5 LESSONS ABOUT CULTURE CHANGE FROM THE BOTTOM-UP

THE CULTURE OF BUILDERS
WITHIN THE UNIVERSITY OF MICHIGAN HEALTH SYSTEM

By Levi Nieminen, Ph.D.
Director of Research & Senior Consultant

denison™

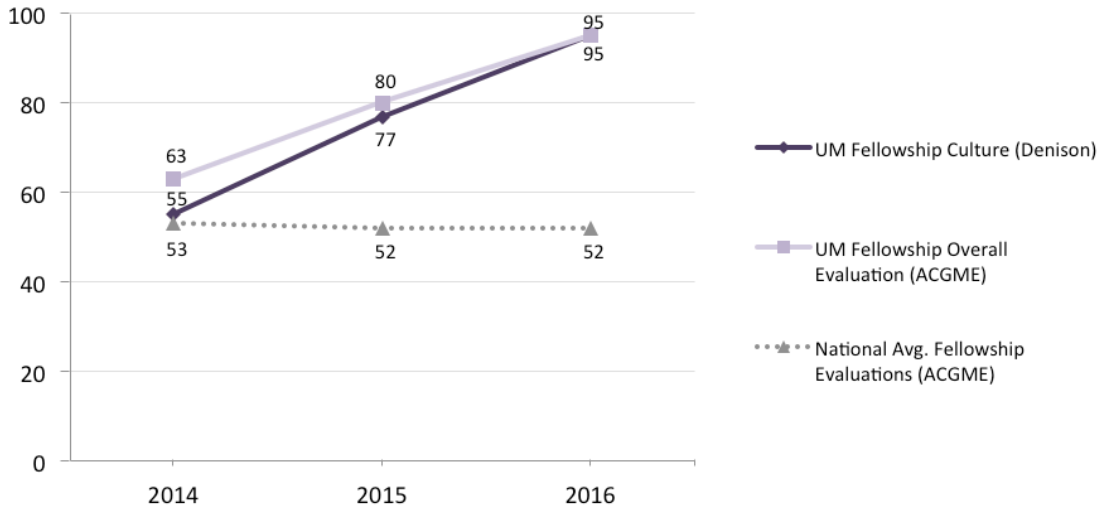
In a previous article for the Transform series, I wrote about the work that is ongoing within the University of Michigan Health System to empower a group of Cardiology Fellows to build the program, training experience, and culture that they want, a concept the Program's Director, Dr. Peter Hagan, has described as a "culture of builders." [1]

For this part-2 article, I sat down with three of the Fellows who have been involved in the culture initiative from the beginning to better understand how they got involved and what the work has meant to them. [2] In talking with the Fellows, I was particularly interested in their perspective on bottom-up change, the notion that the people on the front lines of an organization can lead the way in a culture change by coming up with most of the ideas and driving most of the actions. Of course, their story is ultimately about a mixture of bottom-up and top-down, with the program's director helping to create the space that the Fellows have now stepped into with both feet. And it is also about a small program within a much bigger health system and the opportunities and challenges that those dynamics create.

Nonetheless, one thing is exceedingly clear from whichever angle you look: what they're doing is working. This includes taking a pulse check on the culture annually and using those data to spark regular discussions about what could be improved. From there, the Fellows come up with ideas and get to work on making them happen.

Survey data tracked over the three years since this work began shows a steady improvement in Fellows' perceptions of the culture and their satisfaction with the program. The pattern is striking–they've improved the environment they work in, and their training experience has gotten a lot better (**see Figure 1**). Though the Fellows' story is far from over, the success they've had and what they've learned thus far can illuminate a great deal about the process, impact, and challenges of driving change from the bottom-up. [3]

Figure 1. **Improved Culture Translates to Improved Training Experience**

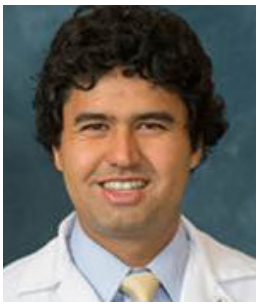


Note: The Fellows' ratings of the program culture are percentile scores in comparison to Denison's global normative database. On an annual basis, the Accreditation Council for Graduate Medical Education (ACGME) conducts surveys of all accredited medical Fellowship programs in the U.S. The numbers shown above from the ACGME survey represent the percentage of Fellows who evaluated their overall experience in the University of Michigan (UM) Cardiology Fellowship Program as "Very Positive", i.e., a 5 on a 5-point scale. In comparison, the national average according to the ACGME has been steady at 52%. For more details on ACGME, please visit: http://www.acgme.org/

Cardiology Fellows

Prashanth Katrapati, M.D.

