

CHANGING POLICY FROM THE INSIDE-OUT: ORGANIZATIONAL LEARNING IN THE HEALTH-CARE CONTEXT

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Introduction

Our interest in organizational learning is rooted in a desire to understand more about how organizations can support the growth and development of individuals and teams, and create life-enhancing work environments. Since Peter Senge et al (1990, 1999) popularized Chris Argyris' (1990) work on organizational learning, the concept has pervaded the lexicon of workplace learning and change. However, despite legions of related books, articles, films, and professional and academic programs, the concept of organizational learning remains difficult to define, and even more difficult to implement. Currently, organizations face challenges in proceeding with such experiments due to a lack of examples of how these complex concepts translate into daily workplace experience.

Within the current climate of change in the Ontario provincial health care system, we discovered one hospital that is progressively working to embed organizational learning practices within their structures and processes. This hospital has been largely successful in creating positive changes in their organizational culture, promoting employee learning and commitment to the organization, and providing the foundation for *both* efficiency *and* innovation.

Hospitals are increasingly complex organizations (Ashmos, Duchon, Hauge & McDaniel, 1996; McDaniel, 1997) and the creation of organizational learning systems within them is a significant challenge. At this time, much of the health care literature on organizational learning focuses solely on training and professional development (Davidhizar, 2000) and there are few case studies of organizational learning located in hospital settings (Lipshitz, 2000). Given the current internal and external pressures facing hospitals, we believe in the importance of creating opportunities to learn from health care organizations that are experiencing success.

Our study

We conducted some of our research in a hospital (referred to in our publications as Urban Religious Hospital, or URH) that had deliberately embarked on a process of developing a commitment to organizational learning. Their attempt to change the culture of the organization preceded the mandated provincial changes to hospital infrastructure and operation throughout the province, and therefore resulted not from legislation, but rather from the administration's desire to create an innovative organization that would truly support the work, learning and development of its employees. It was expected that these efforts would help buffer hospital staff from the chaos that ensued from the turbulent provincial health care climate.

This work was part of a three-year research project, conducted between 1998-2001. The goal of our research was to identify and examine Canadian organizations that were engaged in developing and supporting organizational learning strategies. Specifically, we were interested in exploring how these organizations were working to embed on-going learning within the actual work processes at individual, team and strategic levels.

After initially identifying forty-two Canadian organizations as “learning organizations,” our team solicited ten to participate in the research. Ten randomly selected employees in each completed The Learning Organization 5 Stage Diagnostic Survey (Woolner et al, 1995). Five organizations self-reported at mature stages of organizational learning on the survey. In the end, four of these organizations, including URH, participated in the final stage of our research, which involved individual interviews, focus groups and on-site observation. We interviewed a diverse cross-section of between 7-15 employees in each organization and collected organizational documentation. Data were analyzed using qualitative analysis software and twelve primary themes emerged from our interviews at each site. Using these themes, members of our team wrote narrative case descriptions of each organization.

The health-care case, URH, is a mid-size religious hospital in a Canadian urban centre. A decade ago, URH faced an unprecedented debt crisis, which triggered the establishment of a new senior management team. Under the guidance of their President, URH embarked on a journey to change its culture, support and recognize its employees, share ideas and information internally and improve institutional knowledge and practice. In order to highlight their achievements, the case study explores key strategies employed by the staff of URH to move forward in their efforts to become a learning organization. However, while we focus on the positive changes made within URH, we need to acknowledge that their organizational learning experience is a work in progress, and there remain significant implementation challenges along the way. By way of framing URH’s situation in context, it is important to first begin with an overview of current health care policy changes and their impact on hospitals in Ontario.

Public Policy & the Health Care Context

The highly charged political nature of health care in Canada is the “result of the complex federal-provincial arrangements for government insurance of hospitals and medical services put in place between the late 1950s and the early 1970s” (Burke & Stevenson, 1999, p.598). In 2002, as our population ages and diversifies, the on-going debates about provision and funding continue.

