

The Woes of Implementation Practice: Getting Caught by the “Program of the Month”

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Abstract

Senior leaders from a large American hospital told me that they wanted their hospital to become more “patient-centric” and asked me to help them. I was hired to conduct an ethnographic study of the hospital with a team of six employees and the goal of improving patient experiences. Sixteen months later, the research was completed, effective models of hospital work practices documented, recommendations made, and 16 tools developed to improve hospital culture. Yet none of our work was implemented. I returned to my field notes to discover clues that might explain why. This article explains the process I followed, the stories that revealed unwanted messages, the transcripts that enabled sensemaking, and the program-of-the-month cycle that prevented implementation from occurring.

Keywords

Implementation practice, organizational-culture change, stories, program of the month, patient-centric care, hospital silos

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Setting the scene

It had all the makings to be a critically important, well planned, appropriately resourced, intellectually challenging, and smashing success! An American hospital Vice President (VP), charged with instituting organizational change processes including those related to patients, contacted me. She indicated that her southern regional hospital wanted to become more “patient-centric.” Our discussions led to a collaborative agreement between us for a long-term research and implementation engagement. I was hired to work with six employees to gather and analyze ethnographic data, and develop, test, and implement recommendations and interventions. She assured me that the senior staff and Chief Executive Officer (CEO) were behind the effort and eager to proceed. We settled on the overall goal of improving hospital patient experiences as a way to help change hospital culture. She and the CEO were the official project sponsors.

Numerous factors contributed to my expectation that this project could and would yield significant fruit. First, the VP struck me as honest and forthright, explaining the strengths of hospital culture (e.g., clinical excellence, financial health, well-liked CEO) while also divulging its weaknesses (e.g., “so staff centric,” “low” patient satisfaction scores). Second, I learned that cultural change was to be a core part of the hospital’s new strategic plan. Third, the VP asked me to present at the 2012 Board Retreat, an invitation that suggested a high degree of interest in strengthening hospital culture. Fourth, early conversations with staff portrayed the hospital’s goals as consistent with national health care trends. For example, I discovered that there was strong support for the Institute for Healthcare Improvement’s “Triple Aim” framework to improve the experience of care, improve population health, and reduce per capita health care costs (Berwick, Nolan, and Whittington 2008).

Perhaps most significant in my mind was the upcoming change in U.S. hospital reimbursement through the Centers for Medicare and Medicaid Services (CMS). The Patient Protection and Affordable Care Act (ACA) specified that a small proportion of hospital reimbursement from CMS would be tied to a weighted combination of clinical quality measures and patient perceptions of quality care (as indicated on the Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS survey). The American Hospital Association estimated that up to \$963M would be redistributed in FY 2013 (www.aha.org/content:13:13-linkqualpayment.pdf, accessed August 17, 2017) in an effort to improve patient care. Higher-performing hospitals would likely gain, but lower-performing ones stood to lose. Concerns across America’s hospital landscape were rising steadily as this anticipated policy change approached. It occurred to me then that there had to be a connection between changes in hospital reimbursement and this voiced interest at ABC Hospital (a pseudonym) in “patient-centric” care; indeed, if their

patient satisfaction scores were as low as indicated, a potential funding crisis could be at hand. Nonetheless, I could only imagine that the change in reimbursement policy would work in concert with a project on cultural change.

Fast forward 16 months: The Cultural Change Team or CCT (composed of the six employees and me), successfully completed the research portion of the project, made recommendations, and created 16 tools – all on time and on budget. We identified effective models of hospital work practices that could serve as illustrative examples for areas of the hospital struggling to achieve their goals. We also documented the specific ways in which our research supported and fulfilled the objectives of the strategic plan. However, nothing was ever implemented. Indeed, we were neither allowed to test, nor implement, the recommendations and interventions. One day the VP called, stating that the hospital had “decided to go in a different direction” and that it was winding down the project. The hospital team with whom I had worked was dissolved, leaving CCT members feeling demoralized. The third and fourth quarter and final summary reports were written and submitted. Soon after, the hospital hired a marketing consultant to “energize the Cultural Change Project.”

Implementation processes

Social and natural scientists have been concerned with the application and use of their research approaches and findings. Whole areas of knowledge have developed to facilitate the implementation of change including those associated with *action research* (Tax 1958; Argyris et al. 1985; Beer and Eisenstat 1996), *community based participatory research* (Bolton et al. 2010; Israel et al. 2005; Maiter et al. 2008), *organizational development* (Lewin 1947; Schein 2010; Cummings and Worley 2015), *diffusion of innovations* (Dankowski et al. 2011; Rogers 2003), *culture as a form of motion* (Urban 2010; Urban 2017), and *implementation science* (May 2013; Nilsen 2015). Some recent research has begun to address the “de-implementation” or abandonment of practices that are not evidence-based (Prasad and Ioannidis 2014; Montini and Graham 2015). Thus, researchers and practitioners from many disciplinary backgrounds have investigated the processes, outcomes, and subsequent evaluations surrounding implementation.

In any kind of implementation, understanding the context is critical (Gaglio et al. 2014), as is putting in the necessary time and effort (Shin et al. 2017). Some researchers suggest the importance of goals and measurement (Neta et al. 2015), while others emphasize timely and credible communication (Reichers et al. 1997) and leadership commitment (Armenakis and Harris 2009; O'Hagan and Persaud 2009). Darrouzet et al. (2010: 62) stress the value of “participatory

ethnography” in which staff serve as “paraethnographers” working with the professional ethnographers. In a similar way, the participation by potential beneficiaries (Darrouzet et al. 2010; Armenakis and Harris 2009; Wanous et al. 2004) has been cited. This tremendous body of research, implicitly or explicitly, stresses those characteristics that are likely to raise implementation effectiveness, including its acceptance and use.

I use this research as a starting point to make sense of the CCT’s experience. I initially believed that I was at fault in some way for the failure of the proposed implementation processes. However, in analyzing selected portions of the field notes three years after the project ended, I came to agree with the conclusion that CCT members expressed in the final months of the project: the planned organizational-culture change would not take hold at ABC Hospital. This article is a search for explanations that encouraged the research along with the delivery of recommendations, interventions, tools, and contributions to the strategic plan, but not their implementation.

Theoretical framework

Applying change mechanisms to solve problems

Anthropologists have long been interested in the mechanisms by which cultures and cultural features emerge, survive, change, or disappear (Boas 1920; Kroeber 1919; Tylor 1871; Wissler 1914). It is generally accepted that cultures change through three important mechanisms: invention, cultural loss, and diffusion. Acculturation, a special type of diffusion, involves sustained contact between two or more groups that yields changes for one or all groups over a relatively short period of time (Berry 1980). Innovation is a term connected with invention, though viewed more broadly. It may be an idea, behavior, or object considered new “because it is qualitatively different from existing forms” (Barnett 1953: 7). New ideas travel across cultural boundaries via “diffusion, acculturation, and faddism,” resulting in some form of acceptance or rejection by the recipient(s) (292).

