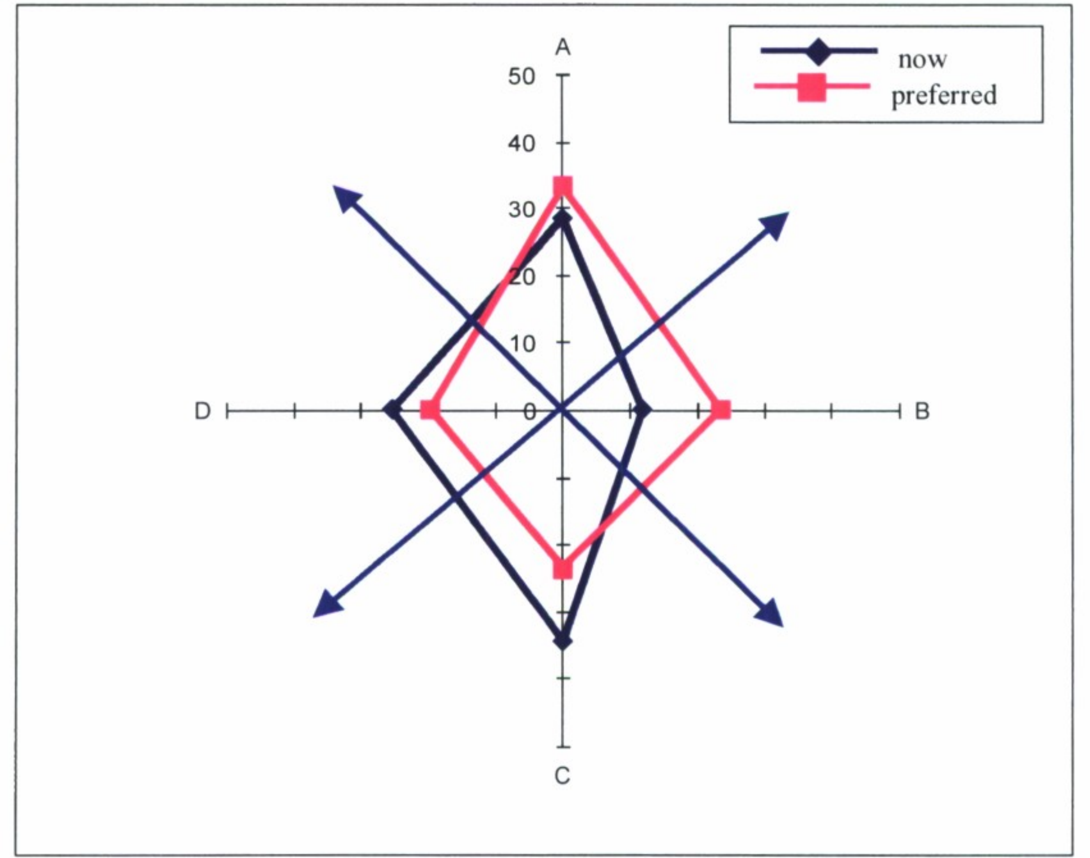

Figure 15. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as medical residents, fellows, and interns, coded position G. The *now* culture is a Marktetocracy profile, and the *preferred* culture is a strong Clan profile.

Table 12.

The OCAI results for the sub-culture of administrative clerks (position H) and depicted in figure 16.

Position H	Now	Preferred
A - Clan	31	44
B - Adhocracy	19	18
C - Marketocracy	26	17
D - Hierarchy	26	21

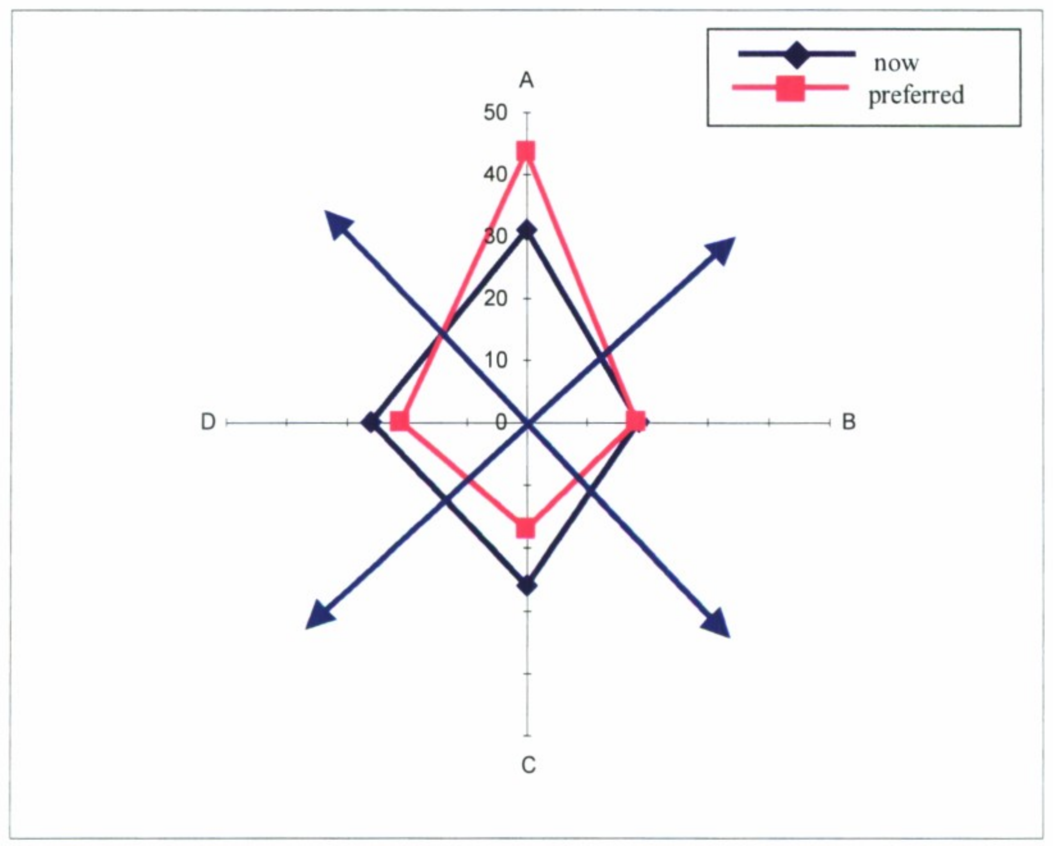

Figure 16. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as administrative clerks, coded position H. The *now* culture is a Clan profile, and the *preferred* culture is a significantly more definitive Clan profile.

Table 13.

The OCAI results for the sub-culture of a combined group of administrative assistants, administrators, other medical assistants, and any others (positions I, J, K, KD, O). These are depicted in figure 17.

Positions I,J, K,KD, O	Now	Preferred
A - Clan	24	31
B - Adhocracy	18	25
C - Marketocracy	28	22
D - Hierarchy	30	22

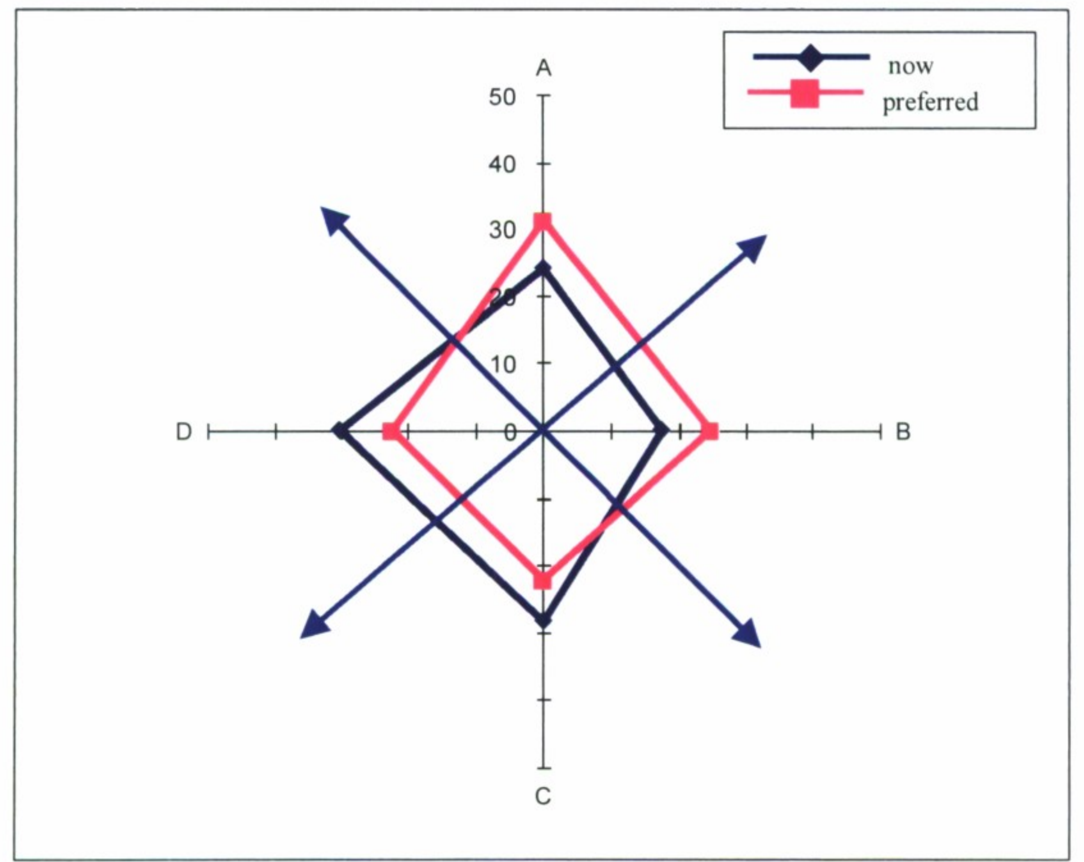

Figure 17. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as administrative assistants (coded H), administrators (coded I), other medical assistants (coded KD), and any not otherwise identified (coded K). The *now* culture is a Hierarchy profile, and the *preferred* culture is a Clan profile.

Table 14.

The OCAI results for the sub-culture of employees who have been at DACH 0-1 year (years A) and are depicted in figure 18.

Years A	Now	Preferred
A - Clan	31	34
B - Adhocracy	16	22
C - Marketocracy	21	18
D - Hierarchy	32	26

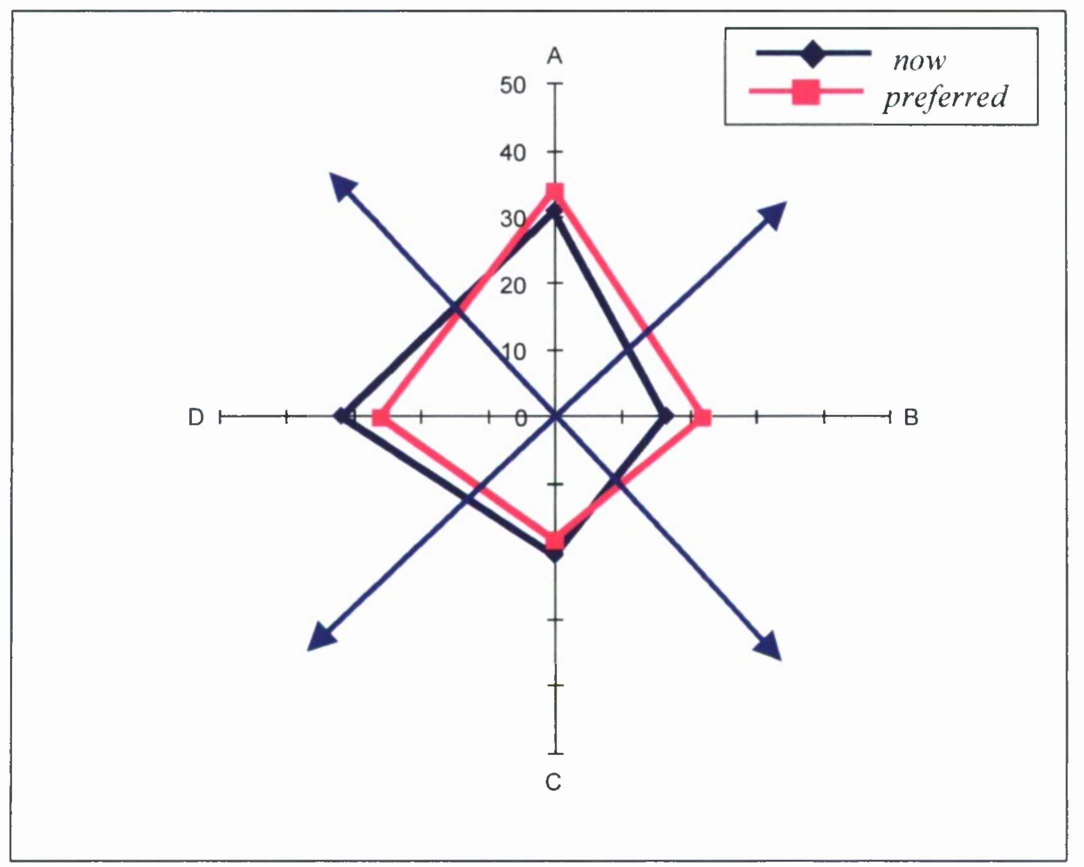

Figure 18. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as having worked at DACH for 0-1 year, coded Years A. The *now* culture is a strong Hierarchy profile, and the *preferred* culture is a Clan profile.

