Thirteen Health Care and Government Organizations

Most of the organization change literature is based on work (research and practice) conducted with profit-making corporations. In the beginning of the field of organization development (OD), the late 1950s in particular, the organizations that gave birth to OD were the Harwood Manufacturing Corporation (Alfred Marrow), General Mills (McGregor and Beckhard), and Humble Oil (Blake, Mouton, and Shepherd). While this predominance of corporations continued for decades, there were other organizations involved in OD work early on as well, for example, the Episcopal Church in the 1960s and the U.S. Army (they called it organization effectiveness, or OE) in the 1970s. In fact the Army devoted a school to OE located at Ft. Ord in northern California. For a couple of years I was a consultant to the school. Neither the school nor Ft. Ord exists today.

Most have probably assumed—certainly I have—that this predominance of corporations in the world of organization change and development continues to this day. But that may not be the case. I do not know the facts, yet I have the impression that more change efforts than ever before are occurring in the health care arena, for example. Of course that world is composed of both profit and nonprofit organizations, but the majority is no doubt made up of the latter.

Let us further assume that "other" organizations have become more involved in organization change and development activities. In any case, with this assumed expansion, do we also assume that changing a health care organization is essentially the same as changing, say, a consumer products corporation? The answer is yes and no. Key principles of organization change like Lewin's unfreeze, change, and refreeze should be essentially the same. How you apply these bedrock principles no doubt needs to be somewhat different. Even more difference lies in the organization's culture. What we pay attention to culturally in health care is not exactly the same as in the corporation—the control and reward systems, for example. The purpose of this chapter, therefore, is to explore these differences in two "other" organizations—health care and government, especially at the federal level. There are many other organizations with which we could make comparisons and demonstrate differences—foundations, museums, educational institutions, community agencies, volunteer networks, and so forth—but the reasons for focusing on health care and government are (a) the differences stand out and therefore must be considered first and foremost in practice and (b) these two other organizations are actually not "other" but quite pervasive and powerful in our daily lives.

Important Characteristics of Health Care and Government Organizations

The most obvious difference between a business/industrial corporation and these two other organizations concerns mission. Most corporations these days have mission statements, but they are not *driven* by mission; rather, they are driven by strategy—how do we beat the competition? Both health care systems and government agencies *are* driven by mission—patient care and providing important services for citizens.

Although different in substance, both health care and government organizations are controlled by dualities. With respect to health care, the duality is characterized by *two* hierarchies: One is the profession of medicine, and the other is the administration of the organization that provides the medical care, whether a community hospital, health maintenance organization, or clinic. This duality is most keenly experienced by department heads, center directors, clinic directors, and the like. They must serve the profession, with its Hippocratic oath and related requirements, and ensure that the organization survives financially and operationally. Sometimes this duality is clearly in a state of conflict—do I see that another diagnostic procedure is prescribed for a patient, even though he or she probably does not really need it, because our clinic direly needs the insurance income that pays for it? Incidentally, the physicians who are serving these two masters are easily recognized in the organization; they wear white coats. Not unlike sergeants in the army, nurses actually run the day-to-day activities and events and can be a strong force for change or just the opposite (i.e., highly resistant to change). Thus, when building a coalition for change, nurses need to be deeply involved. It should be noted that nurses face the same conflict as do physicians: their professional standards as registered nurses versus their responsibilities as administrators.

With respect to government—both federal and state—the duality concerns *time*, long-term versus short-term. The short-term is based on election phases—at the federal level, every 4 years as the nation selects by reelection the current president of the United States or the next president. Thus, the longest short-term is 8 years, but it can be only 4. At the state level the phases are determined by the election of the governor. Many if not most initiatives and changes in the government take time, often more than four years. The duality, then, is a matter of dealing with long-term initiatives that must survive a change in leadership at the top versus short-term efforts that may abruptly end whether complete or not after 4 or at most 8 years. The work of the National Aeronautics and Space Administration (NASA), where I served as a consultant for some 25 years, illustrates this duality where long-term was the norm but so was dealing with potential budget cuts every 4 years. From a hierarchical perspective, periodically, the top executive group is replaced, whereas middle and lower management often remain more than 20 years.