Because the primary focus for 20th century anthropologists was community rather than organizational settings, much of the foundational work on cultural change was carried on by other disciplines. Rogers, a rural sociologist, spent much of his career fine-tuning his understanding of the “diffusion of innovations,” focusing on communication channels, rates of adoptions, and decision processes, among other factors (Rogers 2003). Psychologists and business management scholars have influenced how organizational cultures change over time. The popularity of staged-based process models grounded in Lewin’s (1947) paradigm (i.e., unfreezing, moving, and freezing), and readapted by Schein (2010) and others, continues as an important contribution to the organizational

literature. Indeed, these stage-based models are core to studies of *planned* organizational change (Armenakis and Harris 2009; Cameron and Quinn 2011; Kotter 1996) because of their practical value in guiding the organizational-change process step-by-step.

Anthropological research and implementation in organizational settings

The discipline of anthropology has been undergoing significant changes. Since problem solving, application, and practice have taken on an increasingly prominent place within anthropology (Ginsberg 2016; Fiske et al. 2010; Rudd et al. 2008), more professional, practicing, and applied anthropologists have been involved in organizational-change processes, design, and marketing. Recent edited volumes highlight this work that often reflects principles of action research and community based participatory research (e.g., partnering with organizational insiders on all research phases, improving quality of life) (Cefkin 2010; Gunn et al. 2013; McCabe 2017; Nolan 2013).

Anthropological research on planned organizational change by Briody et al. (2010) incorporates the complementary roles of researcher and change agent. The research is generally consistent with the stage-based and practical approach employed by psychologists and business scholars. An important difference, however, lies in the unit of analysis. In the business approach, “altering individual attitudes and behavior” is the goal (Ferraro and Briody 2017: 195), while the anthropological approach is “organization focused” with attention on “work environment, workforce, relationships, and work practices” (203). “Organization-focused” studies lend themselves to investigations of cultural-change mechanisms – innovation, diffusion, and cultural loss – and the relationship among them.

Stories and new initiatives: how they appear, diffuse, remain, and/or disappear

In this article, two common features of organizational culture, namely stories and new organizational initiatives, are highlighted. Both features represent cultural processes involving borrowing (or diffusion) and disappearance (or cultural loss). Neither survives unchanged in an organization because of connections to other organizational-culture elements.

Stories are typically “of” the organization and tend to emerge internally based on actual or anticipated situations or events (Boje 1991). They may be partially or fully fictitious and result in multiple interpretations. Stories diffuse across employee networks, crisscrossing units, levels, and job types. They serve various functions including raising awareness, problem solving, persuasion, and reinforcing ideals (Connell

et al. 2003; Jordan 1996; Orr 1996). When two or more stories are compared (e.g., illustrating culturally appropriate or inappropriate behavior), the impetus for change can be powerful (Briody et al. 2010; McKinnon 2008) and affect cultural change (Briody et al. 2012). The acquisition, learning, and transmission of stories are subject to various forces (e.g., inertia, drift, interest) (Urban 2010; 2017). For example, stories can disappear when they are forgotten, lost, or no longer shared.

New initiatives are viewed as a form of innovation. They usually reflect external trends – say, those linked with quality improvements or current best practices. Disseminated to organizational members through the media, trade organizations, academia, and consultants (Geller 2014), new initiatives can be helpful in the production, distribution, sale, and use of products and services. They represent hope to organizations because they have been developed, tested, and implemented elsewhere. Their “aura” can also be attributed to their novelty and often to lessons derived from prior efforts. Typically, there is some mutual adaptation process involving the innovation and the organization (Rogers 2003).

However, an initiative’s successful integration into an organizational culture can be compromised and linked with a cyclical process known as the “program of the month” or “flavor of the month” (Best 2006). Explanations for this cycle, which entail innovation, diffusion, and disappearance (or cultural loss), include inattention to “learning organization” principles (Shin et al. 2017), inconsistency with organizational identity and values (Cummings and Worley 2015), unclear rationale (Geller 2014), lack of “principal support” from organizational leaders (Armenakis and Harris 2009), employee cynicism (Wanous et al. 2004), and lack of accountability (O’Hagan and Persaud 2009). Best (2006: 18) points out that institutional fads are based on the belief that “innovation represents progress” and that they have a life cycle characterized by “emerging, surging, and purging.” This seemingly-repetitious pattern of change creates organizational turbulence in which priorities are neither well founded nor well defined. For example, Herold et al. (2007: 949) argued that leaders should not assume each change is an “independent event” because there is a cumulative effect of changes on organizational members.

Implementation practice and outcomes

I examine *implementation practice* defined as the planning and execution of organizational change by key stakeholders. Two stories and selected program-of-the-month initiatives in a “silo-ed” or decentralized organization (Diamond et al. 2004; Lencioni 2006) become the lens for this exploration. My goal is to identify elements that prevented the implementation of recommendations and interventions so that it is possible to explain why “a cohesive pattern of change in an organizational

culture" (Briody et al. 2010: 8) was not achieved.

Few lessons or current best practices are available to guide anthropologists in the specifics of implementation practice. Skilled incorporation of anthropology's virtues (e.g., ethnographic approach, contextual understanding) combined with minimization of communication issues with stakeholders (e.g., use of accessible language, focus on relevant problems, provision of recommendations) certainly can help enhance practice effectiveness (Closser and Finley 2016). However, those elements alone offer insufficient insight into implementation failure. It is now time to move beyond the understanding and explanation that *research* can provide, to an understanding and explanation of *implementation* and its outcomes. I address the following questions:

- What can we learn about organizational culture from stories and new initiatives?
- What do stories and new initiatives reveal about change processes within organizational culture?
- How should organizational-culture change be encouraged in siloed organizations?
- How can we expand our understanding of implementation practice?

Methods

The research design employed an ethnographic approach, crafted to contain a mix of techniques: in-depth interviews and conversations, observation, participation at meetings, and documents and digital materials. The project period extended over 17 months in 2012 and 2013; a few additional conversations and email exchanges with hospital employees occurred since then.

The cultural change team at ABC Hospital

The six ABC Hospital employees were experienced professionals with backgrounds that complemented anthropological research and application (e.g., industrial psychology, organizational development, nursing). Four worked in Organizational Improvement and two were employed in Human Resources. They served as hospital analysts, managers, and directors. Three of them had participated in "Contextualist™" training offered by VHA, Inc., a national healthcare network. The training included practice in a variety of qualitative methods (e.g., observation, clustering themes, story collecting, metaphors) and data gathering and reporting topics (e.g., bias, induction, framing, drawing conclusions).

Collaborating with this team was particularly helpful; each member had unique perspectives and experiences at ABC and could offer specific insights and explanations for emerging patterns.

Because team members had worked at ABC Hospital for many years, their work relationships were extensive. Having access to their networks facilitated data collection, as well as validation of emerging patterns. Together, we (the CCT) developed six PowerPoint reports that included four quarterly reports, one Board report, and one final summary report. Separately, I prepared two pre-contract reports for Board members and hospital leaders. The CCT also created 16 problem-solving and cultural transformation “tools” that targeted hospital cultural issues and employee engagement with patients and family members.

Data collection

Table 1 illustrates our key data collection techniques. We conducted 137 interviews with hospital employees that lasted 45 minutes on average; prior to signing the hospital contract, I conducted some preliminary interviews and observations as well. (The consulting contract limited my interaction to employees; I was not free to speak with patients.) Typically, the interviews were done one-on-one, although there were occasional group interviews. We interviewed across all employee ranks and functional areas (e.g., nursing, environmental services, surgery, pharmacy). We used open-ended questions to gather descriptions and viewpoints of hospital culture. Questions used repeatedly included:

- What is a typical or composite day for you?
- Please give me a list of *everything* that is important to patients during their hospital stay.
- What do you consider to be an ideal patient experience?
- How does your ideal description of the patient experience differ from the current state?
- What aspects of patient flow are working well compared to those needing improvement?
- To what extent is wait time a problem in your unit?
- What could be done to reduce patient wait time when other units are involved?