Table 15.

The OCAI results for the sub-culture of employees who have been at DACH 2-3 years (years B) and are depicted in figure 3.

Years B	Now	Preferred
A - Clan	29	38
B - Adhocracy	15	22
C - Marketocracy	29	19
D - Hierarchy	27	21

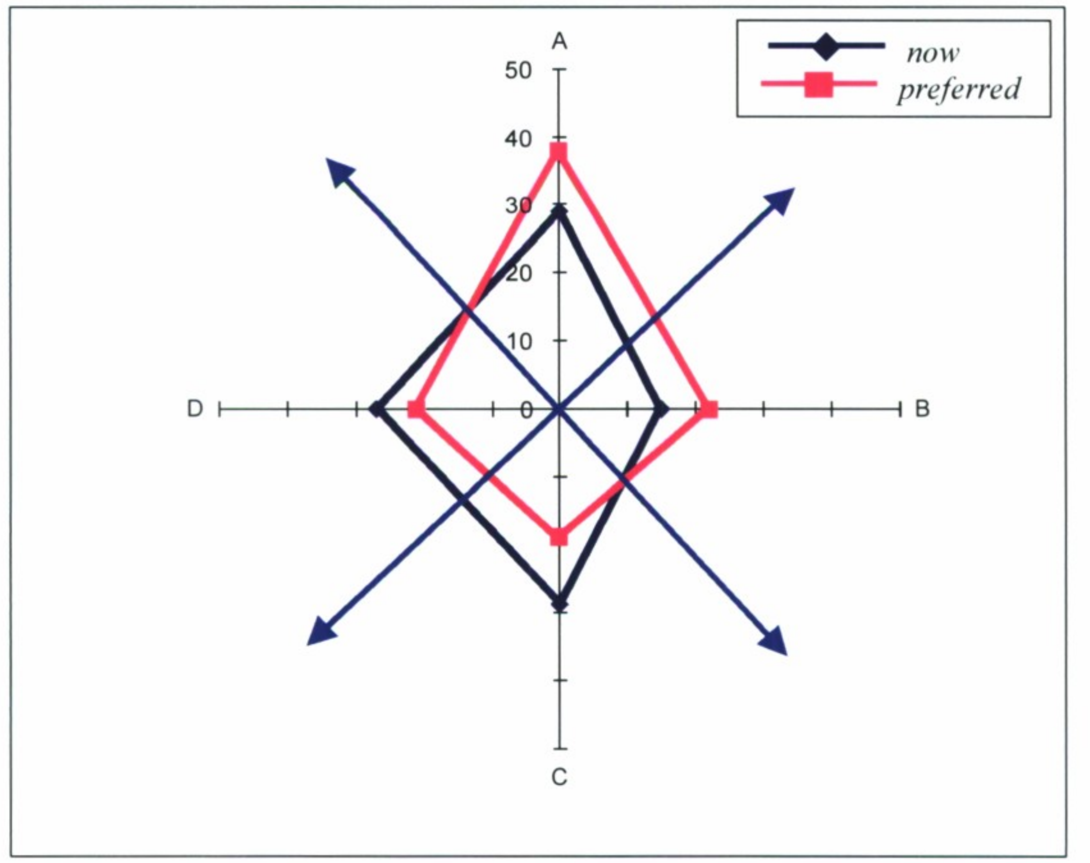

Figure 19. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as having worked at DACH for 2-3 years, coded Years B. The *now* culture is a balance between a Clan and a Marketocracy profile, and the *preferred* culture is a clear Clan profile.

Table 16.

The OCAI results for the sub-culture of employees who have been at DACH 4-7 years (year C) and are depicted in figure 20.

Years C	Now	Preferred
A - Clan	27	34
B - Adhocracy	16	16
C - Marketocracy	19	20
D - Hierarchy	38	29

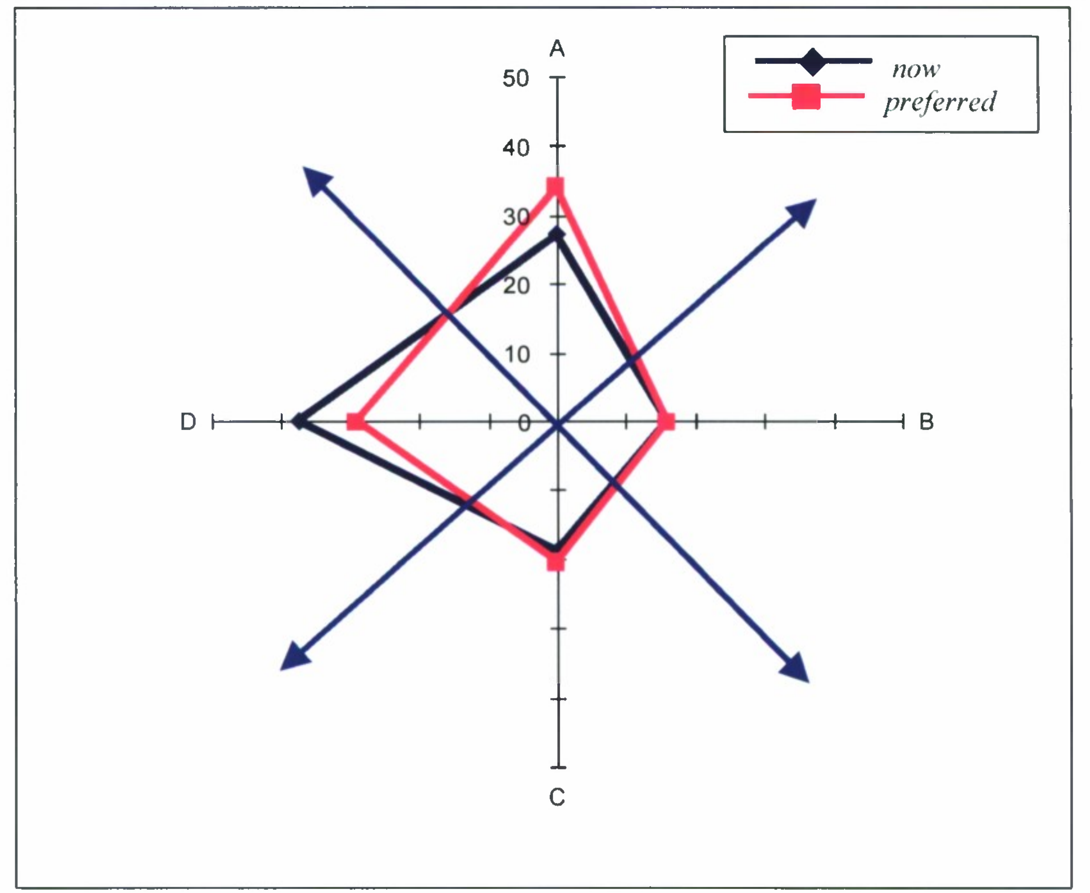

Figure 20. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as having worked at DACH for 4-7 years, coded Years D. The *now* culture is a strong Hierarchy profile, and the *preferred* culture is a clear Clan profile.

Table 17.

The OCAI results for the sub-culture of employees who have been at DACH 8- 10 years (years D) and are depicted in figure 21.

Years D	Now	Preferred
A - Clan	26	38
B - Adhocracy	15	22
C - Marketocracy	30	19
D - Hierarchy	29	21

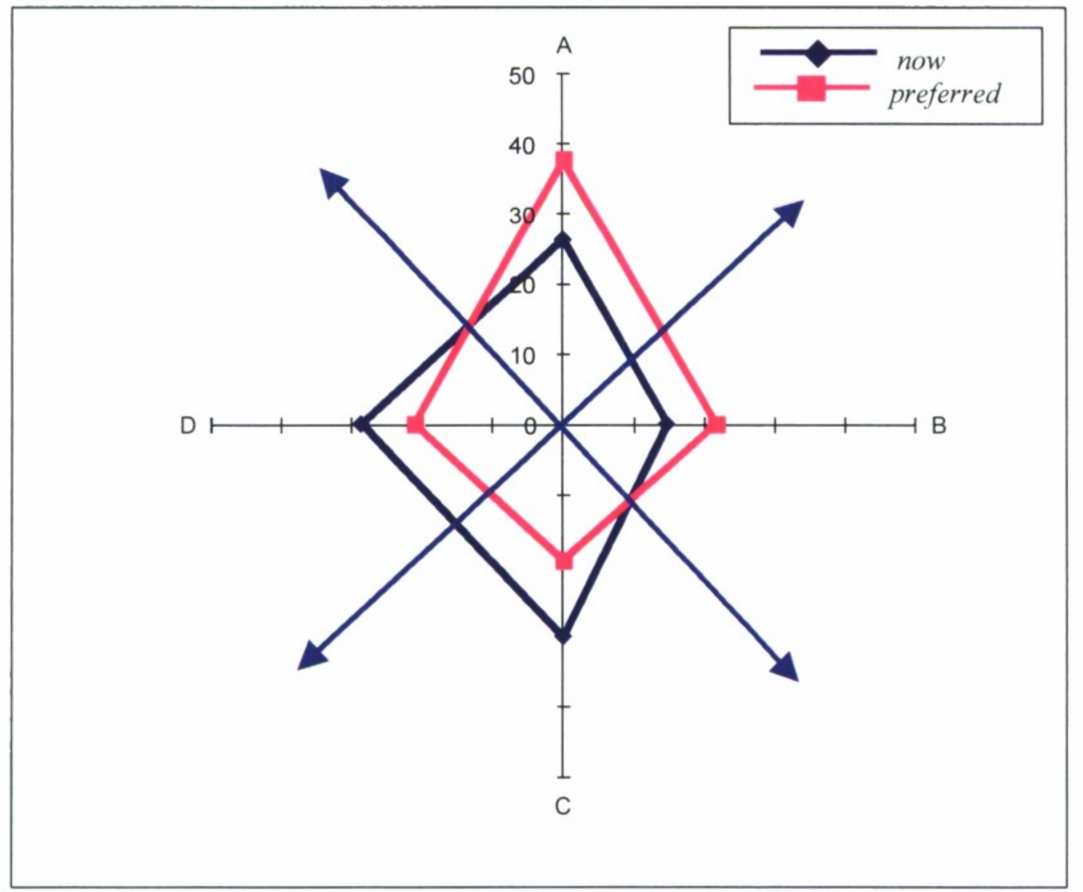

Figure 21. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as having worked at DACH for 8- 10 years, coded Years D. The *now* culture is a mixed Marketoccracy profile with strong hierarchy attributes, and the *preferred* culture is a clear Clan profile.

Table 18

The OCAI results for the sub-culture of employees who have been at DACH for greater than 10 years (year E) and are depicted in figure 22.