Management is therefore always dealing with these changes. The conflict can take the form of the top executive group's wanting to make changes quickly because they don't have a lot of time, whereas middle to lower management may play a "waiting game" as a way of resisting change. After all, they are likely to be facing an entirely different initiative shortly, especially if the regime change shifts from a Republican base to a Democratic base or vice versa.

Now let us consider each of these two "other" organizations in more detail, particularly in terms of organization change—that is, what is applicable from the organization change scholarly literature and from our practice experiences regardless of organizational type and what must be considered as unique for each of these two types.

Changing Health Care Organizations

We know that most organization change efforts fail. That failure rate may be even larger for health care organizations. After all, these organizations are quite complicated, with their (a) duality of hierarchies; (b) at times having to deal with life-and-death issues, especially in a hospital emergency room; and (c) medical practices that are based on multiple sciences, not just one—chemistry in pharmaceuticals, anatomy and biology in surgery, and neuroscience in dealing with mental and emotional issues, to name just a few. And then there is internal medicine, where diagnosticians must know all of the above. Running, say, a newspaper is a complicated business to be sure, but the operation is based primarily on journalism and business acumen, not multiple disciplines.

With such complexities, is it even possible to achieve a successful change effort in a health care system? Done right (i.e., following many of the principles presented in this book), it is possible, as the following cases demonstrate.

Case 1. In a study of change in a large managed health care organization, Caldwell, Chatman, O'Reilly, Ormiston, and Lapiz (2008) found that when primarily concentrating on physician behavior, change was indeed possible. The study was conducted in two phases, the first being interviews with 37 physicians, followed by the second phase a year later, which was essentially a survey based on the content from the interviews. The fundamental outcome variable for the study was patient satisfaction.

Driving the change in this health care system were shifts in the organization's external environment that were in turn adversely affecting the quality of patient care. A change in strategy was in order. The strategic change was support for a new patient care service initiative. The data collected in Phase 2 were from 313 physicians across multiple specialties—for example, surgery, pediatrics, ob-gyn, and emergency medicine—resulting in a 53%

response rate. The researchers' main interests were in three areas (the independent variables): (1) degree of support from the physicians for the strategic change, (2) norms that indicated the degree of readiness for the change, and (3) perception of medical departments' leadership—that is, did the department heads provide leadership for the change? Overall there were positive results, particularly with respect to support from physicians for the change and the interactive effects of the three main independent variables; for example, the positive effects of leadership are strongest when the medical specialty units have norms that support the change.

In their section on "recommendations for practice," Caldwell et al. (2008) provide useful food for thought:

> Not surprisingly, the positive effects of strategic change are greatest when groups support the new direction. Therefore, when strategic changes are undertaken, leaders need to focus on building support for them. This requires direct, relentless communication. In addition, leaders need to look for ways to involve staff in identifying ways of implementing the strategy. As our Phase 1 interviews suggest, building support often involves helping staff members understand both the benefits of the change and the risk of continuing the status quo. (p. 132)

Leaders' endorsements of the change effort are important for most any organization that has a clear hierarchy of authority, but leaders/physicians in health care are critical. Without their support, very little change—certainly not significant change, as in a transformation—is likely to occur. And finally, as Caldwell et al. (2008), from their perspective as the researchers in this case, put it:

> These results illustrate the importance of social control in organizations. In the organization we studied, physicians had a great deal of power, not only because of their roles but also because of the ownership structure of the medical group and accountability of the CEO to the physician shareholders. In such an environment, relying on formal control systems to induce change may be problematic. However, social control, exercised through norms in medical departments, facilitated change. It may well be that it is both the culture of a health care organization and the specific norms that develop in groups that will allow health care organizations to adapt to the environmental jolts that these organizations will face. (p. 132)

Case 2. In the previous case, regarding their conclusions about practice, Caldwell and colleagues (2008) used the term *relentless communication* and emphasized how important it is during times of intense change. This case study by Stein, Frankel, and Krupat

(2005) covers a 16-year period of "relentless" work on enhancing communication skills, especially focused on the doctor–patient relationship, and was conducted within the Kaiser Permanente (KP) health care organization. Their article describes the authors' approach to improving the clinical communication and relationship skills of clinicians. According to the authors,

> the centerpiece of KP's approach has been the creation and dissemination of a unifying clinician–patient communication (CPC) framework for teaching and research called the Four Habits Model. The Model has served as the foundation for a diverse array of KP programs. Sustained improvement in patient satisfaction scores has been demonstrated. Clinician –patient communication training has become a well-established component of professional development in KP. (p. 4)