	Interviews	Meetings	Observations
Number	137	55	57
Hours	102	80	81

Table 1: Type of Data Collection Techniques by Number and Hours

We took extensive notes during our meetings with hospital staff, and our observations of them as they worked. Taken together, the number of hours that we spent in meetings and engaged in observation totaled over 160 (See Table 1). We attended a variety of meetings, some of which were regularly scheduled (e.g., patient experience team, staff meetings). Our observations occurred in various hospital units and at a new employee orientation.

We also gathered a wide range of pertinent documentary and digital materials. Among them were hospital mission, vision, and value statements, patient satisfaction surveys, employee surveys, hospital newsletters and email blasts, meeting agendas, hospital programs, and annual reports.

Data analysis

We transcribed our handwritten notes and shared our work within the CCT. We used content analysis to identify themes and patterns. For example, we created master files documenting categories such as employee hypotheses about ABC culture and hospital success stories. We triangulated across our various data collection techniques, sample, and CCT researchers. Given that CCT members possessed different disciplinary and functional knowledge, we were able to ask our questions, draw our inferences, and test our hypotheses with each other – first. That process gave us confidence in what we were learning and prepared us to discuss it with a broader cross-section of the hospital staff.

The two stories analyzed here reflect the contributions of the CCT. They focus on patient flow, a critical ABC issue. The Flow Story and the Story of Flow Unlocked, respectively, are based on statements drawn from the entire data set.

A subsequent discourse analysis of sponsor reactions to the two flow stories is based on two particular discussions. One meeting was called by the VP to review the content of the first of four quarterly reports, while the other involved presenting the first quarterly report to both the CEO and VP. The attitudes and behavior that the VP and CEO expressed related to organizational-culture change were validated by other field data.

The flow story

Patient flow through the hospital

When individuals arrive at a hospital needing care, whether through Admissions or the Emergency Department (ED) – often referred to as the Emergency Room (ER) – they become part of a process called “patient flow.” Flow is a somewhat standardized, yet customized, sequence of steps in patient diagnosis and treatment; it ends at discharge.

Flow was a significant issue for ABC Hospital. Bottlenecks frequently occurred as staff tried to balance the often-unpredictable influx of patients with the appropriate number of staff and available beds. When the project was initiated, wait times to consult with a physician and, if admitted, secure a bed on a hospital floor could be protracted – up to 20 hours, eight hours on average – as could patients going to or returning from surgery, or patients waiting to be discharged. Such bottlenecks negatively affected comments about the patient experience, contributed to low patient satisfaction scores (i.e., HCAHPS), and lower than expected CMS reimbursement. The CCT focused part of its research on how employees understood patient flow.

A consensus view of the flow story

As one nurse stated, “I mean we all hear stories like ‘The bed was clean three hours ago and it hasn’t been changed in the computer!’ or ‘You have to wait until after the change of shift. We can’t take report now.’” After eliciting employee narratives of patient flow, a consensus view emerged. Indeed, employee perceptions were based on experiences in their own unit. Sometime, a powerful upstream unit was said to be responsible:

...if people said they couldn’t handle it and were running around like chickens with their heads cut off, the charge (nurse) would say, ‘My nurses are saying they just can’t handle that patient.’ And the response we would get from the ER was, ‘It doesn’t matter. The patient has to come (to you) in 15 minutes and you are taking the patient anyway, regardless of what your feelings are....’

Yet, we found criticism traveled freely across all organizational units:

- “An admitting physician will come down here. It could be 20 minutes. It could be two hours...The patient just sits here...and we can’t explain what’s going on. It’s an uncomfortable position for the (ED) staff....”
- “I don’t think the floors understand...that when they have five patients that are set for discharge and they put all five patients in the computer minutes after each other, how that really affects the flow from (the Patient Transport Department) standpoint.”

Employee attitudes and behaviors related to flow

Complaints varied but seemed to relate generally to an inability to control the amount and pace of work. For example, note the highly evaluative words (in bold) used in these quotes:

- “The greater the capacity, the more **frustration** and **gridlock** and **stress** and inability to move the patient...when we get up to 100% (capacity) you get increased **resistance**.”
- “As a bedside person, you are put in the **vise** of doing more work and then being criticized for the patient experience and ... you have proportionately less time to pay attention to all the patients you already have!”

These specialized terms (in bold) stand out because they can evoke unpleasant visual images and/or because an irritable tone of voice (e.g., of anger, exasperation) is apparent.

Staff took actions to level the patient flow through their units. Some simply resisted. Here is a relatively common strategy of slowing down the work:

- “...let’s say I’m taking care of four patients and patient A is admitted upstairs. But I know if I get rid of patient A, I’m going to get another patient and that is going to be more work. So, I drag my feet and I don’t send my patients up as quickly as I could...”
- “...a nurse’s station hold(s) off on a discharge or delay(s) a discharge in order to prevent a new patient from coming to their floor because it’s almost change of shift...”

By contrast, other employees engaged in problem solving. Their strategies were adaptive to the bottlenecks. They often pitched in to assist when it was not among their assigned duties as in this example:

Yesterday, I’m walking down the hallway and I see a patient ... (who asks) ‘Can somebody take me? Where’s my ride?’ And I’m like, ‘Oh no. We (nursing unit X) can’t have that.’ So, I made sure to cancel the transportation request and we took the patient down. A lot of times that’s what we’ll do.

Suggested employee solutions for flow

The Flow Story offers insights into problem solving from the vantage point of those directly affected by the bottlenecks and staff shortages. Several themes appeared in the proposed solutions, all of which add to our understanding of ABC Hospital culture.

One theme, *accountability*, appeared in this potential solution: “I think it’s getting on the same sheet and measuring and monitoring and holding accountable every part of the system where there is a flow problem. You identify it. You drill down....” The salience of weak accountability was validated in an examination of my field notes during the first month of the project. I analyzed the number of freely-elicited mentions of the hospital’s official values: integrity, compassion, accountability, respect, and excellent. The term “accountability” appeared 23 times (61 percent) among the 38 mentions, and always reflected the *lack* of accountability in ABC culture (e.g., “There was no accountability for the action plans”).

A second theme, *employee empowerment*, was evident: “The flow issues...really can get fixed by the people at the bottom if somebody gives them the vision, gives them the mandate to get the job done, and gives them the opportunity to do it. But we try to drive change from the top.” It is evident that employee empowerment is fragile and not routinely the norm. More common in the data set were numerous concerns about the “scrutiny” as well as the “gatekeeping” mechanisms in place.

- “We’re waiting for people (leaders) to say, ‘This can be done!’
- “That (survey tool) still needs to be approved by everybody and their pet puppy.”

Moreover, employees also expressed their hopes for a future ideal ABC culture in which empowerment was pervasive:

- “Everybody has a role...this is about all of us.”
- “Grassroots...it (problem solving) should start from the bottom up.”