Year E	Now	Preferred
A - Clan	28	40
B - Adhocracy	19	21
C - Marketocracy	28	19
D - Hierarchy	29	20

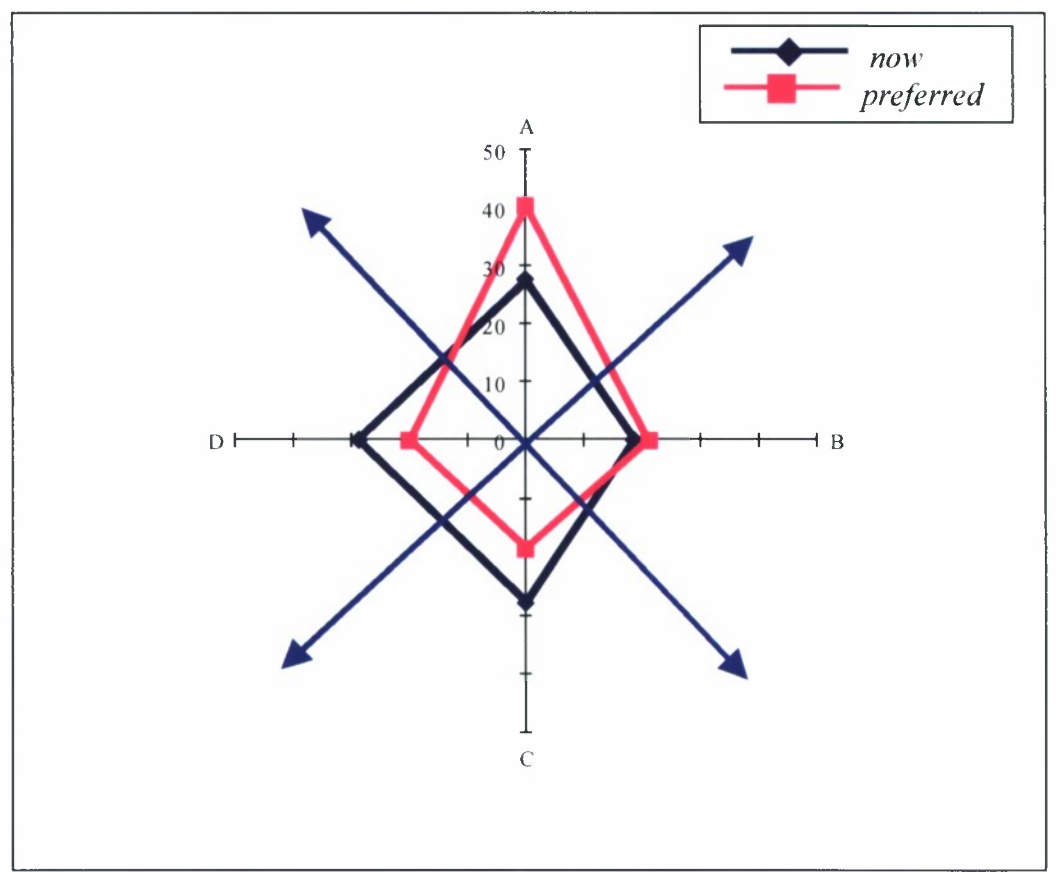

Figure 22. Depicts the *now* and the *preferred* culture profiles for the respondents self-identified as having worked at DACH for more than 10 years (years E). The *now* culture is a mixed Hierarchy profile with strong Clan and Marketocracy attributes, and the *preferred* culture is a clear Clan profile.

Table 19.

The OCAI results for question set 1: Dominant Characteristics and are depicted in figure 23..

Question Set 1	Now	Preferred
A - Clan	30	33
B - Adhocracy	14	25
C - Marketocracy	26	23
D - Hierarchy	29	19

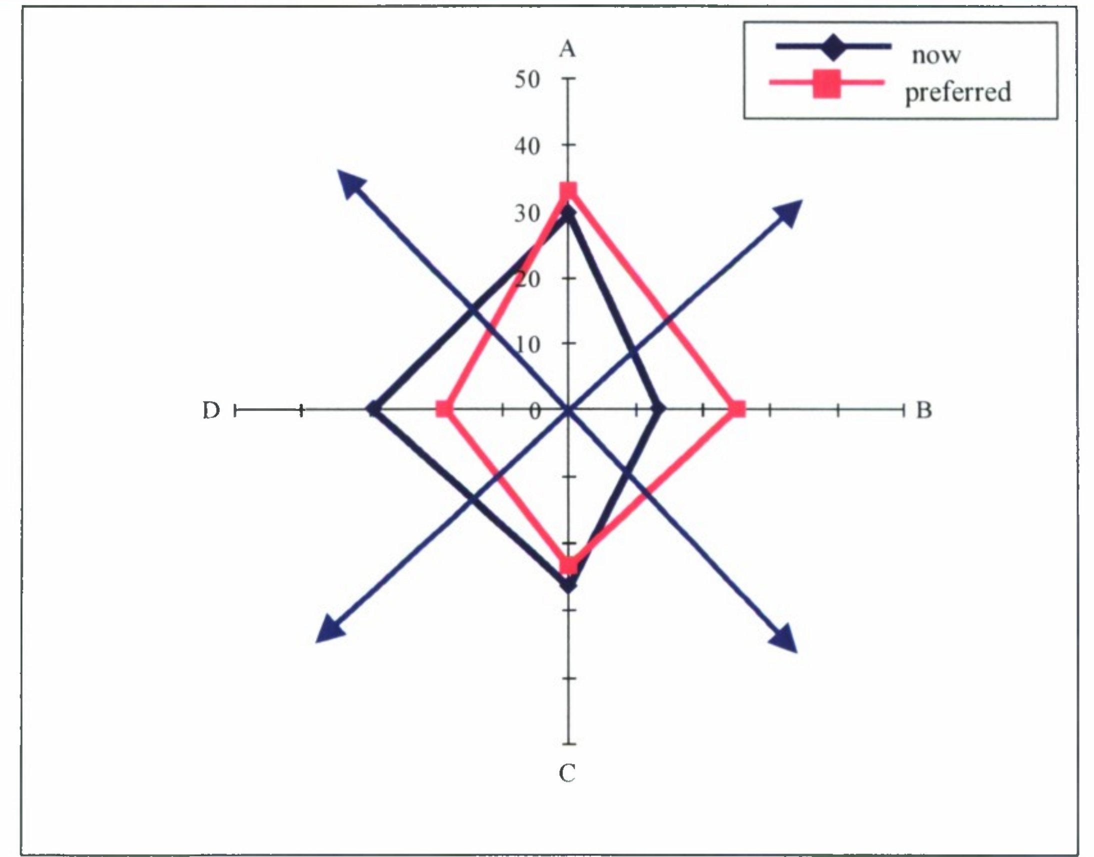

Figure 23. Depicts the *now* and the *preferred* culture profiles for question set 1 of the OCAI: dominant characteristics. *The now* culture is a Clan profile with Hierarchy attributes, and the *preferred* culture is a clear Clan profile. This group of questions uses the culture profiles to show what the most accentuated characteristics or organizational values are felt, and what characteristics the respondents would prefer in the future.

Table 20.

.The OCAI results for question set 2- organizational leadership and depicted in figure 24.

Question Set 2	Now	Preferred
A - Clan	25	34
B - Adhocracy	19	20
C - Marketocracy	32	18
D - Hierarchy	27	28

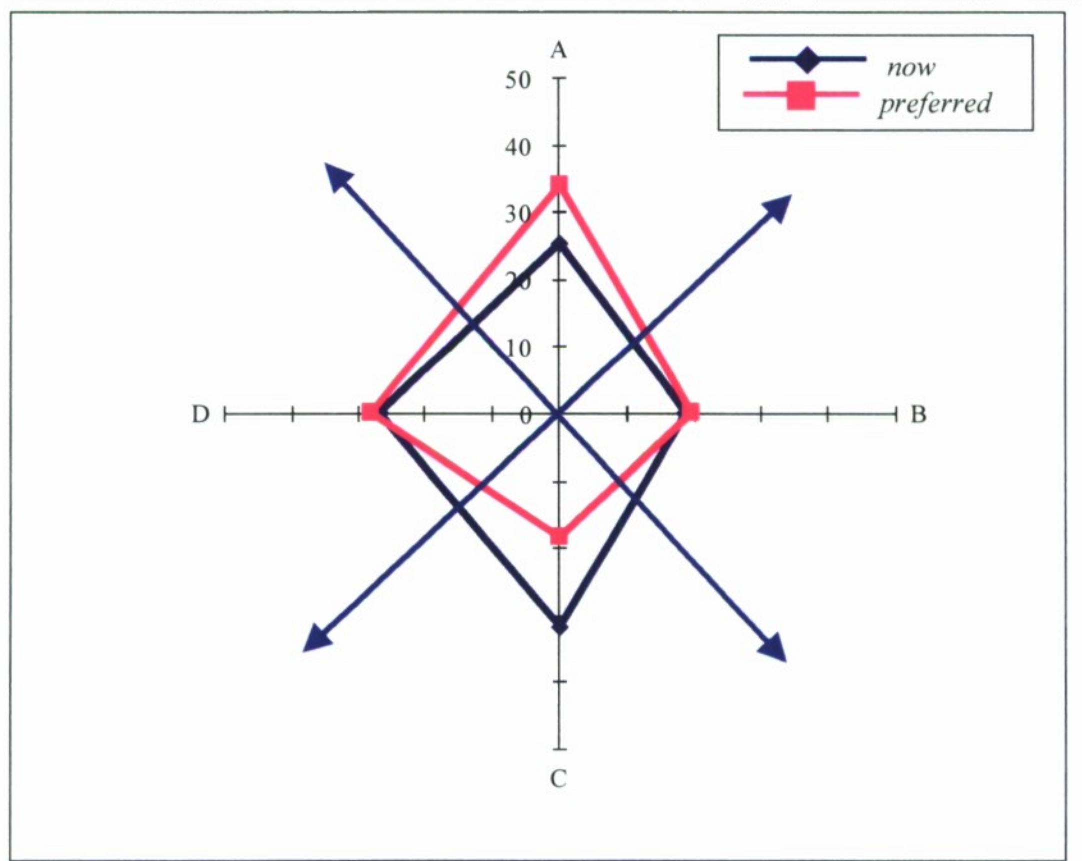

Figure 24. Depicts the *now* and the *preferred* culture profiles for the responses to question set 2 of the OCAI: organizational leadership. *The now* culture is a Marketocracy profile, and the *preferred* culture is a Clan profile. This group of questions uses the culture profiles to show how the organizational leadership is perceived, and what type of leadership the respondents would prefer in the future.

Table 21.

The OCAI results for question set 3: management of employees and are depicted in figure 25.