The political health care climate is equally charged in the province of Ontario. In June 1995, Mike Harris and the Conservative Party were elected into office with their “Common Sense Revolution” platform designed to create a small, fiscally conservative government, reduce public spending and improve public sector efficiency. After the election, the health care system quickly became a target for reform and the new government announced that it would “reduce hospital budgets by 18 percent over a three-year period.” (HSRC, 2000, p, 12).” Subsequently, in 1996, the Ontario Health Services Restructuring Committee (HSRC) was established as an arms-length agency of the government. Its mandate was to “make decisions about restructuring Ontario's public hospitals” and to “improve quality of care, outcomes and efficiency to help create a genuine, integrated health services system.” (HSRC, 2000, p.2)

The initial work of the HSRC led to the closure and/or amalgamation of many urban hospitals. As a result, remaining hospitals are facing unprecedented pressure to deal with additional patients and communities, while addressing the increasing demands for greater fiscal responsibility and accountability. Not surprisingly, the HSRC has been accused of precipitating

“hospital closures, amalgamations, and realignment of patient-care services” (Richardson, 1999, p.59). Additionally, there appears to be skepticism about the quality of the decision-making that led to these radical changes in hospital infrastructure. As one hospital president states, “There is something fundamentally wrong with the restructuring model in Canada” (Coutts, 1998), which, historically, has decreased health care funding in order to encourage efficiency, instead of working to support hospitals in their effort to create new modes of operating and reinvest their saved funds elsewhere. In the same article, the head of the HSRC agrees with this notion, upon which Coutts expands by saying: “very rapid bleeding of resources out of the hospital sector without a plan on how the sector should adapt” is dangerous and that “doing things ad hoc is very expensive.” (p.7)

While most of the mechanical aspects of the closures and amalgamations were in effect prior to 1999, many of the organizational and cultural aspects of these mergers, closures and changes are still unfolding. As such, Boyle (1999) notes that the goal of the second phase is to create a “genuine, smoothly coordinated, seamless health services system.” (p.13). Describing the challenges in reaching this objective, Duncan Sinclair, the head of the HSRC states, “The ultimate goal of health-care reform is to promote collaboration by doctors, nurses, hospitals, nursing homes, community agencies and public health agencies. By definition that is a system. But the fact is that we don’t have a system. We have a group of often excellent individual players who contribute relatively independent of the other players.” (Boyle, 1999, p.13).

The URH Case

Within this context, the staff of URH have created opportunities for collaboration and system-wide learning that mirror the goals of the HSRC, while supporting their own core institutional values. While the hospital’s work towards becoming a learning organization has been significant and far-reaching, we will use this brief paper to focus our attention on two key aspects of their efforts. The first is the organizational commitment to values and learning and its impact on staff morale and attitudes. The second examines how the staff has harnessed information within the organization with a commitment to knowledge, learning and development for the purpose of improving creative practice. We explore the ways in which URH's commitment to organizational learning has created several forms of benefit for personnel, the hospital and the health care system as a whole. We also highlight several ways in which URH has started to reach out to other hospitals and organizations within the system.

As previously mentioned, URH began its journey as a learning organization with the arrival of a new President. At the time, URH was in a state of financial crisis and there was little in the way of collective goals or a formal network for communicating and celebrating organizational success. The President, with the assistance of members of the administrative team, established a process to distill the key goals and values of URH. Staff participation led to the renewed articulation of URH’s longstanding commitment to serve the “urban, poor and homeless community” and provide “excellence in patient care” that has become the focus of their mission.

Mission and Values

URH has deliberately embedded its core values and goals within its systems and processes throughout the hospital, and they are reflected in the culture of the organization as well as in individual members' decisions and behaviour. This evolution, which has taken years of strategic support, has given the values of URH a foundational role within the hospital. One participant explains, "The mission and values guide the hospital in what we want to do in a larger health care frame." To ensure that the mission and values are at the heart of organizational practice, URH has created several strategic initiatives including: 1) the establishment of the office of the Director of Mission & Values; 2) the establishment of an employee recognition system; and 3) the establishment of methods for embedding the values and goals within organizational processes.

Office of Mission & Values. The Director of Mission and Values (DMV) plays an integral role within the Senior Management group at URH, working to ensure that all URH employees are aware of the values, and creating opportunities for the values to be explored and clarified. All new URH employees attend an extensive orientation program within which "there is an open discussion of the Mission and Values, the history of URH, the importance of caring for the disadvantaged and the commitment to the poor."

Awards & Recognition. The creation of the URH's employee recognition and rewards program has been a deliberate and purposeful step towards celebrating the values in action. A research participant commented: "In 1990 there was nothing in the way of staff recognition or values recognition. Now there are plenty of awards. There is recognition within the communication at URH of employee excellence." Employees are enthusiastic about the rewards and the wide range of possibilities for recognition, explaining: "The Most Valuable Player award is nominated by peers for going above and beyond the call of duty. There are also pictures and names of recognized people." Another example is the awards for individuals, teams and projects demonstrating the implementation of values in action, and the "URH Day where everyone is honoured and is given a memento."