The theme of *collaboration* also was among the recommendations employees offered. We saw examples of it, particularly during stressful times (e.g., during a patient “surge,” during a combined patient surge and trauma incident):

- **Nurse:** “Holler at me if you need me. I can do Triage or Unit-3 or whatever.”
- **Charge Nurse:** “Have you eaten yet?”
- **Nurse:** “No.”
- **Charge Nurse:** “What can I do for you so you can (eat)?”
- *Floor 7A sent down a (medical) tech (to the ED) to transport a patient to be admitted to 7A. (Observer Notes)*

Self-optimization as ABC's current cultural model

ABC Hospital's cultural model emerges in the Flow Story. Individuals and units optimize for themselves rather than for the whole. Indeed, the Flow Story is emblematic of a silo-based organizational culture:

- "The rules are, 'Stay in your own lanes until you are asked in.'"
- "Some say, 'My area did just fine and that's all I care about.'"

Validation of this culture can be found in the terms and phrases used frequently at ABC: "kingdom," "fiefdom," "turf," "territorial," "handoff," "hurdle," and "bed dumping," to name a few. Organizational inconsistencies are particularly noticeable at unit boundaries (e.g., ED and floors) where work rules, practices, and processes vary. Participation in a silo-ed culture may be neither desirable nor preferable: "Right now we don't play well, or communicate (but) we want to be part of the solution." However, the Flow Story suggests that adherence to a common set of organization-wide goals, processes, and structures is weak at best.

The story of flow unlocked

The Story of Flow Unlocked, like the Flow Story, is a composite depiction of patient hospital care. It describes organizational boundaries where bottlenecks have been mitigated so that flow can proceed. This story represents the intersection of two or more units working together on behalf of the patient. We found several examples of the Story of Flow Unlocked as patients entered the hospital system, were transferred within it, or were discharged from it.

Goal: relieving bottlenecks

One version of the story concerns a small subunit that "changed hands several times and historically it fell into that Med/Surge overflow." When capacity was high (i.e., all regular beds were filled), patients could be assigned there. During our project, this subunit became part of the ED and was renamed the ADT (Admissions, Discharge, and Transfer) unit:

"...if a patient is ready for admission (from the ED), and the bed or the staff (on the particular floor) is not ready, the patient will go to ADT. A hospitalist (i.e., physician) will be there to write orders (to get the patient's care started)."

A dedicated physician and two nurses staffed the ADT. The patient left the ADT as soon as a bed on the appropriate floor became available.

This small subunit had always acted as a buffer – whether as a Med/Surge overflow unit or the ADT. In both cases, it enabled staff to handle a rise in patient numbers. When the hospital reached capacity, the

beds in this subunit could be made available. ADT differed from the Med/Surge overflow unit in its number of functions, including admissions and discharge. The ADT accepted those patients who were going to be admitted from the ED waiting room so that their care could begin, and also assisted with patient discharges from the floors. Keeping the flow of patients moving freed up beds for incoming patients.

Strategies to unlock flow

The two managers – one in charge of the ER and the other of flow hospital-wide – faced a number of challenges in arresting flow bottlenecks. In particular, they had to figure out how to bridge organizational boundaries. They knew unlocking flow was contingent upon motivating other units to cooperate and work differently. Fortunately, their Nursing VP was strongly supportive of their ideas, and peers and subordinates viewed them as likeable and respected.

Examples of their statements illustrate their determination and blunt and honest approach in generating buy-in:

- “(To) the Pharmacy, Radiology, Lab, I said, ‘We’re going to have extra taxing stuff on you. We’re going to expect you to turn over these orders relatively quick ... Is this something you’re willing to do?’”
- “The ancillaries – Lab, Radiology – never balked once. They said, ‘Okay, we’ll treat ADT as an extension of the ER. We’ll give you the turnaround times that we give you down there.’ And they lived up to it.”

Both managers appreciated experimentation and metrics, building the evidence base, and learning from results. They cemented organizational connections by displaying progress. They also articulated the potential of cross-unit partnerships: the ability to traverse organizational boundaries across any set of hospital silos:

We’re really excited about it. And to me the exciting part is not just looking at what the ADT is capable of doing – it’s that I know we can replicate that anywhere in the building. And that’s my ultimate vision of this ... to say, ‘Yeah, we did it over here, but you can do it over there.’

Contrasting viewpoints: benefits and shortcomings

Versions of the Story of Flow Unlocked expressed employee excitement, motivation, and high energy. Employees identified particular advantages of the ADT including reduced patient wait time, faster patient care under surge conditions, and shared discharge responsibilities for units.

- “We got the patient to a quiet, safe environment.”

- “We utilized ADT last week ... There were 12 patients we were able to get off the floors quicker because they were able to go there while they waited for transportation.
- “The ADT nursing staff helps tremendously! ... When they are free (to do admission or discharge paperwork), it frees us (Unit X) up soooo much. It’s great.”

Employees believed that ABC’s patient satisfaction scores would improve. Their beliefs were borne out as the ADT pilot soon transformed into a permanent hospital unit.

Yet, some staff expressed skepticism about ADT’s benefits. Some floor staff resisted using both the ADT as well as its “roving nurses” to assist with patient discharge:

- “So, they want to move the patient to ADT and then move them to (Unit X) or another unit when they get a bed available, and I think ... “That’s three beds, two moves, but whatever’s good for the flow!”
- “There’s some other floors that are not transparent in what they do, and they refuse to let us (roving nurses) come ... You (floor staff) know when that patient leaves, you are going to get another patient. So, we’re not even allowed on that floor.”

Others suggested that interference with ADT’s charge was underway: “...the purpose of the ADT is good...Trying to make it work and dealing with the staff frustrations associated with it is a challenge. Last week when we were at a high capacity, it was used as a holdover area.”

Optimization of the whole as ABC’s imagined future cultural model

An ideal cultural model for an imagined future appears in the Story of Flow Unlocked. A “changed vision” designed to “tackle the high-priority areas” where flow blockages occurred guided hospital activity and involved the following key elements:

- Middle management outreach: “We win together.”
- An invitation to participate: “Jump right on board!”
- Experimentation and testing to counter resistance: “(We are) no stronger than the weakest link in our chain.”
- Selected senior leadership support: “Challenge what we are used to doing.”

Sponsor reactions to the flow stories

Long after the CCT project ended, I undertook a discourse analysis of two meetings with the project sponsors (i.e., the VP and CEO) to present the

findings from our first quarterly report and gather their feedback. The February 2013 meeting involved the VP, who wanted to review the findings in advance; all CCT members attended. Approximately one month later, I presented a revised PowerPoint deck to both the CEO and VP; CCT members were not invited. These meetings occurred approximately halfway through the project's trajectory. Two of the spheres in the center of Figure 1 are highlighted to reflect these meetings. The delivery of PowerPoint reports is depicted by triangles.