Question Set 3	Now	Preferred
A - Clan	30	39
B - Adhocracy	17	23
C - Marketocracy	20	18
D - Hierarchy	33	20

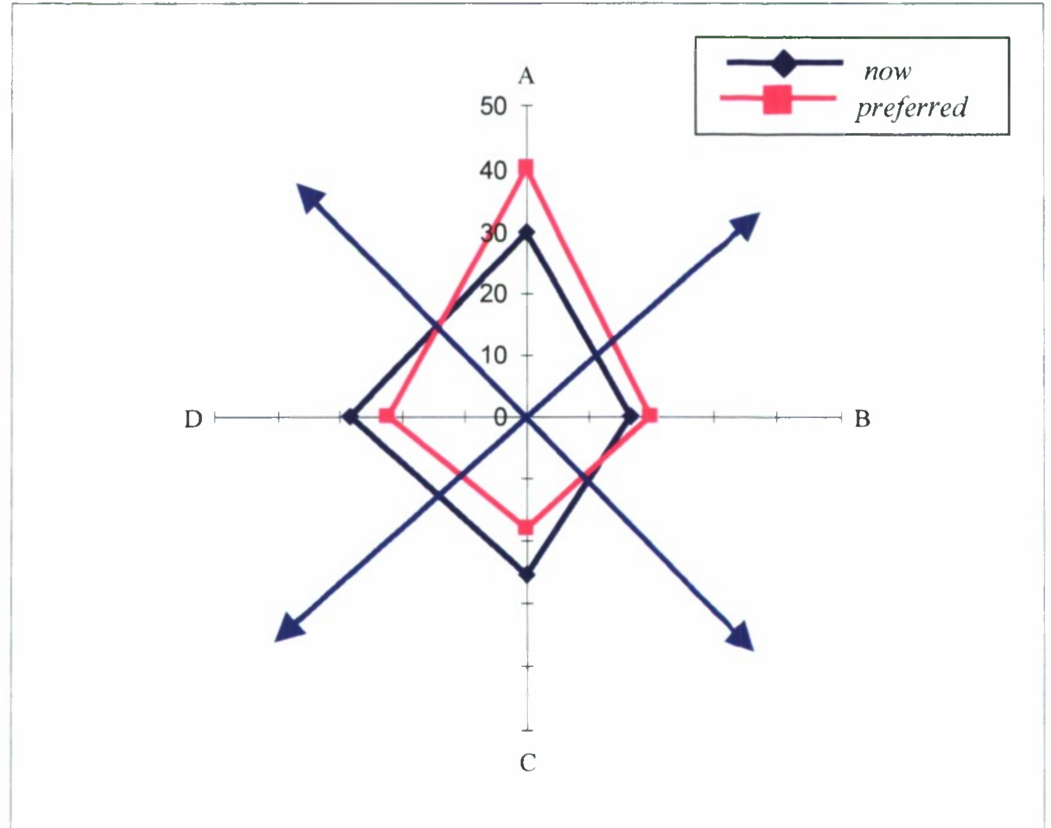

Figure 25. Depicts the *now* and the *preferred* culture profiles for the responses to question set 3 of the OCAI: management of employees. *The now* culture is a Hierarchy profile, and the *preferred* culture is a Clan profile with the ideal kite shape to the whole profile. This group of questions uses the culture profiles to reveal the perception of how employees are managed both *now* and how the respondents would *prefer* the emplyees be managed in the future.

Table 22

The OCAI results for question set 4: organizational glue and are depicted in figure 26.

Question Set 4	Now	Preferred
A - Clan	30	39
B - Adhocracy	17	23
C - Marketocracy	20	18
D - Hierarchy	33	20

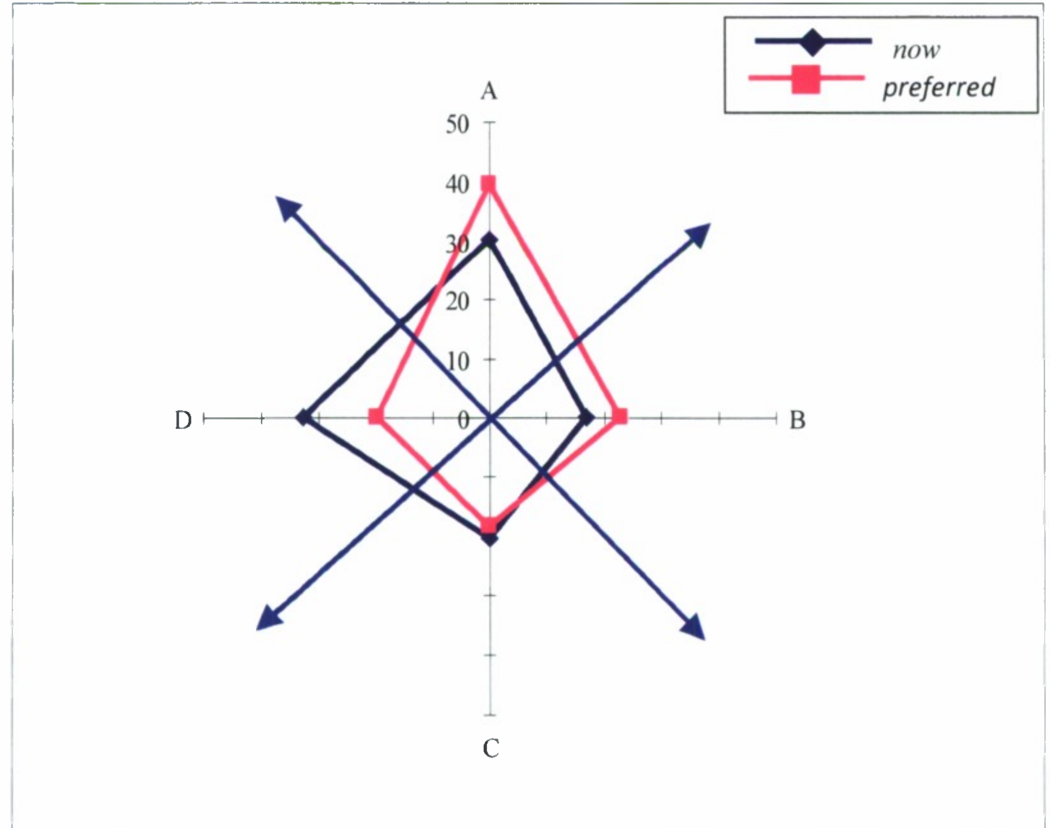

Figure 26. Depicts the *now* and the *preferred* culture profiles for the responses to question set 4 of the OCAI: the organizational glue. *The now* culture is a Hierarchy profile, and the *preferred* culture is a Clan profile with the ideal kite shape to the whole profile. This group of questions uses the *preferred* culture profile to clarify the critical elements for cohesion of the organization.

Table 23

The OCAI results for question set 5: strategic emphasis and are depicted in figure 27.

Question Set 5	Now	Preferred
A - Clan	24	32
B - Adhocracy	18	23
C - Marketocracy	24	17
D - Hierarchy	33	27

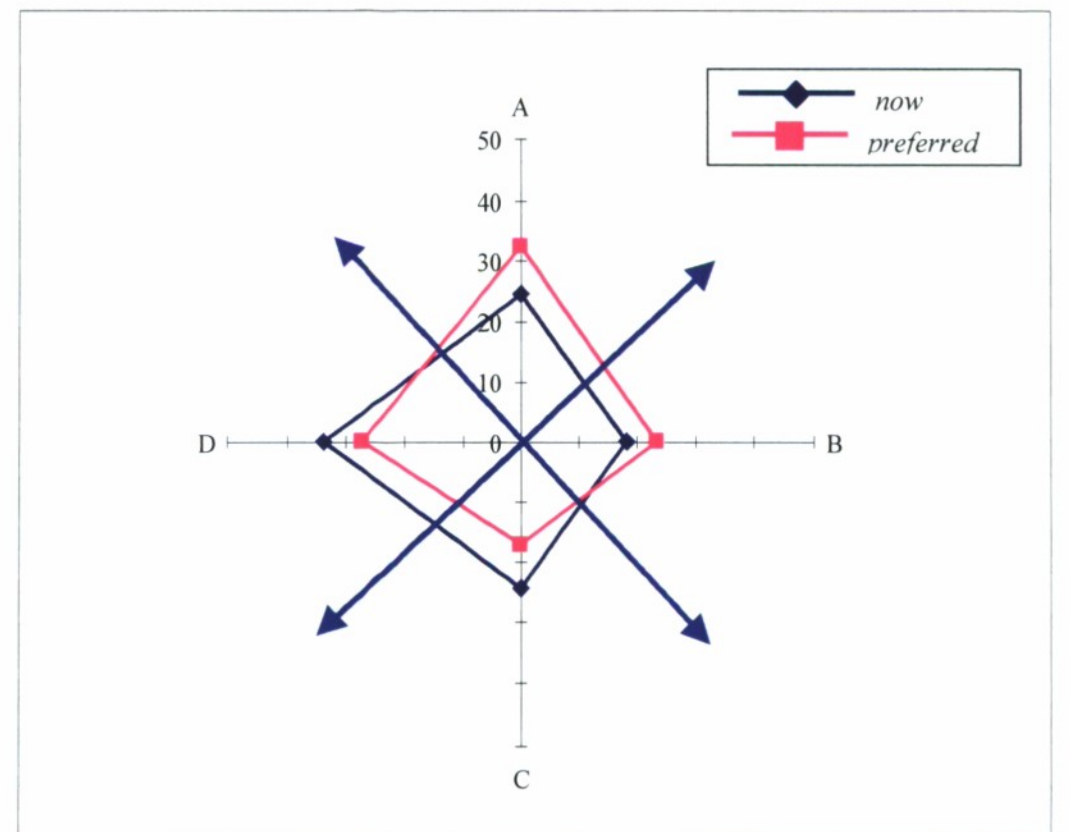

Figure 27. Depicts the *now* and the *preferred* culture profiles for the responses to question set 5 of the OCAI: strategic emphasis. *The now* culture is a Hierarchy profile, and the *preferred* culture is a Clan profile.. This group of questions uses the *preferred* culture profile to clarify possible strategic courses of action, or strategic goals.

Table 24.

The OCAI results for results of question set 6: the criteria for success and are depicted in figure 28.

Question Set 6	Now	Preferred
A - Clan	35	41
B - Adhocracy	12	18
C - Marketocracy	24	18
D - Hierarchy	28	24

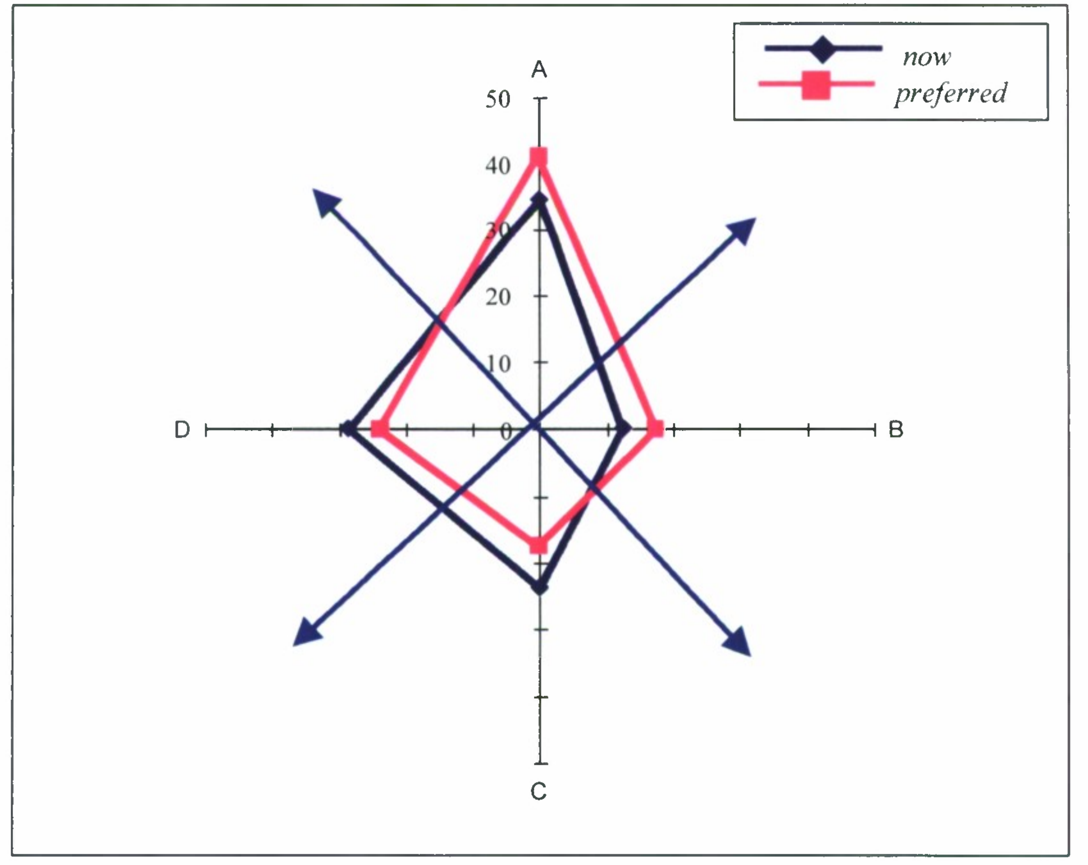

Figure 28. Depicts the *now* and the *preferred* culture profiles for the responses to question set 6 of the OCAI: criteria for success. *The now* culture is a Clan profile, and the *preferred* culture is an increase in the Clan profile attributes. This group of questions uses the *preferred* culture profile to clarify what future success looks like.