What follows is a synopsis of the Four Habits Model:

- *Habit 1: Invest in the beginning*. The skills needed at the beginning involve creating rapport quickly, eliciting the patient's concern, and providing an overview of the present session.
- *Habit 2: Elicit the patient's perspective*. The skills for this habit are asking for the patient's ideas and point of view, seeking out specific requests from the patient, and exploring the impact on the patient's life (e.g., effect on loved ones).
- *Habit 3: Demonstrate empathy*. The skills that help ensure expression of empathy include being open to the patient's emotions, making an observation and asking if it is accurate, and conveying empathy nonverbally, such as by touching the patient.
- *Habit 4: Invest in the end*. These skills include providing a working diagnosis, educating the patient about the problem (e.g., symptoms that are experienced), involving the patient in making decisions, and summarizing the visit and clarifying next steps.

These four habits may seem rather obvious and relatively easy to do, but the secret to success is in the execution, applying the skills associated with each habit to each individual patient. And no two patients are the same; thus the skills must be applied uniquely to each patient. Paying attention to cultural and background differences is also a key to a successful clinician–patient interaction and relationship. In our overspecialized world, following these habits can help provide a more common experience for patients, regardless of whether the physician is a neurologist or cardiologist.

And finally, to our underlying theme of the importance of power and social control in the health care world, Stein and his colleagues (2005), in discussing the training programs they have conducted, observed, and collected evaluative data from, conclude: "One of the most important lessons learned was that departments with the greatest success in participation and

enthusiasm were those in which the chief promoted and attended the program" (p. 8).

Case 3. A number of years ago, I was asked by the medical school dean to help with the implementation of an overall change in the school's curriculum. Prior to my arrival, a curriculum change had been in the planning process for 2 years. The planning was being done by a small committee of 10 people from both the faculty and administration. The committee was planning on behalf of a total faculty group of about 200 people.

In the early stages of my work, it became clear that the committee had a sound plan and was very enthusiastic about it, but the faculty as a whole was suspicious. The committee had been working on and off for 2 years, but no one beyond the committee members knew anything about the plan, and rumors were rampant. In my meetings with the committee, members expressed their concern about faculty suspicion and rumors and their fears that the new plan would not receive the necessary faculty vote for ratification. The dean and committee chairman wanted it to pass with at least a 2-to-1 vote, but they were realistic enough to realize that, if a vote were taken at the moment, the plan might be defeated.

I began by confronting the committee with the probability that, if they wanted ratification, they would have to risk possible modifications to their plan. For overall faculty commitment to occur, something more than information sharing would be required. Regardless of the logic and elegance of the new curriculum design, simply explaining the new plan to the faculty would not overcome suspicion and guarantee ratification. Resistance could be expected because of the degree of change involved in the plan. The plan called for greater coordination across courses and a shift away from the solo-instructor model toward more team teaching, with consequent loss of some freedom for the instructors. It thus involved a degree of loss of choice. I explained that, although the committee could remain in control of the planning, its responsibility and roles would need to shift from that of planning the curriculum content to that of leading and managing the change process.

The committee began to organize the further planning process. It formed itself into a steering committee and assigned major managerial roles to each member. Four individuals were chosen to head the more detailed curriculum planning for each of the four medical school years, and four primary subcommittees were formed. The subcommittees were composed of faculty members other than those on the original committee. At that point, about 40 additional faculty members were included. Other special committees were then formed as extensions of the four primary subcommittees. These "sub-subcommittees" became involved in planning specifics, such as how cell biology would be taught within an overall organic systemic approach. Eventually, some 100 faculty members were involved in planning at least one piece of the new curriculum.

With so many people involved and with such a complex new plan, it took most of a year to get the job done. When the faculty vote finally came, however, the new curriculum was ratified by a 4-to-1 margin. The dean was happy, to say the least. With respect to the original 2 years of the planning committees' existence, perhaps a James Thurber quote is an appropriate way to conclude this case: "Progress was all right. Only it went on too long." When the faculty got involved, the change did indeed occur. A fundamental principle of organization change is, "Involvement leads to commitment." Once again, this case demonstrated the validity of that principle, whether one is employed by a health care organization, government agency, or most any other organization.