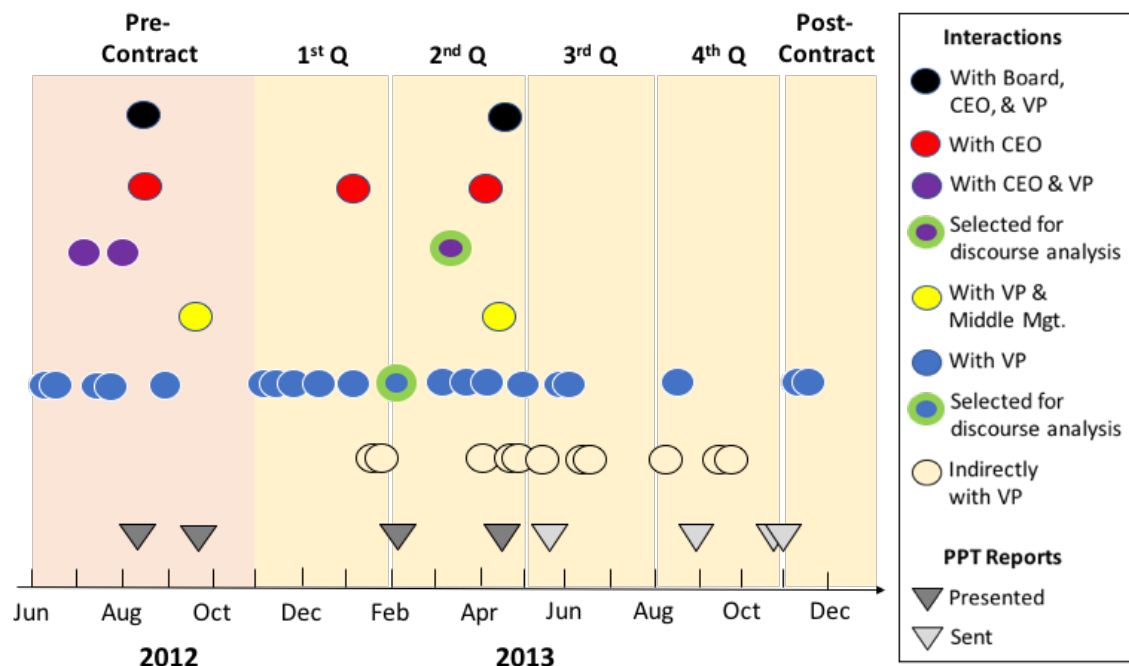


Figure 1: Project Sponsor Interactions and Reports by Phase

Figure 1 also illustrates the positioning of these two meetings within the context of all key interactions with the VP and CEO during the program. I return later to describe other attributes of this figure.

VP's emphasis on themes

The VP (Chloe) indicated that we would review our work with her first, and later with the CEO (Mitchell). (All names are pseudonyms). For the February meeting, I joined the Chloe and the six CCT members by conference call. This particular discussion lasted 55 minutes.

Chloe began talking almost immediately:

I don't think it's on track ... I *know* what Mitchell is looking more for ... what themes we think exist in this organization and how we vetted those, at least in flow, and confirmed them at a leadership level ... Holly, did you send the themes report to Elizabeth? He's looking more for the themes and what evidence did we find of that

– whether we’ve gotten to them all or not.

Themes appeared to be highly salient for Chloe. I wondered why identifying “all” themes would be useful? Later I realized that the “Contextualist” training that she and about 30 others from ABC had taken involved stressed themes. In particular, the training focused primarily on the *identification* of themes rather than their explanation, impact, or problem-solving potential. It is likely that Chloe had no practice in understanding ABC’s cultural themes in relation to hospital issues and no practice in formulating policy to address hospital issues based on the themes.

VP’s counterarguments to the stories

Methodology concerns voiced

A combined admonition-denunciation of the two flow stories characterized Chloe’s comments as she called into question our methodology:

- *Interview sample*: “I had some *real* questions about the quotes ... I was told by the team that they only interviewed leadership, but these are like staff-level comments.”
- *Flow Story not validated with actual behavior*: “It’s like citing the behavior that’s happening that you don’t really know is happening.”
- *Definition of a story*: “I have a problem with the ADT Story and I’ll tell you why... ADT has existed as about 56 different animals for the last five years. What you have here as far as the innovation is about two weeks of pilot. I don’t think there is a story yet.”

All three statements fault us for inappropriate analyses. In the first two, Chloe argues that we made errors in sampling (because the results were unexpected) and in quality control (because without comparing a story to actual behavior, it is impossible to know the story’s accuracy). In the third statement, Chloe insists the Story of Flow Unlocked cannot count as a story (because it is too new and its long-term outcomes are unknown).

Beliefs in leadership misaligned with leadership performance in the flow story

Chloe’s second critique revolved around our findings from the Flow Story analysis and their implications for ABC’s culture. She returned five times to our analysis (see time stamps):

- *At 3:52*: “So is this a leadership thing – what they think the staff is doing? Because we’re in big trouble if that’s what this is – I mean big trouble with the culture!”
- *At 4:51*: “I’d fire them – the leader that said this because they know this problem is existing that’s impeding patient care and they’re not stopping it? That’s their goal as a leader!”
- *At 13:48*: “I’ll tell you, as an Executive Team member, when I saw this, I wanted to go and fire the whole lot...If this is your perception of leadership, if this is what is going on, if we as leadership are not stopping it?”
- *At 36:14*: “If this is what leaders are saying happen that other people *do*, this is a terribly compelling.”
- *At 36:56*: “These *other* quotes are *absolutely heart-sickening* when I find out that they’re not somebody admitting to their own behavior, but it’s somebody saying what they think somebody else said.”

Chloe’s interpretation of the Flow Story evolves. She seems to exhibit disbelief and alarm in the first statement, followed by anger in the second and third, resignation in the fourth, and dismay and bewilderment in the last statement. In the end, she appears to have come to terms with the Flow Story’s validity.

Cost effectiveness in the story of flow unlocked

Similarly, our VP was upset about our selection of the ADT as an example of Flow Unlocked:

Chloe: I think this can be appendix material, as a potential future story. But, I think that it (ADT) could grow up to be as bad for us as it might look good right now ... while all of them pin their hopes on this pilot as a way of reducing silos, it’s run for two weeks!

Elizabeth: Well, it’s less about the story – it’s less about ADT – and more about the idea of a buffer, which allows the flow to move. And when the flow is able to move, it reduces the bottleneck, and it enhances patient satisfaction, and it breaks down silos.

Chloe: And it (ADT) adds *significantly* to the cost of each patient’s care in a way that I’m not sure...the organization can bear, simply because we haven’t unclogged or solved the problems on the flow. So, we’ve added another whole system.

Chloe tied the ADT story’s definition, accuracy, and usefulness to its long-term cost effectiveness, dismissing it in anticipation of a poor return on the ADT initiative.

CEO's support for disseminating the CCT presentation

The CCT made a few revisions to the deck, calling greater attention to key themes. However, we made no substantive changes in the content, offering convincing responses to Chloe's counterarguments. The review with Mitchell, accompanied by Chloe, lasted 57 minutes. I joined by conference call.

I began with a general overview of lessons from the two stories, summarizing: "ABC employees are really showing us the way" to which Mitchell affirmed, "How's that for you?" I continued,

We just have to find a way to listen, and then figure out what are the best ways in which we can support them, and then grow the model further; in other words, figure out ways of replicating the story (of Flow Unlocked) in many other contexts within the hospital.

Mitchell seemed to understand.

Toward the meeting's end, he expressed interest in sharing the presentation with the Executive Team:

...we just want to have a dedicated day just for the topic. I think from a co-ownership perspective...it's going to require everybody...We will talk through culture. We're going to talk through findings...and talk about how we can change culture and use flow as a vehicle to be our first driver, our first area of focus.