Table 25.

The OCAI results for the sub-culture of personnel working in the Internal Medicine clinic (workcenter I) at DACH and depicted in figure 29.

Workcenter I	Now	Preferred
A - Clan	29	39
B - Adhocracy	17	20
C - Marketocracy	23	17
D - Hierarchy	31	23

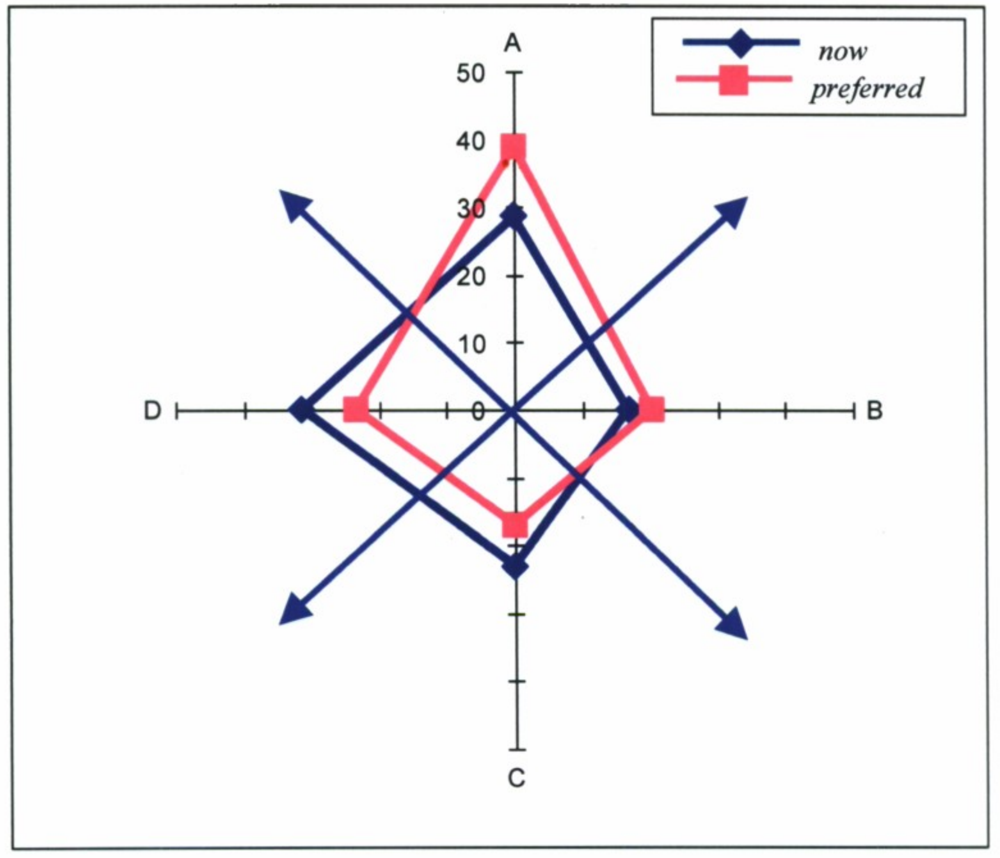

Figure 29. Depicts the *now* and the *preferred* culture profiles for the respondents identified as working in the Internal Medicine clinic, coded workcenter C. The *now* culture is a Hierarchy profile, and the *preferred* culture is a Clan profile.

Table 26.

The OCAI results for the sub-culture of personnel working in the Primary Care clinic (workcenter C) at DACH and depicted in figure 30.

Workcenter C	Now	Preferred
A - Clan	29	37
B - Adhocracy	13	21
C - Marketocracy	30	20
D - Hierarchy	27	22

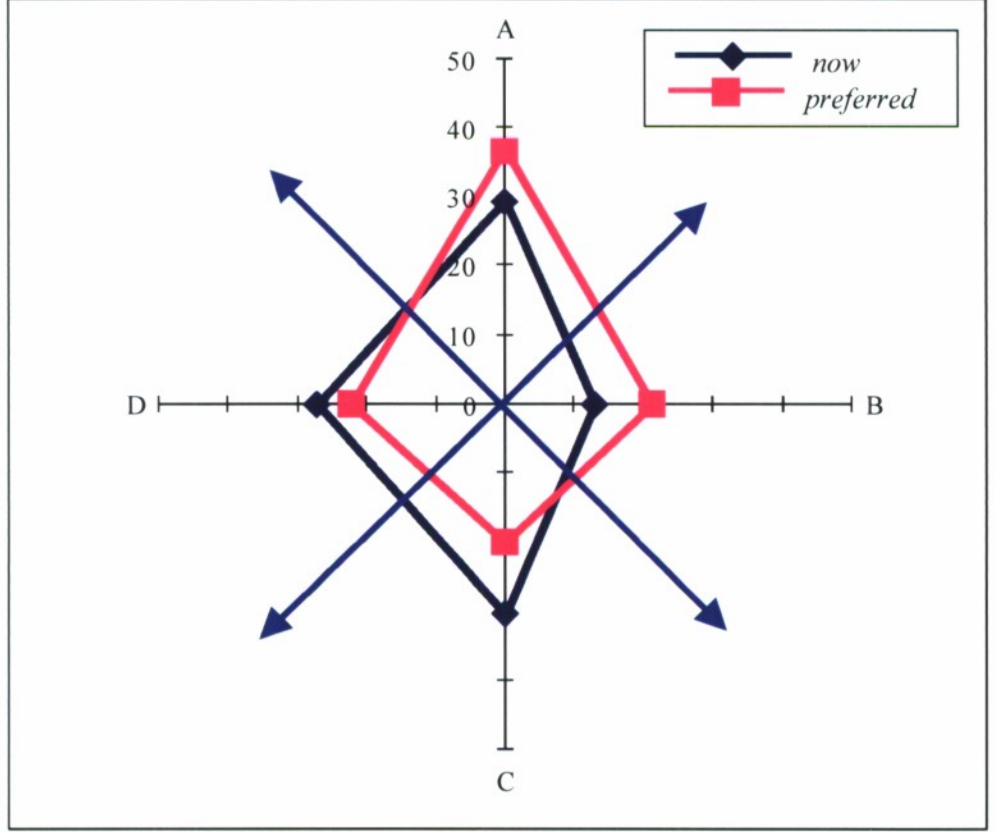

Figure 30. Depicts the *now* and the *preferred* culture profiles for the respondents identified as working in the Primary Care clinic, coded workcenter C. The *now* culture is a marketocracy profile with strong Hierarchy and Clan attributes, and the *preferred* culture is a Clan profile.

Table 27.

The OCAI results for the sub-culture of personnel working the Pediatric clinic (workcenter P) and depicted in figure 31.

Workcenter P	Now	Preferred
A - Clan	30	34
B - Adhocracy	18	22
C - Marketocracy	22	20
D - Hierarchy	30	24

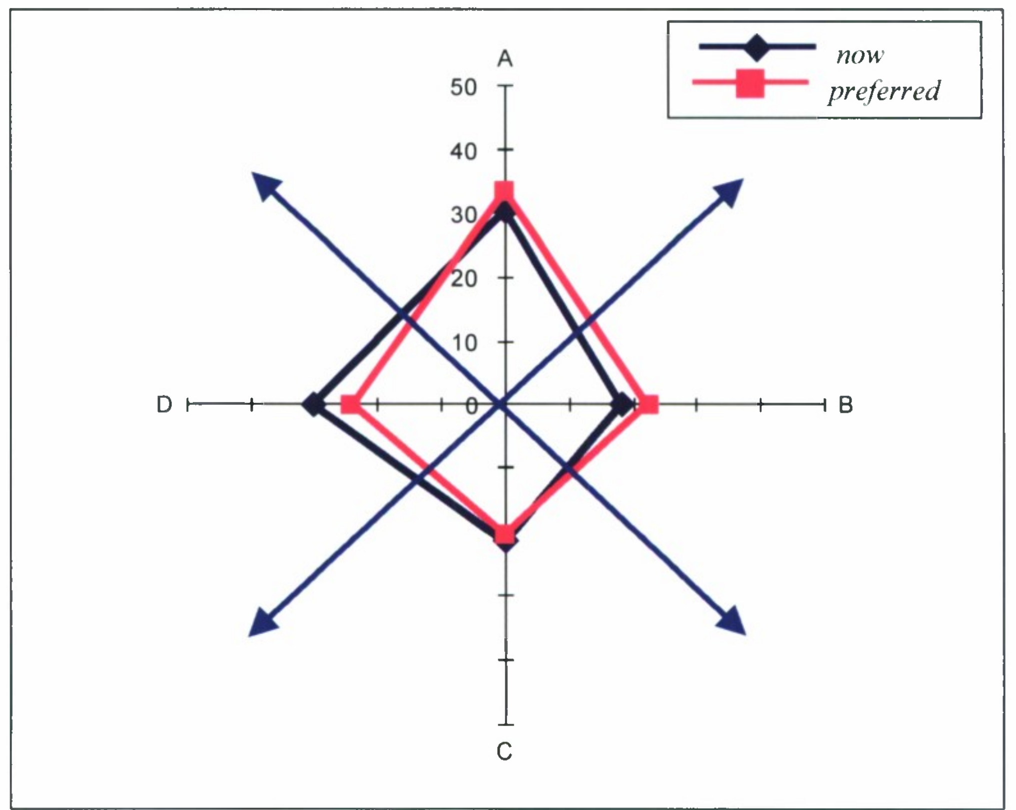

Figure 31. Depicts the *now* and the *preferred* culture profiles for the respondents identified as working in the Pediatric clinic, coded workcenter P. The *now* culture is combination of Hierarchy and Clan profiles, and the *preferred* culture is a Clan profile.

These profiles are best understood in the light of other measures and some anecdotal qualitative information. In discussions with personnel from the FHC, a number of people claimed that the contract personnel did not adopt the culture or did not know the culture of the DACH. They also claimed that the leadership treated the employee types differently. Additionally, the employees themselves interacted with each other differently based on employment type and profession. These observations have more to do with climate than with culture. However, since climate is derived from the culture, they point to some things that could be addressed to build the Culture of Excellence. The Culture of Excellence can only exist if every employee, no matter the employment type, has the best interests of the patient, the customer, fellow employees and the organization at heart. Changing the culture will necessarily involve inculcating the values of the organization in every person who works at the DACH, contact, GS, and military.

The culture profiles of the two contract clinics and the clinic with separate senior leadership, Radar Clinic are of particular interest. As was mentioned in the first iteration of the OCAI in the FHC, contract personnel perceive the culture differently than both government employees and staff service members. The OCAI results from the two contract clinics would probably be a strong, distinct subculture. It would probably not be a contrarian culture, but will probably be more skewed to one particular profile than the other three. The two military, distant clinics would probably not be culturally homogeneous. Radar clinic is a small Army clinic, which may relate closely to the FHC but because of the proximity of senior leadership to junior personnel, every employee may perceive more Hierarchy than Clan. The Culture of Excellence demands every employee seek to do more than perform their duties to the letter, they must perform their duties in the spirit of excellence. For the personnel who feel that they have been

giving their best, asking more may be disheartening. For those who have survived on mediocrity for a number of years, doing more may be more than they can produce.

The authors of the OCAI discuss in depth the issues of subcultures. For the contract clinics and the two outlying clinics, a subculture may be the ideal culture for the Culture of Excellence for those clinics. The whole point of the OCAI is to discern the culture so that, as is done in the previous paragraph, the command does not have to make educated guesses from proxy measures, or experiential assumptions.