Matthew Konerman, M.D.



Dan Alyesh, M.D.

I would also like to mention the central role played by **Craig Alpert, M.D.**, who is a former co-Chief Fellow in the program and was unable to participate in the interviews for this article.

Going back to the beginning, the Program's Director was very intentional about making this a fellow-driven initiative. How would you describe the process of buying in to the idea that the program's culture could be improved and that the improvement could be driven by your efforts? Were you and/or others skeptical?

Dan Alyesh, M.D. [DA]: I had already done my own reading on the science of improvement and the importance of culture, so I was already very much a believer. The only skepticism that I had was, living in this large world of academic medicine–of hierarchies and experts, the hesitancy to change, and reverence for the models that made us who we are–how would we approach these challenges? Within the Fellowship, we believed change was possible pretty quickly because we had leadership and we had the Program Director who believed in the need to change, to improve.

Matthew Konerman, M.D. [MK]: I think the key moment for me was when I came to really believe in the idea that I could create something. It was very important to hear the Program Director reinforcing that message and acknowledging some of the ways the Fellowship could be improved. When I became the Chief Fellow, I tried to do my part to empower the other Fellows in the same way the Program Director had done.

Prashanth Katrapati, M.D. [PK]: It was also important to identify a problem. When I went to my classmates I didn't say, "Hey guys, let's change the culture." I went to them and said, "We know we're not happy with XYZ in the Cath lab, we know we're not happy with some of the curriculum, and so on." What we did well at the very beginning was to identify a few things that were specific and also easy to achieve. We didn't go for the home runs in the beginning, and I think that helped a lot.

In a performance context which could certainly emphasize the individual (after all, getting a job post-Fellowship is not a team game!), where does the incentive or motivation to improve the program come from?

[PK]: In the medical field, where you come from is a big deal. No matter where you go for the rest of your career, everyone asks you "where did you train?" That's why I think people bought into it. They realized that Michigan is going to become a better Fellowship program with better talent and recruits, and that's going to pay off for me when I am applying for a position five years from now.

[DA]: Recruitment is a big part of it. The people who come into the program are highly motivated. They see something bigger than themselves. And then one thing that the Program Director does is get us to think about our Fellowship as a locker room, a team–check our egos at the door–and not see each other as the competition. This combination of the people and the milieu was the raw material for succeeding in what we did.

[MK]: I also think we were able to promote ourselves through the culture work. We learned that we could be creative and start projects that would benefit us personally. Some of the projects were turned into papers

and benefitted peoples' academic résumés. But people also really got behind the projects that supported quality and patient care. That stuff carries beyond the individual.

All indications point to a program culture that is on the rise. I've heard a number of people in and around the program describe the change as a "palpable difference". From your view, what's different?

[MK]: At the surface, I think there is less negativity, less complaining today. But the most palpable difference is the greater sense of community around the Fellowship. I've also seen the Faculty more attuned. One of the things we did was organize dinner events at Faculty members' homes. Those have helped to build the relationships and interest, and we have examples where we've been able to go back and engage those same people to help the program.

[PK]: The number one thing was that everybody realized that they could make a change, and I don't think that was the case before we started this process. The guy at the bottom now has a voice, and that voice is heard. And the guys at the top are more open to the idea that change can happen.

[DA]: There is a collective belief in the ability and the need to get better. There is a tremendous amount of pride–there was always pride–but that has escalated.

In my previous article, I described the range of Fellow-initiated projects, from the fleeces the Fellows wear (with cardiology logo) to barbecues and program curriculum changes. From your view, what actions have had the biggest impact and why?

[PK]: Most importantly, at the end of the day, the reason that you're there is to learn and set yourself up for the future. And the fact that we were able to now tailor our own education to our needs, and be able to speak up about it when it wasn't set up to our needs, was the biggest action item that I think helped overall.

[MK]: Anything affecting patient care or Fellow training. These are the core. One example of a program that was very successful was the creation of a clinician education pathway which addressed a core need in our training. We proposed the idea to the Graduate Medical Education at the University and got it approved–GME-sponsored with a budget. We had trainees across the hospital apply, and we selected 25 to participate in the initial program. The program has scaled to other departments.