Twice during Mitchell's statement, Chloe indicated her agreement. Both appeared pleased with the review and in agreement on informing the Executive Team. Mitchell again reiterated his decision for an Executive Team review, identifying two possible dates. If this discussion occurred, no CCT member was invited.

CEO's allusions to hospital initiatives

Raising awareness

While calling attention to the recommendations and interventions as part of the general overview, I advocated the creation of problem-solving teams composed of Executive Team members, the CCT, and those staff experiencing bottlenecks. These teams would 1) set improvement goals and metrics for patient wait time, 2) engage in cross-organizational problem solving related to bottlenecks, shortages, and other flow issues, 3) implement flow solutions, and 4) evaluate the impact of those solutions on the patient experience as well as staff.

The presentation had been underway about eight minutes when Mitchell asked:

Has anyone talked to you about one of our initiatives – moving

toward a hospital-wide, or actually what I would call, Enterprise-wide, Interdisciplinary Shared Governance program? ... It's going to include everybody. It's going to be enterprise-wide...While there are some successes (with Interdisciplinary Shared Governance in Nursing), it has not been optimally instituted (throughout the hospital). So, what we're going to borrow is some off of their experience. But, we are really gonna just take – I won't say a blank palette approach to it – but we're really going to focus on engaging the entire house (hospital) around making it a patient-centered process.

Mitchell continued:

"But I'm wondering if we move to a Shared Governance, can we integrate what we are doing here (with the Cultural Change Project) with that (Shared Governance) process?" I responded in the affirmative, indicating that we had some suggestions for how that integration might occur.

At that moment, the cultural pattern embedded in Mitchell's questions was not clear to me. However, in analyzing his questions later and comparing them to other hospital examples, I recognized that his questions reflected program-of-the-month initiatives. He

- Used language ("actually what I would call") suggesting he considered it his initiative
- Named the initiative: "Enterprise-wide, Interdisciplinary Shared Governance"
- Distinguished this initiative: "Enterprise-wide, Interdisciplinary Shared Governance" from its predecessor "Interdisciplinary Shared Governance"
- Viewed his expansion of the initiative ("engaging the entire house") as an improvement
- Tied this initiative to the hospital and the Cultural Change Project's focus: patient-centeredness.

Noteworthy was how he changed the discussion's focus to his new initiative – just eight minutes into the meeting. As was soon evident, his initiative foreshadowed an emerging disinterest in our proposed implementation. Moreover, his push to change what others were advocating – whether Nursing or CCT – now appeared to be part of a larger cultural pattern. I had observed numerous hospital programs during the project including the waxing and waning of initiatives in communication (e.g., "Crucial Conversations," "AIDET"), Nursing (e.g., patient whiteboards, "Colleague Health and Wellness"), and Human Resources (e.g., "Transformational Leadership," "Diversity and Cultural Proficiency Assessment Tool for Leaders"). And, Chloe's mention of

themes was most likely connected with the Contextualist training.

Bypassing implementation

At about 45 minutes into the presentation, I offered a general statement about organizational-culture change processes:

Elizabeth: So not only do we need this extremely strong leadership support, and leadership involvement in the change processes themselves, but we also have to have employees actively involved in the change processes. (I invite a discussion on suggested roles for proposed flow interventions.)

Chloe: Let me tell you what we have done so far. A: We've blown up the two flow teams...Bettie, David, and I have talked about meeting and huddling to have one (**Mitchell:** One) team that is workable size that people can do to actually get this work done. (**Mitchell:** Right!) The other thing that we've done is we've fully vetted and tried and know the weaknesses or strengths of a number of different metrics. So, we are well on our way to getting the metrics and measurement down to what we need to really tell the story of delays and bottlenecks or whatnot...You can't hide behind it anymore...So, we've done the beginning steps on these two pages, Elizabeth. When I first saw some of these (recommendations), and we've been asked to talk about some of these others (recommendations), I think we are well on our way to a beginning effort...So, right on target, Elizabeth. Thank you!

About five minutes later, I asked Mitchell and Chloe to consider the following questions:

1. "Who will be responsible for implementation (of the recommendations)?"
2. "How will roles be assigned?"
3. "Who will people report to on their progress?"
4. "How should we engage the leadership *in general* about change?"

Chloe deflected, "We need to engage the Executive Team and then some of these (responses) need to flow from what the Executive Team feels. Who will be responsible? Let's just not have one person." Agreeing with her, Mitchell then reiterated the value of his new initiative:

This is where I'm thinking ... To say we are doing Enterprise-wide Shared Governance is one thing. If we just do it as a perfunctory exercise, it has no real meaning. (But) We can actually marry these (Cultural Change Project and Enterprise-wide Shared Governance) together and have Enterprise-wide Shared Governance have *real* meaning, real functional improvements

coming out of it. It's more than just something that we say we're doing.

Chloe quickly added, "Or where we present information."

I left the meeting believing that both leaders found our first quarterly report worthwhile, an improvement over Chloe's initial reaction. At face value, the ideas in it seemed consistent with Mitchell's governance initiative. Yet, as I revisited the data set, my original interpretation of Mitchell's enthusiasm was dampened. No decisions or substantive follow-up steps related to implementation were identified. No attention focused on discussing solutions to ABC's cultural problems. There seemed to be little appetite for engaging and empowering employees to problem solve together across "siloes," though Chloe articulated that the Executive Team would need to lead any change effort.

Discussion

Organizational culture in stories and new initiatives

Comparing the Flow Story with the Story of Flow Unlocked helps to isolate cultural themes reflecting the hospital's current culture and an ideal state, respectively (See Figure 2). When understood holistically, the themes portray important aspects of the current and imagined structure and dynamics. While this approach is aligned with earlier analyses of stories and oral histories (Briody et al. 2012; McKinnon 2008; Orr 1996), the explicit pairing of two flow stories exposes stark cultural differences and yields distinct cultural models. In a silo-ed, change-resistant culture, individuals and units optimize for themselves. By contrast, a collaborative, innovative potential-future culture optimizes for the (organizational) whole.

	Current Culture	Imagined Future Culture	
Silo-ed Micromanaged Change-resistant Optimized for Own Unit	Individualized work	Both team and individualized work	Collaborative Empowered Innovative Optimized for the Whole
	Compartmentalized units	Permeable open units	
	Primacy of hierarchical relationships	Primacy of horizontal relationships	
	Control focus	Problem-solving focus	
	Suppression	Sharing	
	Blaming	Praising	
	Lack of accountability	Accountability	

Figure 2: Cultural Themes Derived from Flow Stories

While some innovations become embedded in the organizational culture, others morph into the program-of-the-month pattern. New initiatives come to be labeled as programs of the month when employees have little confidence that they will endure. The literature has documented the negative effects of this pattern using individuals as the unit of analysis (Herold et al. 2007; Reichers et al. 1997) rather than a focus on new initiatives. We believe there is value in explaining this repetitious cycle from a cultural perspective.

The availability and access to innovative programs and practices seem to arise as a protective device for organizations in turbulent industries. Healthcare has followed a path similar to the quality movement of the 1980s, complete with its quality of work life programs, statistical process control systems, and various quality training programs (Deming 1982). With the paradigm change toward patient-centeredness, numerous organizations (e.g., theberrylinstitute.org, studergruop.com) offer their programs and services. At the same time, however, the carrot-and-stick approach of the ACA initially created uncertainty around hospital finances; poorer-performing hospitals today are at a high risk of losing millions of dollars in CMS reimbursement.