Some concepts that affect the results

Response rate

The OCAI was first distributed electronically by e-mail to the leadership of the Family Health Center (FHC) with the instructions to distribute to their subordinates. Two responses were received. A second e-mail was sent to all personnel who worked in the FHC. At the same time, paper copies of the OCAI were distributed. 140 copies of the OCAI were distributed. Only 45 total responses were received. Five by e-mail and the rest paper copies. 144 persons work for the FHC. The 32% response rate is below the 50% response rate anticipated but it is sufficient to provide a statistically usable, valid, and reliable sample. The FHC is 10% of the DHCN. The FHC may not be representative of the organization as a whole. The responses were not a

Table 28. *The response totals and percentages for the OCAI given to the FHC at DACH.*

Group	# of responses	% of Total Responses	% of Total FHC Personnel
ALL	45	100%	32%
TYPE M - military	9	20%	6%
TYPE R - contractor	9	20%	6%
TYPE C – DA civilian	27	60%	19%

representative mix of the FHC employee composition and so may be biased toward the Department of the Army (DA) civilian workforce.

Another factor in the response rate is the intensity of work in the Family Health Center. Though the Residents were addressed directly, response rate was low among this group. Response rate was low among all providers. Some other surveys have been conducted recently that added to the paperwork of the caregivers. One comment expressed to the researcher was that the OCAI was just one more survey. Although how to complete the survey was well explained, the importance of the survey was not well explained. Moreover, it was poorly supported by some key leaders in the FHC. The survey became the lowest priority. Some personnel confessed to having lost the paper copy of the survey they had previously received. The survey could best be done in a more controlled situation, such as work-center meetings. If the survey was given at a meeting in which attendance was mandatory, and completion of the survey was part of the agenda, response rate would certainly improve.

One of the chief complaints of respondents was that the instructions were difficult to understand. The response method is one that most respondents have not encountered before and thus understanding it may not be as easy as a Likert scale with which most are familiar. The OCAI uses an ipsative scale. With one group of respondents, the medical residents, a block of instruction was given describing the survey, its purpose, and how to complete it. Giving such instruction to everyone prior to issuing the survey could alleviate the stated problems.

The DHCN has many surveys, in many formats, at many different times, sponsored by many different work-centers, and focused on many different populations, with numerous variables, etc. The point is that response rates dwindle as the staff becomes inundated with requests for responses to somebody else's survey. The Business Objects Department (BOD) is

the data roundhouse. All surveys should be tracked by the BOD, results stored and readily referenceable by other personnel in the DHCN as allowed by the classification of the survey. A trained survey writer and analyzer ought to be hired who will be the Subject Matter Expert (SME). A *psychometrician* is a person (such as a clinical psychologist) who is skilled in the administration and interpretation of objective psychological tests. It is also someone who devises, constructs, and standardizes psychometric tests (Merriam-Webster). This person will be well versed in the TMA and MEDCOM regulations on surveys, the AMEDD survey bank, the AMEDD survey results, Federal regulations and surveys and civilian surveys that are used by TJC or other agencies that affect the DHCN in some way. This person will be able to coordinate efforts, ensure questions are properly formatted, reduce redundancies and provide coherent, actionable data to the department and the command team. This survey specialist can help with, response rate. This specialist can time the surveys, ensure leader support and build employee desire to complete the survey. This way, each survey has improved data quality and the respective leadership and the command team can respond with confidence.

Analysis and Discussion

Intent of study

The intent of this study was to identify objective measures that strategically align with organizational priorities and provide the Command a method to monitor progress toward its strategic goals, and specifically to identify a measure for the strategic objective of the Culture of Excellence. Research has supported the impact of hospital culture on the job satisfaction, patient commitment, and extra-role performance on providers (Williams, Rondeau, Francescutti, 2007).

Meaning of Results - defining the culture type

The survey results, once computed and graphed, depict the culture currently in the FHC as a Hierarchy as defined by the OCAI and Cameron and Quinn (1999, 2005). The preferred culture, as identified by the FHC personnel, is the Clan culture, similarly defined. This is not necessarily the strategic ideal culture now or in the future. It is what the employees think the culture is, and what they would prefer to see in the future. Neither the now nor preferred culture is high on the indicative axis indicating a lack of homogeneity of effort, According to Cameron and Quinn (1999, 2005) each of the four primary culture profiles has unique characteristics resulting from underlying competing values. Therefore, using the discrepancy between the *now* culture profile and the *preferred* culture profile, the leadership can readily deduce directionality for the desired change. Any difference greater than 10 points is statistically significant.

Implication of culture type

Strategically, the OCAI provides the leadership with information that it did not have before, namely, what is the current culture. The *now* (current) culture of the FHC is a Hierarchy. This culture type indicates that the work-center is a very formalized and structural place to work. The culture profile is not solely a product of the persons within the organization. The leadership plays a formative role in the culture. What the leadership values, becomes valued by the workforce. A Hierarchy culture profile implies that the leaders pride themselves on being good coordinators and organizers, and are efficiency minded. The command team is perceived to define success with dependable delivery (consistent quality), smooth scheduling (access and phone appointments), and efficient use of resources (budget utilization). This information allows the command team and other leadership to assess workforce motivation. The behaviors

witnessed by the commander are those that the employees think the command is stressing. The culture that exists will comply with the expectations of the command in so far as the expectation is measured and reported. This is one reason why the OCAI is most beneficial in conjunction with other measures.

The *preferred* culture is a Clan culture. The Clan culture is what is preferred but it, like the culture that exists now, may not be the most strategically desirable culture that would be the Culture of Excellence. The Clan culture is a culture that exhibits loyalty and tradition where the leaders are mentors and emphasize cohesion, moral, and the long term benefit of the human resources. Success in a clan culture is realized through sensitivity to customers and concern for people. Though this culture sounds very much in line with the commander's intent for the Culture of Excellence, it may not be the most advantageous in terms of achieving other goals. The Culture of Excellence cannot subordinate quality and safety for happy employees. However, as per the culture pyramid identified previously, the Culture of Excellence will lead to happy employees. Happy employees are a critical factor of the quality and patient satisfaction goals, but these do not necessarily arise out of satisfied employees. Each employee must value the patient, customer's interests as important as or more so than their own. The Clan culture supports this in that the employees' cohesion would reinforce behaviors.

Subcultures

The OCAI can identify a culture among any group of individuals within an organization. The demographic sheet that accompanied the OCAI in the FHC provided the data to determine the existence of subcultures within the FHC. Mindful that the FHC could well be a subculture different than that of the entire DHCN, each demographic was computed and graphed as

depicted in the results section. The three clinics (Pediatric, Internal Medicine and the Primary care clinic) showed minimal variation in either the now or preferred culture from the overall culture profiles (see Tables 26-27 and Figures 29-31). The various positions (see Tables 7-13 and Figures 11-17) were also consistent with the overall FHC culture profile (see Table 3 and Figure 7). A distinctive subculture does not present itself. The resident subgroup evidenced greater characteristics of the Market culture but the preferred culture mimicked the overall FHC clan culture profile (see Table 11 and Figure 15).

A subculture is not a negative attribute. Knowing that the subculture exists allows the command team to incorporate this into its Culture of Excellence plan. The subculture might actually be an asset. The surgical suite might have a different culture than the hospital as a whole. Though different, the subculture may be more beneficial to the operational effectiveness of the surgical suite.

The FHC subcultures might exist between each of the three clinics, or from day versus evening shift, or between the nurse and the providers. The results did not evidence a distinct subculture. A subculture can be a problematic if it is a counter culture, that is, one that is contrary to the Culture of Excellence. This may exist in subgroup of employees, such as the medical assistants, or contract providers. Identifying such a subculture depends on both measuring the culture with the OCAI and ensuring the capture of the demographic data.

Culture type that would best meet the strategic objectives of the DHCN

A Culture of Excellence does not mean that everything is perfect. It means that every individual strives to perform all duties and serve every customer/patient with excellence. From a patient's first contact with the network, through arrival, parking, facility appearance, the front

desk personnel and nurses, to the provider, then to ancillary services of the lab, radiology and pharmacy, every experience and encounter affects the patient satisfaction and evidences the culture.

Effective organizations can be supportive and develop their employees (Clan) and still demand output and achievement from them (Market). The Clan culture profile can be tempered with some elements of the Hierarchy, Market and Adhocracy culture profiles. A Culture of Excellence is a culture that values the employee, high performance in every task, quality, efficiency, effectiveness and patient satisfaction. The Culture of Excellence is not just a smile, but a truly engaged employee able to interact with patients and all customers, internal and external. The Clan culture best approximates the Culture of Excellence.

The recommendation for the Clan culture is therefore not a recommendation for an absence of characteristics associated with other culture types. As the BRAC law has enacted dramatic changes in the NCR, and the DHCN will change in many, and sometimes unpredictable ways, the culture must be able to allow for the creativity to resolve the numerous issues involved with the growth. The Adhocracy culture could well be the culture for the change, and the lead in to the Culture of Excellence. An Adhocracy culture is the culture that is temporary. This aspect of the culture would also allow the approximately 2000 new employees to assimilate without themselves or the current employees perceiving the new employees as foreigners. If the clan culture is developed too quickly, perhaps the family will have difficulty accepting the new members. If the Adhocracy culture is the transition culture on the way to the clan culture, those new employees will be members as the family is developed. This is in line with the Culture of Excellence as a journey and not a destination.

Other measures that may serve as proxy organizational culture measures

As discussed previously, organizational culture proxy measures generally measure well what they are intended to measure. The OCAI is not as beneficial for discerning and changing organizational culture by itself, as when it is used in conjunction with organizationally appropriate outcome measures or ancillary process measures. Discussion of why other measures may be beneficial to use in conjunction with OCAI to best account for the organizational culture

Consumer Satisfaction Survey

The DHCN does not monitor the Army MEDCOM monthly Customer Satisfaction Survey as a performance measure. This survey has proved a useful tool for MEDCOM as a policy tool, and for Army Medical Centers to focus improvement efforts. This measure will be an excellent companion to the APLSS. The CSS has been well tested for validity and reliability. Multiple researchers have evaluated each question format and the significance of each question relative to every other question (Barido, Campbell-Gauthier, Mang-Lawson, Mangelsdorff, and Finstuen, 2008). The model for which question is most reflective of the patient's perception of care and each aspect of the care has also been repeatedly analyzed. Additionally, the quantity of questions allows for analysis of specific variables of patient satisfaction.

The CSS and the OCAI support each other because the CSS can be dissected and specific questions paired with sections of the OCAI. Though no one question on the OCAI is an adequate summation of the whole survey as with the CSS, each letter category does comprise a particular culture profile. The CSS questions that reflect aspects of a given culture profile can be sources of initiatives.

HEDIS

The DHCN has been the leading MTF in the Army in every HEDIS measure tracked by the DHCN. DHCN has been rewarded through the PBAM and notably, more so than any other MTF in the Army for superior performance. As is evidenced in the *Now* graph of the culture (*figure 4*), the personnel in the FHC perceive the culture as Hierarchical. This suggests that whatever the commander is focused on is the focus of the employees. As soon as the commander focuses on something else, the employees focus on something else. If the commander stops focusing on something, so do the employees. These measures have improved at least in part, because of the command emphases. However, if the next commander does not monitor these measures as closely, the efforts to achieve excellence may recede. This is why the Culture of Excellence is essential. The effort to be excellent in the HEDIS measure areas will only continue if the culture of the DHCN is a Culture of Excellence.

The quality of healthcare is directly an effect of the employees who administer it. Employees who are satisfied (whether it is with pay, benefits, or internal customer support) provide better care of their own accord, than those who are not. Comparing the current results of the OCAI to the exceptional numbers on the HEDIS suggest that the HEDIS are subject to the hierarchical culture. The HEDIS will be a key proxy measure because as the culture changes, the quality should maintain and even improve. Likewise, the change in leadership could lead to a decrease in the HEDIS measures. If it does not, and compared to the OCAI, the culture is transforming into the Culture of Excellence.