Case 4. This final case is a brief description of an attempt a few years ago to resolve conflict between two important service functions—human resources (HR) and information services (IS)—in a large managed health care organization in the western part of the United States. The conflict was fierce, even to the point of name-calling; for example, the HR people labeled the IS folks "idiots." In a careful and diligent approach, the internal OD specialist decided to intervene. The OD specialist interviewed people on both sides and verified that the conflict was widespread and feelings ran deep and were indeed vitriolic. The OD specialist was patient and understanding, yet at the same time persistent about attempting some degree of resolution. Eventually, the OD person persuaded the key players from the two functions to meet off-site to work on their issues. The OD specialist decided to follow as closely as possible the steps explained in an article by Burke (2006), which consisted, first, of facilitating an exchange of perceptions between both parties—how do we see ourselves, how do we see the other group, and how do we think they see us?—and second, creating cross-functional groups to work together on ways to reduce the conflict. In other words, an intervention used effectively in business-industrial organizations (Burke, 2006) was applied as closely as possible in a health care setting. Data were collected before and after the intervention in this health care organization. The data showed that the conflict between the two service functions had been reduced significantly. Data collected informally and over time looked promising; that is, the degree of resolution was lasting.

The point of including this brief case is not to report on a research study as such—the study was a simple before-and-after comparison, not a rigorous research effort—but to illustrate that tried-and-true interventions from OD in business-industrial organizations can work effectively in health care organizations as well.

In summary, these cases demonstrate that physicians in management and leadership roles have considerable influence and control. Without their involvement in a change effort in health care organizations, little if any change is likely to occur. And finally, techniques and interventions from the OD and change world of business industry can also work effectively in the health care world.

Changing Government Organizations

The literature on organization change in government organizations is sparse. There are a number of reasons for this meager situation. First, most government organizations are large, unwieldy, and complicated, thus making change difficult. *Complicated* in this case means that these organizations typically serve many different constituents—especially at the federal level, with Congress itself at the top of the list—and therefore, having total organizational focus is difficult. Second, even though much may be espoused about change with each new administration, very few organization change efforts are actually undertaken. Third, and as a consequence of the above, not much is known about how to bring about change successfully in government organizations. Finally, as noted already, government executives face the fundamental issue of time; therefore long-term change (and large-scale organization change takes time) is rare.

We do have one study of organization change in the federal government to review and, although limited with respect to the number of organizations studied and methodology, it is worthy of our consideration.

Case 1. Kelman and Myers (2009) in their research wanted answers to such questions as:

- How are senior government executives who attempt to realize a lofty vision that requires significant change able to succeed?
- Do they have a clear strategy and does that matter?
- What form of leadership, behaviorally, seems to be critical to success?

Kelman and Myers (2009) attempted to answer these questions and others by studying executive behaviors of those from the Clinton and Bush administrations (1993–2007) who led change efforts and were identified by independent experts as having led successful change, compared with those executives who attempted change but failed. For Kelman and Myers *successful* change meant that these top executives had a strong vision that required significant organization change and that the implementation required paid off.

As mentioned at the outset, the Kelman and Myers (2009) study was based on a small number of cases, yet considerable information was gathered about each one. Incidentally, the researchers were adamant about *not* considering "best practices" research, since the results of such studies are usually based on success cases only. They explained their position this way:

> If one chooses only successes and finds they did A, B, and C one really cannot conclude from this that A, B, and C caused success because others (about which one has no information) may have done A, B, and C as well.

> Central to our research design, therefore, is creation of a control group alongside the successful executives, so we can compare successes with those of others. (p. 3)

They cite Lynn (1996) as support for their position of avoiding "best practices" research.

Kelman and Myers then proceeded to generate 17 hypotheses that guided their study. A sampling of their hypotheses is as follows:

- H1: Successful agency heads will be more likely than others to engage in the strategic planning process for strategy formulation.
- H2: Successful agency heads have a smaller number of goals than other leaders.
- H3: Successful agency heads pay significant attention to creating alignment between their goals and their agency's internal capacity more than other leaders.
- H4: Successful agency heads pay attention to engaging their external political environment more than other leaders.
- H5: Successful agency heads use a collaborative, participatory management style more than other leaders.
- H8: Successful agency heads use performance measures more than other leaders.
- H12: Successful agency heads tend to come from agencies with relatively more political appointees as a percentage of agency employees, compared with the average agency.