[DA]: All the raw materials were here. It was the small things that added up to the big things: the fact that we started having a tailgate with the faculty; we had a fellowship reunion at the national conference; we met every month to talk about how to make our program better; the fleeces with the logo–putting it on your chest as a reminder of what you're a part of. Those little things added up to a place where now, I'm thinking of myself as part of something.

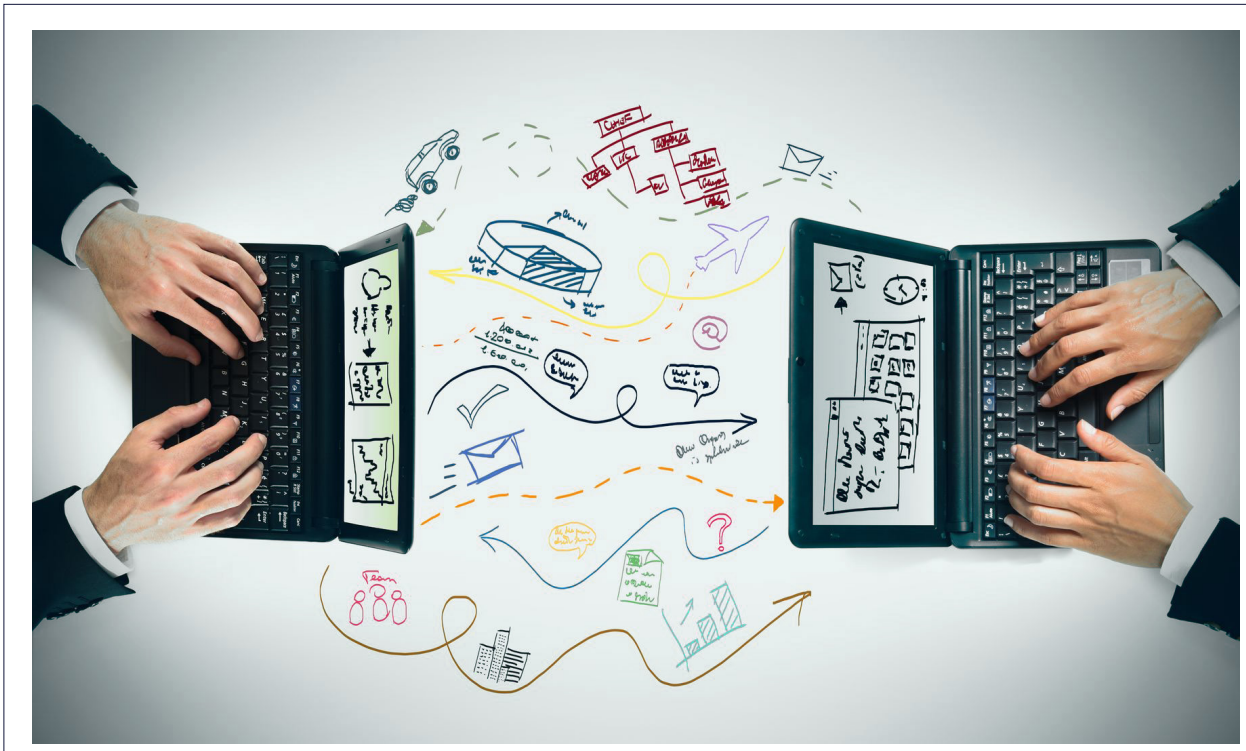
As you think about the program over the next several years, what do you view as the biggest risk factors or obstacles to continued improvement of the program and the culture?

[DA]: The Chief Fellows are like Atlas, sometimes–they hold a lot of this up. I don't think that's a model that can exist forever. We have to get beyond person-dependent solutions. You have to impact the system that you live in–that's your limit. We interact with faculty, nurses, technicians, and most importantly, patients and families. How do we translate some of these important lessons to our interactions with all of these other people?

[MK]: I think we need to continue to find ways to engage the Faculty. I think this is the ceiling of our improvement. The bottom-up efforts of the Fellows can only go so far, and then you really need the support and active engagement of the Faculty and the Division. I also think we need to continually focus on improving the 8-5 [8am to 5pm] experience of the Fellows beyond some of the social or community-based activities where the impact is outside the 8-5.

[PK]: One additional concern is that we might plateau at some point–we might conclude that the education is pretty good and the Fellows are pretty happy, and that we don't really have anything to improve.

One of the things I've been most interested in is how the Fellows' experience with the culture work has shaped how they will approach leadership roles in the future. What are you taking with you?



[MK]: In a way, the culture work was a sort of crash course in leadership. One of the basics I've taken with me into my new role is the importance of getting organized and clarifying objectives with the teams I'm leading. With my nursing team, I'm paying more attention to how I can adjust my style and expectations based on their needs.