APLSS

The DHCN uses the APLSS as a primary performance metric. For the period of July 2006 to February 2008, the DHCN has exceeded the civilian benchmark in the *Overall*

Satisfaction with Provider question. It has also exceeded the AMEDD and NARMC average. The *Courtesy of the Staff* is a little different. Though the DHCN does exceed the AMEDD and NARMC averages, it is still 20 points below the civilian benchmark. The staff comprises the clinic staff and every other hospital employee the patient encounters. This is where the culture has an effect. The culture influences every employee, not just the clinic. The APLSS question *Overall Satisfaction with Visit* is also mostly positive for the DHCN During the same period satisfaction has decreased by six points. This measure is reflective of most of the staff, access, pharmacy, ancillary services, and many others. An initiative would not be sufficient to improve the *Overall Satisfaction with Visit* score. These scores can indicate a shortcoming in the performance of some staff. It can suggest a culture that tolerates or even condones less than satisfactory interactions with customers, but it doesn't present any other conditions or how to change it. Excellence cannot be wholly directed by policy.

The excellence that the command team expects and wants to see evidenced in the APLSS scores can be correlated to the existence of a Culture of Excellence using the OCAI. The current culture and the current scores suggest that the current culture is not aligned with the values and goals of the command team and the DHCN. The OCAI does quantify the culture and can allow the command to mold the culture to align with its values and exhibit a Culture of Excellence. Future APLSS *Overall Satisfaction with Visit* will improve as the Culture of Excellence becomes inculcated in the DHCN. The most important aspect of the APLSS is not the individual provider because, of all the time spent in the hospital, the least amount is spent with the provider. The staff in the ward or clinic, the ancillary services and others, spend the most time with the patient. The culture becomes the unifying factor in all of these work-centers and along every hallway.

Employee Satisfaction Survey

National Defense Authorization Act for Fiscal Year 2004 mandated federal agencies conduct an employee satisfaction survey. The Office of Personnel Management (OPM) established the final rules in 2006. MEDCOM contracted an employee survey of 3000 providers. The DHCN has not conducted an employee satisfaction survey of the civilians that work within the DHCN. The Health and Human Services (HHS) department conducted a human capital survey in 2007. These data include civilian personnel in federal medical facilities, comparable to military medical facilities.

This survey is a starting ground for employee data for the DHCN and can be extrapolated for comparison to the OCAI results. The comparison is limited because of the variation of culture profiles that exist across the HHS. Nonetheless, as a large sample of Federal Employees, the survey results have relevance to, at least, the civilian government employees of the DHCN. Item 25, 26 and 31 of the HHS survey are relevant to the culture profiles from the first iteration of the OCAI. Item 31 asks if managers communicate the goals and priorities of the organization. 61 % responded with agree or strongly agree. Item 26 asks if leaders in the organization generate high levels of motivation and commitment. 58% responded unfavorably. The Culture of Excellence would demand that leaders do generate motivation. Moreover, the OCAI results show a *now* profile of Hierarchy in which leaders communicate the goals, but don't inspire motivation or commitment. The goals on the measures have been reached, mostly, but the culture has not changed. The OCAI *preferred* culture of clan, and the recommended principle profile for the Culture of Excellence, would both generate motivation and commitment and communicate goals. The culture would encourage performance and commitment to achieving the goal, and beyond.

Conclusion, Recommendations and Plan for implementation

Culture of Excellence

Intent of Command

The new commander must build on the history of the organization. Future commanders must be able to tap into the Culture of Excellence to achieve their particular objectives. Some of the problem with the hospital is that each new commander has not built on historical successes, but each has had a different focus and tried *new* initiatives that did not necessarily align with previous efforts. Additionally, the new command may not support or commend efforts made before, which is tantamount to making their efforts meaningless.

Implementing the Culture of Excellence will follow a culture change model. The command team will determine the milestones and develop the aspects of each phase. The command team will also establish working groups for six areas of focus for the Culture of Excellence. The areas of focus are supported by the literature, the needs of the DHCN and the collective experience of the command team. The command team will define the purpose and direction of each workgroup and establish meeting dates, deliverable deadlines, and set the dates for the many interim deadlines. These interim deadlines will support the sense of urgency and build to the 2011 final.

The leadership from the areas of the DHCN will comprise the membership of these groups. This arrangement provides first-hand knowledge and a breadth of experience and understanding to the working-groups. Communication is paramount. For this reason, an initial all-day session will introduce the subordinate leadership to the Culture of Excellence, the working groups' composition, and the timeline.

Plan to move from current culture type to intended culture type

The OCAI results depict the culture now, and the culture preferred by the FHC employees and staff. The command team will assess the culture types and determine what preferred culture will best suit the development and propagation of the Culture of Excellence. As mentioned before, this researcher recommends an initial transition culture and then a more stable culture with the Clan profile prominent with aspects of the Hierarchy and Adhocracy culture profiles.

Usefulness of Culture Proxy measures

The proxy measures provide the additional information that will enable the command team to change the culture. Each measure has historical and communal awareness and each can communicate to the rest of the DHCN via graphs, charts and other diagrams changes that approximate the journey to the Culture of Excellence.

Management Application

Dashboard to monitor Culture

In order to properly ascertain relationship measures to culture, multiple iterations of the OCAI should be compared with HEDIS (those measures monitored by DHCN), Army Provider Level Satisfaction survey, DoD Command Climate Survey (note that this survey is limited usually for the use of military only. Also remember that there is a difference between culture and climate), an employee satisfaction survey and a nurse/provider relationship survey among others.

If command team and other leaders focus on the aforementioned measures, they will be able to shift the culture appropriately, fine tuning as needed along the way. Ultimately, the DHCN leadership will be able to identify actualization of the Culture of Excellence. The OCAI,

paired with other traditional measures, will present a clear picture of the culture; whereas the traditional measures by themselves leave an informational void.

Recommended 5- Step Culture Change Model

Step 1-Identify the end state, metrics, and attainment

The first step of any effort to change is to identify an end state, a tool to measure progress, and the quantifiable point that equates to success or attainment of the aforementioned end state. The DHCN's first action, then, is to identify *culture* as a strategic objective. Next, it must identify a tool to measure the culture. Finally, it must determine what within the measure indicates achievement. Whether the Commander dictates this, it is decided at higher levels, or the command team derives it through strategic planning meetings, it is imperative that the change objective be a part of the strategic plan.

Upon identifying culture change as a strategic objective, the DHCN must determine a metric. Typically, the leadership will seek a measurement tool that is already in use. An employee satisfaction survey would have been initially administered as the metric for another strategic objective. Measures that do not directly measure culture are not valid because there can be no way of knowing if the measure will actually change if the culture changes, or if it does, the change may not have been affected solely by culture. A direct measure is required. The measure must be a valid and reliable tool with substantial history and literature to support its use. Additionally, return rates and report time is improved if the measure is easy to administer and simple to score. These factors are all fulfilled by the OCAI. The OCAI is the ideal metric for a culture change.

After identifying the strategic objective and the measure, the leadership must identify what defines success in terms of a target on the metric. The quantifiable goal empowers the

entire organization to its pursuit. Presuming the leadership chooses to use the OCAI as the measurement tool, the final part of step one is building a unified understanding of an organizational culture profile that would best meet the organizational mission, vision, values and goals of the DHCN. The Hierarchy culture allows for top down driven changes. The Culture of Excellence requires *buy-in* from every level of leadership and the employees. Consensus among the leadership ranks is not to imply that a committee determines the culture profile. Rather, it is a way of getting *buy-in* by way of mutual agreement on the command teams' concept, instead of a dictate. The culture profile derived from the leadership OCAI results may or may not match the command teams' idea of the Culture of Excellence profile. If it does not match, the command team can build a unified understanding (i.e. consensus) by starting from the resultant *preferred* profile and guide the work groups to the command team profile.

When implementing step one, the OCAI original instructions can be amended to allow for organizational variance. Normally when completing the OCAI, the administrator instructs the respondent to complete the *preferred* column, as the respondent would like to see in 3 – 5 years. In the case of the DHCN Culture of Excellence, the question to ask for the *preferred* column would not be, "what would you like to see in 5 years?", but "what does the Culture of Excellence look like?". This would help the leaders apply the Culture of Excellence definition and facilitate a unified understanding.

Step 2-Working groups

The next step in the culture change model is to build teams and working groups oriented around the principle concepts of employees, patient and families, quality, service, building and reinforcing the culture, valid metrics, and keeping customers and employees well informed. For the DHCN, four working groups will be able to address these concepts. These working groups

are: Communication, Culture & Standards, Employee Loyalty, and Customer Loyalty. Additional groups can be designed, but more than 6 groups make the process overly cumbersome. Many of the facets of an organization intersect without cooperating on these points of intersection. The working groups have the mission of establishing and inculcating a Culture of Excellence. They have the mission to find ways to do that within a given area of influence. The command team will monitor the teams' efforts to ensure timelines, appropriateness of initiatives, coordination of efforts and alignment with purpose.

Next, it is necessary to specify timetables, benchmarks, accountability targets and all other measures that will be used in the hospital. These include the OCAI and the proxy measures. A culture change demands more than a routine time line. To change a culture requires a sense of urgency. Establishing short-term, mid-term, and long-term goals with specific timetables and identified, defined milestones creates this sense of urgency. For the DHCN, the advent of the new hospital sets the stage for this sense of urgency. The new hospital timeline of opening in September 2011 is also the basis for the timeline for the Culture of Excellence.

Backwards planning from 2011, the DHCN will inculcate the Culture of Excellence in four phases. Phases 1 will involve the DACH FHC, the ancillary services of Pathology and Radiology and the Emergency Department as a pilot effort. Phase 2 will bring in the rest of the DHCN beginning with the leadership of every department. Phase 3 will introduce initial standards, metrics, customer loyalty initiatives and employee loyalty efforts. Phase 4 is the integration of new personnel, personnel that transfer from Walter Reed and Bethesda, and the move to the new hospital in 2011. Phase 4 will require maintenance as well as increases in the Culture of Excellence metrics. This also means the administration of another iteration of the

OCAI. The *now* profile of this iteration ought to match the previously determined profile for the Culture of Excellence.

For the Culture of Excellence, the phases of the inculcation of the Culture of Excellence and the external deadline of the new hospital opening for business in 2011 are more overarching milestones than end states. Intermediate timelines include the 30, 60, 90, and120-day initiatives. The proxy measure goals also need to be indentified and publicized beyond the provider allowing the whole organization to realize the team effort required for achievement. Milestones allow for reward and recognition en-route to the final goal. Milestones help keep difficult goals from being sources of discouragement. Each milestone represents success and actualization of the Culture of Excellence. As the Culture of Excellence is a journey and not a destination, the timetables and milestones also allow employees and leaders to make continual efforts at excellence without losing hope because of the lack of defined end-states.

Step 3- Indentify current status

Step three in the culture change model is to establish a baseline using an organizational culture assessment tool, (e.g. the OCAI), and organizationally appropriate proxy measures. The Command team and designated leaders within the DHCN all complete the survey first. Then, starting with the work-centers involved in Phase 1, the OCAI is administered to the rest of the DHCN. This may be done in phases or all in one try. Response/return rates may be better if there is a focused approach that includes face to face reminders. These face to face reminders would be most easily accomplished if the OCAI is administered in phases. The profiles derived from the leadership group and the work-centers establish a baseline. The leadership can also assess the amount of variance between what the leadership perceives the *preferred* culture to be, and what the work-center would prefer. Though the OCAI is an effective tool by itself, it can be an even

more useful tool if the demographics of the respondent are identified. A survey supplement that identifies gender, employment type, workcenter, and time on the job among others, will provide the information to identify sub-cultures, trends, commonalities and response rates for every group identified on the supplement.

Step 4 - Communication

Designing a communication strategy is step four. Communication skills will be taught and reinforced to all levels of leadership. Communication from the command team to the various work-centers is an absolutely essential part of any culture initiative and even more so for the Culture of Excellence. The communication methods must be evaluated routinely to ensure they are effective. A graph of the percent of enrolled beneficiaries who have received the influenza vaccine may communicate the data, but not inspire the staff to increase the percentage. Communicating the importance of the measure, a justifiable goal, and every employee's immersion in the effort may require something more. The communication strategy should include the newcomers brief that will inform incoming employees about the Culture of Excellence – as a recruiting tool – it needs to let the new folks know – this is how we are, this is how we operate, and then ask, "do you want to be a part of this?".