The executives studied by Kelman and Myers (2009) were nominated by two groups of independent experts: fellows from the National Academy of Public Administration (N = 410) and principals from the Council for Excellence in Government (N = 450). The researchers also provided criteria for these experts to apply to their nominations—for example, those executives for nomination who had an ambitious vision, who were successful in implementing strategy, and so forth. Kelman and Myers received 111 responses from these experts, for a 13% response rate. Those executives to be studied had to have at least three nominations from experts. In the final list there were more successes nominated (N = 8) than failures (N = 3). With so few failures Kelman and Myers added another source for comparison, that is, *counterparts* to the successes:

> Those in the same positions, appointed at the same time in the lifecycle of an administration, in the administration other than the one of the success. So if the success was Bush's first appointee, the counterpart would be Clinton's first appointee to the position. The idea was to control for as much as possible, to make comparisons as free from noise as possible. (p. 18)

Thus, the control group for comparison was three failures and six counterparts, that is, a comparison of eight successes with nine controls.

The major data source for their study, therefore, was individual

interviews with these nominated executives. All interviews were transcribed and analyzed qualitatively. The primary measure was the number of spontaneous mentions of a technique by the interviewer.

With respect to the results of the study, the techniques mentioned most frequently by the successful executives were

- collaborative/participatory management style employees (seven mentions);
- strategic planning, proactively working with Congress using performance measures, and reorganization (six mentions each);
- proactively working with interest groups, appealing to public motivation, and developing slogans reflecting goals (five mentions each);
- relationship building with external constituencies and/or employees and using the period between nomination and confirmation to think about goals/gather information (four mentions each).

Regarding the sampling of seven hypotheses noted above and labeled H1 through H5, H8, and H12, all were supported by the research except for H3 and H12. With respect to H3, executives simply do not pay much attention to aligning their goals with the organization's capacity to accomplish those goals. And with respect to H12, the opposite seems true. It may be that the greater the number of political appointees in a given agency, the less attention is paid to long-term change efforts.

Some other important highlights from this study are as follows:

1. Strategic planning with goal specificity is important.
2. H5, executives' use of collaborative, participatory management style and practices, was supported, yet there was no difference between successful change executives' behavior and their counterparts'. It would appear that in government all or most executives endorse and try to practice these behaviors. The difference is that the successful change executives also paid the same amount of attention to good, general management practices focusing on performance management, matters of efficiency, few goals, reorganization, and strategic planning. As Kelman and Myers (2009) cleverly captured this point, everyone has read about change management and McGregor's Theory Y, but only the successful executives have read both the change management literature and Drucker's (1974) masterpiece *Management*.
3. Even though change experts emphasize the importance of establishing a sense of urgency—the so-called "burning platform"—to provide the motivation and readiness for change, in government this technique carries little if any import. Again the key variable in government is time, and there is rarely if ever a sense of urgency. If it is really important, then Congress has to be involved and that will take a while.

As pointed out earlier this study has its limitations—small number of executive agencies, the basis of comparison of success

and failure/counterparts, the small response rate from the experts, to name the primary ones. Nevertheless, Kelman and Myers (2009) believe that their findings add to the literature and also provide helpful advice to practitioners. I tend to agree.

To conclude this first case on a sardonic note and use a quote that Kelman and Myers use, let us point to the problem of government executives', particularly political appointees', lack of attention to the organization they supposedly lead.

> Many appointees are captivated by the glamour of their positions and ignore the fundamentals. They lavish their attention on travel opportunities, public appearances and speeches, press interviews, top-level policy meetings, and White House contacts, but they have little patience for the critical spade work that makes programs and organizations function effectively. They devote little or no time to working out key regulatory provisions, making budget allocations, building and nurturing the organization, determining critical personnel assignments, or translating policy concepts into operational reality. . . .