Decision-Making & Leadership. The values play a significant role in the decision-making processes at URH. "There are strong mission and values at URH. We have worked to keep it alive. We talk about it a lot. Leadership and decision-making all work to keep it alive." Another staff member explains, "There is recognition of the values in the leadership. It is evident in their behaviour. They support staff. You are recognized for hard work. The values and mission also influence teams and staff report that most teams refer to the values in their work. They check the mission." In times of crisis in particular, team members are expected to make decisions within the framework of the hospital's mission and values.

Knowledge Management

URH has turned its diagnostic sensibilities upon itself by conducting extensive research on the organization and continuously evaluating its own performance. Building on the mission and values to provide excellence in patient care through committed employees, URH is devoted to gaining a better understanding of how both groups experience the hospital. It conducts on-going studies of its employees' opinions, its organizational culture, and the patient experience to learn more about its performance and inform its practices. This information is continually reported

back to employees, who are then engaged in team problem solving on the issues which are identified as priorities. Thus, over the years, URH has developed a culture that is deeply rooted in reflection on and analysis of its organizational health. Commenting on URH's commitment to knowledge generation and introspection, one employee explained, "there is an underlying thirst for knowledge." Another said: "We are measuring things constantly. There are lots of indicators." A specific example is the recent Culture Study, which explored issues of organizational culture and quality throughout the organization. One participant explained, "We need to know what they believe is happening. It gives us good insights. There is constant reinforcement."

URH is committed to understanding how patients' experience the hospital. In order to gather evidence of patient experience, and in turn to use this data to improve service, URH has an extensive array of quantitative assessments of patient satisfaction, patient outcomes and waiting time. In addition, "There is a patients' complaints process. There is a designated person who deals with this as the Patient Satisfaction Coordinator, who is the survey (master). There is also a community advisory committee to address specific inner city program needs."

Case Summary

It is important to note here that URH balanced its budget and developed fiscal accountability practices long before the HSRC policies were implemented. URH has moved towards reaching its goals with an approach to organizational and personal learning that is centred in the values, the culture and in the commitment to knowledge creation. The hospital has established an organizational culture for which the values and mission serve as the foundation. Upon this foundation, a system of staff recognition has been planfully created. A process for self-reflection, both through qualitative data collection, as well as with a scientific eye for metrics, has been devised to assist staff and management in learning more about their internal and external functions, clients and work.

We believe that URH's commitment to organizational learning has created several clear benefits for personnel, the hospital and the health care system as a whole. First, there is a very apparent sense of enthusiasm and appreciation from staff regarding URH's systemic adherence to the explicit values of the organization. While many say that they are not directly motivated by the awards, they view them as an effective tool to help individuals remember the values and mission, as well as learn more about various individuals and work projects within the hospital. During times of retrenchment and restructuring, organizational commitment to this sort of staff recognition, while only a small token, remains an important element of organizational culture and tradition. It contributes to cohesion among employees, and reminds staff that they are making significant contributions to the organization (Wenger, 1999).

At all levels and in many departments within URH, staff shared their experiences with reflection and internal knowledge generation, noting that many new programs have grown from their data gathering and analysis. This commitment to knowledge generation and management is seen to be a key strategic advantage that supports innovation and the creation of improved practices and processes within the hospital (Senge et al, 1999; Ahmed et al, 1999).

Within many learning organizations, reflecting on “best practices” often involves expeditions to other similar organizations to compare performance and experience. Our research participants included several employees who have taken responsibility for exploring how their particular work function is organized in other similar hospitals. In some cases, our participants have organized groups of staff from other hospitals to facilitate the mutual sharing of experiences and learning. URH staff, working with colleagues from other institutions, have made policy recommendations to the government and suggested possible opportunities for the hospitals to work together, share costs and reap mutual benefits.

Conclusion

This case presents an example of a hospital that has managed to maintain its focus and its ability to succeed in the increasingly chaotic health care climate. By adopting strategic and proactive organizational learning strategies, URH has developed a preventative, long-term approach to insuring its own organizational health. The hospital has evolved a culture in which systematic testing and diagnosis of its organizational functioning, process and performance creates baseline data that provide a platform for organizational change and improvement. This is framed by a set of shared values which employees are supported to enact; they are then rewarded and celebrated for their success. Staff experience autonomy in making decisions in collaborative projects which reflect the hospital’s values and goals. Although we have not explored them in this brief paper, the hospital also provides models for authentic teaming, strategic planning, and individual professional development. Thus, while URH exists within a context of constraint and retrenchment, we believe that their approach to organizational health maintenance provides a potential template for enacting the HSRC vision within the entire provincial health care system.

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