The integration into the DHCN Culture of Excellence will include a *Standards of the Culture of Excellence* form that each new employee will read and agree to abide by as an employee at DHCN. The effort will be extended to Contract workers who also work at the DHCN. This will also bridge the culture gap between the civilian workforce and the contractors. The lack of affiliation with the organization's culture was identified as one of the major gaps in the first iteration of the OCAI.

The symbols the organization uses to identify itself, and communicate internally and externally must be assessed for effectiveness. The symbols must align with the Culture of Excellence. The systems, process, policies, protocols cannot be inflexible. The Culture or Excellence calls for flexibility to allow for variance between work-centers, leaders, and situations.

Step 5- Indentifying focus of change effort in 3 phases

Step five is to identify the various aspects of the organization that must be changed in order to reinforce the preferred culture change. Using the OCAI, the *Now* culture profile will have aspects that are not part of the *preferred* culture.

Phase 1

Compare the profiles of *Now* vs. *Preferred* culture profiles and identify gaps that help identify the changes in culture that need to be initiated. The first iteration of the OCAI may not be sufficient to accurately depict gaps. However, the baseline does provide the starting point. These gaps can be compared with the proxy measures, which can then be linked to movement in the culture. Identify which quadrants will need to increase in emphasis and those that decrease in emphasis. An overall unified understanding is not necessary for this step; however, everything that is identified must fit with the profile and be consistent with the Culture of Excellence. Changes that require new policies may not be a culture shift, but a climate shift. Initiatives must also align with the rest of the DHCN strategic plan.

Gaps between the *now* and *preferred* culture profile are not prescriptive. The command team and the working groups' intuitive and experiential awareness of the work-centers tempered with the evidence from literature will be the best way to contrive culture change initiatives. For example, one suggestion for an initiative was to allow employees to earn points or merits for the

number of times they earn a compliment. Though this may seem like it would be an incentive for employees to perform, it does not build teamwork but individual competition. Employees may thwart one another in order to earn merits. The literature finds this to be detrimental to the Culture of Excellence. Periodic recognition and rewards do not have the same effect. Also, rewarding team success does build cohesion and contribute to the Culture of Excellence.

Phase 2

The second phase of step five is when the command team and the working groups will identify specific interventions or initiatives that can be implemented immediately, thereby providing an opportunity for everyone to begin working in a prompt manner toward the Culture of Excellence. Also, once the initiative is accomplished, it shows the rest of the organization that the Culture of Excellence is a priority of the whole organization. The success of the short term initiative builds momentum for the longer term initiatives. The initiative cannot be simply a command policy change. The 30 day fix is something that makes common sense and is sustainable. Be aware that a 30 day fix that is not reinforced, that is not sustained, and fades in 60 days changes the culture but in a way that is contrary to the Culture of Excellence. Advertising these initiatives adds to the stories, demonstrates leader commitment, and allows the whole organization to share in the enthusiasm.

Another essential task is to identify incidents that illustrate the key values of the organization and create stories that capture the essence of the future culture. A story about how an employee in a given situation exemplified the desired traits of the Culture of Excellence. Stories bind the concrete experience to the more abstract concept of the Culture of Excellence. Stories give people an example to follow, a sense that they are part of a group that is unified by shared values. Recognition and rewards from the command team is a critical part of culture

change, but day-to-day mutual support from colleagues is the *life blood* of changing a culture and the Culture of Excellence. Fellow employees going the extra mile, taking verbal abuse and returning kindness, finding the solution for someone who is non-compliant with every process and protocol, seeing the patient who is 15 minutes late for the appointment, exceeding production goals for the sake of it – these are all stories than can inspire others to adopt the values of the Culture of Excellence and put them into action. These stories personalize the Culture of Excellence for the patients and visitors of the DHCN as well as the employees. The patients can add to these stories with their own experiences as well as be a check and balance for the culture.

The symbols the organization uses to identify itself, and communicate internally and externally must be assessed for effectiveness. The symbols must align with the Culture of Excellence. The systems, process, policies, protocols cannot be inflexible. The Culture or Excellence calls for flexibility to allow for variance between work-centers, leaders, and situations. Additionally, the Lean Six Sigma model provides for evaluation of processes that affect a given outcome. The outcome of patient satisfaction, quality care, employee satisfaction, or another metric are partly the function of the Culture of Excellence.

The Federal Civil Service system has a procedure for the dismissal of employees who are not performing to standards. The system is changing and adapting a performance based pay system and simplifying the dismissal procedures. Employee satisfaction and teamwork are supported by the leadership's efforts to ensure that those who do not seek excellence can be removed. Likewise, the organization will attract those who are seeking to work in a Culture of Excellence. An employee who is not willing to participate in the Culture of Excellence may not need to be terminated. An employee whose conduct disrupts the moral and/or the duty

performance of the work-center will find the Culture of Excellence difficult to work in. The employee may convert and adopt the values of the Culture of Excellence or may voluntarily quit. If the employee does persist, fellow employees will alert management. The management can actively engage the employee to either convert or leave-voluntarily or involuntarily.

The OCAI and associated proxy measures are valuable tools for the leadership of the DHCN. However, those same leaders must adjust their style of leadership to align with the Culture of Excellence culture profile. Leadership styles may vary from leader to leader, work-center to work-center and situation to situation. The leader's style may have achieved a performance level on a metric, but that style may not foment the *preferred* culture profile in support of the Culture of Excellence. A survey with metrics and associations with the OCAI culture profiles can assist in helping leaders match their styles with the *preferred* culture. Training of every level of manger in skills that support the Culture of Excellence provides congruence of the leadership style. Counseling of employees more routinely in order to indentify new behaviors and encourage new competencies is one of the skills.

Personalize culture change by identifying the behaviors and competencies that each team member will need to develop or improve to reflect the new culture using a management skills assessment to assist managers. A sense of ownership of the success of the organization coupled with employee stewardship forms the basis for the new mindset, leading to the new behaviors and the willingness of the employees to learn new competencies.

Future Studies

Previous research on DHCN assessed the culture after one year of TQM, the facility, the organizational structure, and strategic metrics. Previous commanders have sought to improve the organization through administration efficiencies, clinical quality, and patient-centric care. This

command team and this study have sought to know, understand the culture of the DHCN and then change it to ensure excellence through the transition to the new hospital and the addition of 2000 employees. Future endeavors could evaluate the effectiveness of the OCAI, subcultures in workcenters, the most appropriate proxy measures, or the difference in the culture profiles of military, civilian and contract employees.

The plan for this study is for the OCAI to be adopted as the culture metric and that the command team will continue to apply the OCAI to reassess culture. The proxy measures will be compared with each new iteration of the OCAI and analyzed. The members of the working groups ought to complete the OCAI, and then, as per the phases, the whole DHCN ought to complete the OCAI. Each successive group can be compared to previous groups. The first groups can detect differences from previous iterations. The group that has taken it for the first time can be compared to those who have already begun the Culture of Excellence journey.

Keeping the DHCN on the azimuth of the Culture of Excellence is a strategic imperative. As the months move toward 2011, trends can be assessed to evaluate initiatives, speed of progress and adequacy of training and communication efforts.

Conclusion

Organizational culture is an important aspect of organizational success. The DHCN has identified the Culture of Excellence as a strategic objective. The OCAI operationally defines culture into four culture types. Discerning internal adoption of organizational values requires a direct measure since performance excellence can be accomplished without inculcation of organizational values. Creating a Culture of Excellence is only possible if organizational values are adopted internally by everyone who works at the DHCN. The OCAI is a better tool, in conjunction with proxy measures, than any proxy measure. This research concludes that the Clan

culture type, with some aspects of the Hierarchy and Market types is what he Culture of Excellence looks like. Initially, however, an Adhocracy culture type will allow for a smooth transition to the clan culture and adoption of the organizational values. The OCAI helps leaders figure out what to do to facilitate this internal adoption. Current metrics used as proxy measures, compared with the OCAI, be connected to moving the culture toward the Culture of Excellence. Implementing the culture change plan will help the DHCN achieve the objective. A Culture of Excellence can transcend personnel turnover, including command changes.

BRAC is changing the NCR. The DHCN will double its current workforce. The Culture of Excellence strategic objective must be achieved and maintained. The OCAI will allow the command to determine what the culture is, and over time, using trends, determine where it is going. The Culture of Excellence can be the basis for employee satisfaction, leading to increased quality of care, and ultimately, to patient increased patient satisfaction.

Glossary of Acronyms

AHLTA	Armed Forces Health Longitudinal Technology Application
AMAP	Army Medical Action Plan
BRAC	Base Realignment and Closure law
BSC	Balanced Score Card
COE	Culture of Excellence
CMS	Centers for Medicare and Medicaid services
DA	Department of the Army
DACH	DeWitt Army Community Hospital
DHCN	DeWitt Health Care Network
DMHRSi	Defense Medical Human Resources System-internet
DoD	Department of Defense
EHR	Electronic Health Record
GME	Graduate Medical Education
GPRA	Government Performance and Results Act
HA	Health Affairs
HEDIS	Health Plan Employer Data and Information Set
IMIT	Information Management Information Technology
JTF CAPMED	National Capital Area Medical Joint Task Force
MGMC	Malcolm Grow Medical Center
MEDCOM	United States Army Medical Command
MHS	Military Health System
MTF	Military treatment Facility

MRR	Medical Readiness Review
NARMC	North Atlantic Regional Medical Command
NCA	National Capital Area
NCR	National Capital Region
NNMC	National Naval Medical Center
NMMC	National Military Medical Center
OCAI	Organizational Culture Assessment Instrument
OMB	Office of Management and Budget
OPM	Office of Personnel Management
QDR	Quadrennial Defense Review
RMC	Regional Medical Command
SME	Subject Matter Expert
TMC	Troop Medical Clinic
TMA	Tricare Management Agency
TQM	Total Quality Management
TRICARE	Military Health System Health Benefit Administrator
TSG	The Surgeon General
USHUS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs
WRAMC	Walter Reed Army Medical Center
WRHCS	Walter Reed Health Care System
WTU	Warrior Transition Unit
WIT	Warrior in Transition

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The data of military, civilian and embedded jobs were obtained from the 2005 BRAC Report, except for National Geospatial -Intelligence Agency (NGA) and PEO EIS. The estimates of military, civilian and embedded contractor jobs for National Geospatial -Intelligence Agency (NGA) and PEO EIS moving to are calculated based on the proportion of National Geospatial -Intelligence Agency (NGA) jobs moving to Maryland and the ratio of total military, civilian and contractor jobs moved out of Fort Monmouth, New Jersey.

Appendix

Letter of Permission for use of OCAI

Subject	RE: request for permission to use OCAI
From	Mandy Liu <mandyliumichigan@yahoo.com>
Date	Monday, June 2, 2008 8:27
To	edward.schupbach@us.army.mil

Dear Captain Schupbach:

Thank you for your inquiring concerning the following instrument: OCAI.

The OCAI instrument (Organizational Culture Assessment Instrument) was copyrighted by Professor Kim Cameron in the 1980s, but because it is published in the Diagnosing and Changing Organizational Culture book, it is also copyrighted by Jossey Bass.

We have a local company (BDS, Behavioral Data Services, 734-663-2990, sherry.slade@b-d-s.com) which can distribute the instrument on-line, tabulate scores, and produce feedback reports. These reports include comparison data from approximately 10,000 organizations--representing many industries and sectors, five continents, and approximately 100,000 individuals.

The instruments may be used free of charge for research or student purposes, but a licensing fee is charged when the instrument is used by a company or by consulting firms to generate revenues.

At least two different alternatives exist for accessing the instrument: (a) pay a licensing fee for unrestricted use of the instrument for a specified period of time; or (b) arrange with BDS to administer the survey, analyze the data, and produce feedback reports on a per-use basis. A fee schedule has been generated by BDS for these services.

I hope this explanation helps. Please let me know if you have other questions.

Best regards,

Mandy Liu
Administrative Assistant for Kim Cameron

Kim Cameron
Professor
Ross School of Business and
School of Education
University of Michigan
Ann Arbor, Michigan 48109
734-615-5247