[W]hat's the harm of letting political appointees play the amateur government game? Isn't it a small price to pay? It is *not* such a small price, and it does a *lot* of harm. (Cohen, 1998, pp. 475, 478)

Case 2. Rather than a large sweep across many government agencies, as reported in Case 1, this case concerned one government organization that was comparatively small, 3,264 employees. The change effort itself was widespread; therefore, all employees were affected. Although the research was conducted with just one agency and generalization of the results is problematical, the strength of the study rests on the fact that it was longitudinal, spanning a year, and not just a snapshot of change at only one moment in time. In fact the overall change took about three years; so the survey, taken twice a year apart, was essentially at the midway point. Thus, the study conducted by Shin, Seo, Shapiro, and Taylor (2015) focused on the sustainment of change; that is, did the change a year later continue? Were employees still *committed* to implementing the change? And if so, what were the primary sustainers?

Data were collected at two levels: individual and work unit. The three measures at the individual level were (1) commitment to change, assessed according to effect (e.g., "I believe in the value of this change") and normative behavior (e.g., "I feel a sense of duty to work toward this change"); (2) turnover intention assessed at Time 2 only and posed rather straightforwardly by three items, one being "I will probably look for a new job within the year"; and (3) behavioral support for change, also assessed at Time 2 only, using four items, with an exemplar being "I speak very positively about the change to others to show them why this is an important and needed set of changes."

At the work unit level, three measures also were conducted: (1) control variables, that is, those factors that can potentially influence the study, such as (a) overall commitment to the organization, not just to the specific change effort, (b) the quality of exchange between leaders and followers, and (c) the degree of impact on employees' daily routines as a result of the change; (2) informational justice climate (perceived fairness), assessed by five items, with one being "Has the manager tailored their communications about the change effort to people's specific needs?"; and (3) transformational leader behavior, using 12 items developed by Podsakoff, Mackenzie, and Fetter (1990), with a couple of examples being "My boss has a clear understanding of where we are going" and "My boss challenges others to reexamine some of their basic assumptions about their work."

Most of the predictions (some 13 hypotheses) by the researchers were supported by the results of their study, leading them to draw three main conclusions:

1. Employees' commitment to their organization's change tends to be sustained over time.
2. Employees' maintenance of commitment to change is stronger when their work unit leaders provide sufficient and sincere information and exhibit transformational leader behaviors during the change.
3. Organizations undergoing change are more likely to produce positive outcomes (e.g., lower turnover intention and greater change-supportive behaviors by their employees), particularly at the later phase of the change, when employees maintain higher levels of affective and normative commitment to the effort to change (Shin et al., 2015; pp. 517, 518, 521).

Even though this case is government specific, the researchers' findings could likely occur in a business-industrial corporation as well. Their study of change emphasizes the importance of *commitment*, a sense of *fairness* regarding communication, and the critical role of *leadership*, especially transformational leadership (see Chapter 14). I suspect that organizational size played a significant part in this change effort reported by Shin and her colleagues. In a manner of speaking, as a leader, one can get her or his "arms around" the complexity of this organization. We are not dealing with the Department of Defense. This point may argue that for change to be successful in huge bureaucracies, it is better to work with comparatively independent subunits rather than attempt to change the entire organization.

Case 3. The last chapter of this fifth edition of the text (Chapter 17), in the section on selection of potential leaders, outlines an informal study conducted at NASA. The study was based on data collected from a multirater feedback and work unit climate process that was part of a management and leadership development program. This final case on government organizations briefly describes change at NASA. This description provides the broader context for the study reported in Chapter 17.

This NASA case is an obvious example of evolutionary, not

revolutionary change, but change nevertheless. For a report of part of that long-term change effort, see the article by Burke, Richley, and DeAngelis (1985). About a decade prior to the publication of this article, one of the coauthors, Lou DeAngelis, who was responsible for training and development at NASA, contacted me about working with him. The work to be done was a long-term change effort beginning at the individual level, the target being managers and administrators. DeAngelis had been authorized to build a management development program and a center, the point being that having some of the top scientists and engineers in the world on the NASA payroll did not guarantee good management. DeAngelis and I planned and gradually implemented two significant initiatives: designing the original program and finding an appropriate location for the management education center. The place was Wallops Island, Virginia, which NASA had "inherited" from the U.S. Navy. It was a Navy installation during World War II. It was tough going for DeAngelis and me at the outset. Fighting mosquitos large enough to drain most of the blood from one's body, we pressed onward and survived. We arranged for a complete rehabilitation of the dilapidated base, with good food and comfortable sleeping quarters at the top of the list. Our conference rooms were constructed with the latest audio-visual equipment. Some 40 years later, the center is still operational.