Any number of new initiatives can be active in an organization at any given time. I was aware of more than 10 at various stages of development; almost all originated externally. Labeling a pattern as a flavor of the month suggests its short-term nature and relative inefficiency or ineffectiveness. A new initiative is transformed into a flavor of the month when 1) key members of the recipient organization have not embraced it, and/or 2) it has fallen out of use by organizational members who adopted it. Sometimes, organizational members draw upon current initiatives to inspire new ones. For example, the CEO emphasized the terminology “Enterprise-wide Shared Governance” in lieu of Interdisciplinary Shared Governance to distinguish his emergent initiative from an existing one. In my interactions with hospital leaders I did not hear them refer to program-of-the-month costs. Yet, Best (2006) cautions that the cost of institutional fads should not be discounted – both in implementation and in the high likelihood of failure.

Hospital leaders representing different functions (i.e., silos) knew the Flow Story. Their shared knowledge suggested that stories were able to spread within and across unit boundaries. Boje (1991) used the phrase “the storytelling organization” to emphasize important storytelling functions including sensemaking and introducing change. The Flow Story involved sensemaking, or what Darrouzet et al. (2010: 73) refer to as “puzzling,” around the process and meanings related to patient flow. Themes, such as blaming, resistance, and workarounds, symbolize employee frustration and coping strategies aligned with the sensemaking or puzzling. In the Story of Flow Unlocked, change was introduced in a celebratory fashion – replete with excitement.

Stories can be dismissed as irrelevant, inappropriate, or lacking credibility. Initially, the VP was upset by the messages conveyed in both stories. Her expectations for how patient flow was being managed (in the Flow Story), or should be managed (in the Story of Flow Unlocked), were not met. Her reactions incorporated blaming behavior. She faulted leaders for inaction in addressing flow, and the ADT for its attempted launch, which she anticipated would fail. Fortunately, the CCT prevailed by challenging her reasoning. Ultimately, she allowed the stories to remain part of the first quarterly report, though she had the power to suppress the analyses and implications generated from the stories – and action which would have led to cultural loss.

The stage-based characteristics of the Program of the Month

New initiatives are often unveiled as innovations, defined as “an idea, practice or object that is perceived as new by an individual or other unit of adoption” (Rogers 2003: 12). Such activity occurs during stage 1. We found some preference for a new initiative to be internally consistent with a current or past one, yet distinctive in its own right:

- The VP led the Contextualist training that was introduced a couple of years before the Cultural Change Project started.
- The VP proposed a reconfiguration of the CCT’s problem-solving teams into existing hospital committees and councils.
- The CEO’s proposed Enterprise-wide Shared Governance was directly connected to Interdisciplinary Shared Governance.

In stage 2, new initiatives often experience resistance in permeating unit boundaries. Structural differentiation within silo-ed organizations is consistent with an “us versus them” mindset” (Diamond et al. 2004: 46) and with a “parallel but minimally interactive work environment” (Curtis and Shannon 2006: 16). It was rare for any hospital initiative to be associated with more than one unit. For example, Interdisciplinary Shared Governance was associated with Nursing but did not spread beyond it. Similarly, AIDET was embraced by Environmental Services but was thoroughly resisted by Nursing. If two or more units reported to the same individual, the expanded group of units might adopt the new initiative, as was the case with both Environmental Services and Dietary that supported the AIDET initiative.

Cultural loss, a process tied to vanishing cultural elements (Ferraro and Briody 2017), is part of the program-of-the-month phenomenon. During stage 3, cracks in this process often foreshadow the weakening of an initiative, which eventually leads to its displacement and disappearance. A staff member reported one such crack, stating that the ADT had been “used as a holdover area” when patient capacity was at its highest. Such situations raise doubts and create ambiguity. Sometimes

an initiative can recover by arresting the specific disruption and shoring up support structures. In other instances, it cannot: approximately five months after the Cultural Change Project ended, the ADT unit was renamed and repurposed to care for cardiac patients. As such, ADT was no longer an innovation, but had drifted back to an earlier state. Stories might continue to capture its former glory, but as organizational memory fades, the ADT becomes part of cultural loss.

Finally, stage 4 involves the launch of another innovation. ABC Hospital hired a marketing consultant who offered “seven steps toward providing quality patient care” shortly after the Cultural Change Project ended; the tenure of this consultant was brief. Initiative overlap highlights the ongoing processes of continuity and change when newer initiatives are purposely built on older ones.

Program-of-the-Month complexity

Best (2006) identifies various images (e.g., steps, waves, cycles, a pendulum) linked to the flavor-of-the-month phenomenon. Yet, he expresses dissatisfaction with these visuals because they are unable to take into account the complexity associated with innovative efforts. Let's return briefly to Figure 1 which illustrates some of the complexity associated with our fieldwork:

- Board, CEO, and cultural-change meetings involving the VP and hospital leaders ended (by second quarter)
- PowerPoint reports changed from verbal communication based on a deck to submission of the deck without an opportunity to discuss with leaders (between second and third quarters)
- VP input was conveyed “indirectly” through a member of the CCT to me; this pattern was evident throughout 2013, but became especially prominent as formal interactions with hospital leaders ceased.

Yet, this complexity is useful. Such communication activity is reminiscent of the movement of waves along a shore, some appearing and disappearing suddenly, with others gathering strength up to a point until they too end. Overall, Figure 1 illustrates hospital leader waning interest and disengagement from an in-house initiative over the course of the project. Even the VP retreats from her interactions with me, preferring instead to share information indirectly through a CCT member. Indeed, the communications depicted in Figure 1 seem to be a miniature version of the broader flavor-of-the-month pattern that is pervasive in ABC Hospital culture.

Value ascribed to evidence

Data, analyses, narratives, and examples are always subject to interpretation. The VP exhibited negative reactions to the story messages, while the CEO seemed to accept them. Their organizational roles are largely predictive. The CEO's time and energy were spent largely building external partnerships and focusing on population health. Developing a strategic plan, working on the "cutting edge," and creating "legacy" were among his key hospital goals. By contrast, day-to-day hospital operations were left to Executive Team members to manage from their individual functions. As VP of continuous improvement, our sponsor had a visible stake in decisions related to patient flow, while the CEO did not. She also had to join hands with Nursing on flow, an issue where functional leaders held competing priorities (e.g., reducing patient wait time, limiting cost).

Evidence may be used in different ways. The VP singled out two CCT recommendations at the review with the CEO. She argued they had "done the beginning steps" for cultural change, indicating, "We've blown up the two flow teams" and "vetted...a number of different metrics." Her argument used CCT evidence as *confirmation* that the hospital was in lock step with the recommendations: "So, right on target, Elizabeth. Thank you!" Indeed, she suggested that action was now underway and consistent with the recommendations. The CCT's interpretation of her statements ran counter to her view. Implementation science also has faced this issue of beliefs and perceptions, most recently in "de-implementation" or abandonment of practices that are not evidence-based (Prasad and Ioannidis 2014; Montini and Graham 2015).

Strategies to encourage change in silo-ed organizations

Clues from the two stories and the program-of-the-month pattern systematically point to cross-unit collaboration as a critical factor in promoting organizational-culture change. Bottlenecks appear at the boundaries where "handoffs" occur and receiving staff scramble to accommodate them or ignore them – at least in the short run. The best way to break the bottleneck begins with cross-unit collaboration founded on trust, but that change process does not end there.

Lencioni's (2006) prescriptive model in which all organizational members share a goal, follow a set of objectives, and use common metrics are necessary, but not sufficient conditions, to address organizational-change issues. Work practices and processes must change across the organization so that boundaries (e.g., disciplinary, functional) do not act as impediments (Cilliers and Greyvenstein 2012; Margalit et al. 2009). The use of incentives and sanctions can encourage the desired behaviors – both for individuals and groups (Newhouse and Spring 2010; Zorich et al. 2008). Commitment to the changes at all organizational levels

(Cummings and Worley 2015), especially leadership (Armenakis and Harris 2009) can also help. Just as no “magic bullet” exists to address patient flow, no simple solution can tackle the problems faced by silo-ed organizations.

Under current conditions, neither the VP’s designation of a single flow committee, nor the CEO’s call for “house-wide” implementation, will bear fruit. Those closest to the work should be actively engaged, working together rather than at cross-purposes. When employees come to believe that their ideas matter, their attitudes shift toward an embrace of change (Armenakis and Harris 2009). Without modifying hospital structures, processes, and interactions, new initiatives will continue to face near-certain demise.

Expanding the concept of implementation practice to include failure

What do the ADT and Cultural Change Project share in common? Both

- Necessitated building rapport with hospital employees and reliance on their goodwill
- Engaged employee knowledge and efforts – directly or indirectly
- Had as their goal improving patient centeredness
- Were experiments to effect organizational-culture change, revealing alternatives to the status quo
- Required alternative work practices and structures for accommodating that work
- Cost money but demonstrated salient benefits in patient care and staff satisfaction
- Faced long-term resistance from at least some senior leaders, and noteworthy acceptance from remaining organizational members
- Experienced a limited impact in changing hospital culture.

These characteristics reflect five features reported by Briody and Erickson (2017: 34-35) to help ensure implementation or “system-wide innovation success:” collaboration, leadership buy-in, structural change, work practice change, and evidence of benefit. Yet these five features do not fully explain why the ADT and Cultural Change Project were not successful in the long-term.

The explanation, I believe, is that the ADT and the Cultural Change Project became entwined in the program-of-the-month cycle. Key organizational stakeholders – particularly leaders – ultimately rejected CCT efforts, despite denouncing programs of the month. This critical error built on existing cynicism (Wanous et al. 2004; Reichers et al. 1997) pertaining to implementation of organizational-culture change. Cynicism

has corrosive effects on an organization's ability to adapt and innovate. It can decimate employee commitment to the organization and to its customers. It can quell creativity. It can resist innovation. It can undermine, for the long-term, all future efforts to help the organization improve and thrive. ABC leadership's refusal to move forward with organizational-culture change, developed hand-in-hand with six competent hospital professionals (i.e., CCT), dashed staff hopes for a collaborative work culture providing focused and effective patient-centric care.

This leadership decision was also tied to a lack of attention to organizational-culture issues generally. For example, despite identifying accountability as a core value, we discovered few consequences (Kennedy et al. 2014; O'Hagan and Persaud 2009) for either inadequate performance or active resistance to organizational expectations. ABC Hospital had no mechanisms in place to analyze and share lessons learned, and as such was poorly positioned to learn from its mistakes. Consequently, hospital leaders initiated and cycled through program after program, thereby accounting for the slow pace of sustained change, and avoiding a commitment to continuous organizational improvement.

Future Directions

What can be done about the woes of implementation practice? To address this question requires attention to our definition – the planning and execution of organizational change by *key stakeholders*.

The two crucial meetings with the VP and CEO – in February and March 2013 – sent strong signals that ABC Hospital leaders were reticent to engage in cultural change. We recognized their reluctance at the time, but believed later opportunities to unify the Leadership Team around the concept of patient-centeredness would emerge. Unfortunately, we gambled and lost in helping ABC change in the way it initially indicated it wanted to change. We had to come to terms with the CCT representing only one actor in the cultural-change process, a process that we could not lead. The CCT's many roles (e.g., researchers, guides, translators, implementers) entailed working alongside others as one stakeholder among many others. Without the cooperation and collaboration of other key stakeholders, implementation practice would remain elusive.

On the other hand, the CCT project led to some additional questions:

- Why did the policy change in CMS reimbursement – a seemingly-important change in organizational incentives – *not* lead to any durable changes in the metrics (e.g., improved clinical outcomes, higher patient satisfaction)?

- To what extent does resistance to change vary by industry, organization, size, reputation, budgetary constraints, and customer characteristics, among others?
- Under what conditions can levers be applied to enhance the likelihood of cultural change given client resistance and/or the program-of-the-month pattern?

Another question also merits exploration: Do programs of the month and other failed initiatives serve some purpose beyond attempted innovation? If we consider the set of initiatives active at ABC during the Cultural Change Project, we learn that they are not just reflective of the latest fad, but perform an important communication function. They send both explicit and implicit messages to stakeholder groups (e.g., internal units, organizational leadership, government agencies). For example, creating the ADT seems to have been a sincere attempt at improving patient care, as well as a reaction to hospital leadership inaction. By establishing this unit, ED leaders were able to garner resources and attention to patient flow – at least while the ADT was in operation – thereby improving the patient experience temporarily.

When new initiatives morph into programs of the month, they can still leave their mark on organizational stakeholders by accomplishing some goals. New initiatives perform a communication function that I call “impression management” in which some aspects of an issue are highlighted, while others are not mentioned, downplayed, or obscured. The Cultural Change Project had enthusiastic senior leadership support initially. Indeed, for eight months our VP and CEO sponsors championed the project with ABC’s Board because it would help lead to a patient-centric culture and higher HCAHPS scores. Our project sponsors left a *positive impression* with the Board about our work, backed up by our research results and recommendations.

Yet, sometime after our April Board review, communication with the Board was filtered through our sponsors. The CCT was never again asked to present any subsequent results to hospital leaders and no implementation of its work occurred. Our sponsors’ view of the Cultural Change Project had changed, and with it, their management of the Board’s understanding. Still, boards generally leave an organization’s administration to the CEO and his/her direct reports, focusing instead on strategic matters (e.g., long-term growth). Boards have little incentive to intervene in day-to-day operations, as long as the future appears bright. So, while ABC’s patient satisfaction scores had not improved, thereby contributing to lower CMS reimbursement, it was not enough at the time to cause ABC’s Board undue worry.

In the event that the Board requested a subsequent update, the discussion could be framed as what *was* accomplished, rather than what was *not* accomplished. There would be no need to mention

implementation, let alone engage in implementation. Leaving the impression that accomplishments had been achieved, supported by numerous reports, would likely satisfy the Board. If asked about next steps, it would be easy to point out that the hospital was moving on...to *another* exciting initiative. The status quo would remain intact and there would be no reason or incentive to set in motion organizational-culture changes – even to fix flow and to improve patient care. Future research might consider whether unstated ancillary benefits to the initiators or the organization explain the persistence of the program-of-the-month pattern (and their failures) across organizations of different types and sizes.

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