The programs we designed were based on two objectives: (1) to bring to the educational process the latest thinking and evidence from organizational psychology and (2) to establish a process of developing one's self-awareness. Thus, individual feedback was fundamental. We also worked with NASA centers (Burke et al., 1985) and eventually conducted organizational surveys for NASA as a whole and for the centers.

This effort on the part of DeAngelis, me, and many others was a long-term effort, which continues, and it is unusual for a government agency to make such a commitment. It was a gradual process, to be sure, but I am convinced that culture change did indeed occur. Executives and managers saw the value of feedback, at the individual level with multirater feedback and at the organizational level with survey feedback. And we tried to remain as evidence-based as possible with all our exercises and presentations.

Even with all this effort over time, NASA did not improve to a state of perfection. It may have been that the *Challenger* accident had more of an impact on changing NASA's culture than anything we did. I would like to believe, however, that the work we did might have helped NASA executives cope more effectively with that tragedy and others that followed.

Summary and Some Conclusions

Because organization change and development practices in the

early days of the field (1950–1960s) in the United States and United Kingdom were conducted predominantly in business-industrial organizations, the applicability of that earlier work may have established a strong precedence for how change efforts should be done. That precedence could be described as following the overall sequence of Lewin's unfreeze, change, and refreeze, in general, and more particularly conducting attempts to support (a) more open communication regardless of level, (b) more employee involvement in the decision-making process, that is, including them in the decisions that directly affect their work, (c) increased teamwork, and (d) initiatives that provide vision and clear direction for the future.

Yet when considering the change cases reported in this chapter, all of them, whether in health care or government, quite appropriately used the thinking and practice of organization change and development from the past and from business-industrial organizations. So it would appear that the *process* of effective change that we have known and practiced for many years is applicable beyond business-industrial organizations. Possible modifications of this conclusion should be considered, depending on how loosely coupled the organization we are attempting to change—see Chapter 12—not necessarily whether the organization is in health care or government. The conclusion I am presenting, therefore, is that the *process* of change (i.e., *how* we bring about the change) should remain the same, but the *what* will differ. And that *what* concerns power and control. Besides conducting surveys, resolving conflict between groups and functions, team building, and so forth, our overriding goal in health care is likely to be focusing on the conflict between professional loyalty and allegiance to the organization's administrative requirements and helping those directly involved, doctors and nurses, deal with that conflict. In government the conflict we as change consultants need to help with is long-term versus short-term goals.

But what if our organization of interest is the U.S. Department of Veterans Affairs (VA)? It is *both* a health care and government organization. The VA is attempting a massive change due to incredible need. It has been a broken system for quite some time, and changing it for the better will take quite some time. The VA is (a) huge, with more than 300,000 employees nationwide (e.g., it's the largest employer and trainer of clinical and counseling psychologists); (b) complex, providing most of the wide range of health care for U.S. veterans; and (c) bureaucratic, with layers upon layers of administration. The VA may be the most difficult organization on the planet to change.[1]

1. In 2014 Congress passed the Veterans Access, Choice, and Accountability Act. A part of this legislation required that a study be conducted to assess the current capabilities, problems, and issues of the VA. The prime contractor conducting this study from mid-2014 through September 2015 was the Mitre Corporation. Because the study needed to be done comprehensively yet quickly, Mitre subcontracted with McKinsey, Grant Thornton, and the RAND Corporation to provide assistance and expertise.

Mitre also established a “blue-ribbon panel” of independent experts to provide overall evaluation of the study. I was a member of that panel, and my information came from that oversight activity.

Change for the VA, which continues to the present, has been considered from practically every possible perspective and potential—carve it into more manageable units, make it a private corporation, decentralize the structure, establish a more limited mission and give veterans more choice from the private sector regarding their health needs, and so on. In any case, and finally regarding change, it may be best to concentrate a change effort at this stage on one critical component of the VA instead of the entire system, such as the clinics (not the hospitals for now) that provide outpatient care. And not so incidentally, it may be that the head of the VA needs to be a physician, not a military general or admiral and not a former business executive. Respect from followers for their leader is no doubt linked to expertise in both health care and government. Whom followers give power to is of utmost importance. Appropriately, then, we now move to the next chapter, on leadership.