[DA]: The most important thing that was reinforced for me is that leadership is about trust–trusting those that you lead and them trusting you. You need to trust in their abilities and recognize their strengths and interests, and then believe in them to do the right thing. And you both develop in the process.

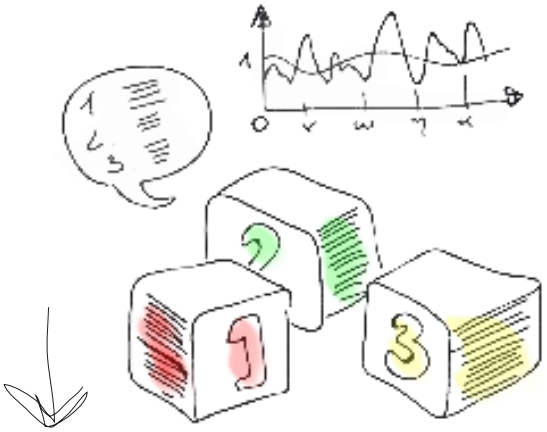
[PK]: My biggest takeaway is that there is a way to assess culture, and that you can actually change it. But you have to identify what is wrong and where the problem is in order to impact change.

Finally, in 50 words or less, what advice or insights can you share for the manager who is reading this thinking about how he or she can create a "culture of builders"?

[PK]: The number one thing is that this whole process is nothing without an idea that everyone can gather behind. For us that idea was improvement of the Fellows' education. You need to find that idea that the folks at the bottom and folks at the top can buy into.

[DA]: Listen to those who are in the trenches and do the hard work. Recognize what they care about, what they're interested in, and what their strengths are. Harness their creative energy toward making an improvement in what they care about, and trust that they'll do a good job.

[MK]: You also have to learn who to engage. I made that mistake at first by trying to call a mandatory meeting with all the Fellows. You're not going to get everyone. Instead, find the people with the most energy and work on leveraging and focusing that in the right ways.



5 Lessons about Bottom-Up Culture Change

Every day, clients ask some form of the question, "Can culture change really happen from the bottom-up?" In my opinion, there is an easy answer, and then there is a much more complicated one with all of the shades, versions, and complexities of each unique situation.

The easy answer is, no. The Cardiology story shows that. It's hard to imagine the Fellows having a comparable opportunity to shape their program without the Program Director championing or supporting it, and they've received support from other leaders along the way too. [4] On the other hand, we know that the demonstration of leadership is not constrained by job title and that the people at the "bottom" can have a huge impact and even lead the way in the change process. And furthermore, change can start small and scale from there. The Cardiology story shows that too. [5]

While the impact and stickiness of bottom-up change will unfold somewhat differently in every situation, there are also some common threads we can learn from cases like the Fellowship program. Briefly, here are 5 that can serve as takeaways for us all:

1 Start with the opportunities to be better.

Starting with the question, "how could we be better?" is more reachable than "how can we improve the culture?" and safer than "what are the problems?" From there, focusing the discussion on the core of what we do and what we are about–the mission–is the best way to find a cause that several people will get behind.

2 People need to hear and see that change is possible.

Leaders demonstrating humility and curiosity can create a space for dialogue and give people hope. But many will believe it when they see it. And they might even need to create their own cognitive dissonance paradigm by making a change happen before they believe it is possible.

3 Bottom-up culture change has a ceiling.

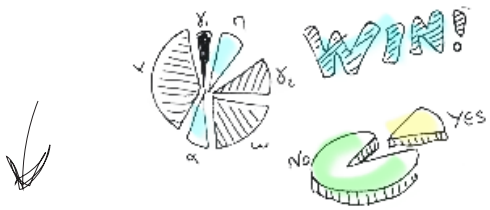
It's unlikely that a purely (or mostly) localized change process can sustain in the long-term with limited influence on the surrounding systems of which it is a part. This dynamic is acute when the "local" improvements that are most needed are dependent on big support from leaders and system-level coordination and change.

4 Improvement of community and individual both have a place.

People buy in for selfless and selfish reasons that are rarely mutually exclusive. For some, creating more community is motivating, and for others the process can help them to see 'more community' as a worthy objective over time. For others still, the process might work best when engineered around mutually beneficial objectives.

5 Go where the energy is and help others to follow.

Most groups have a distribution of people, from the most engaged to the least. Change is often nonlinear and driven by the herculean efforts of a few key people. The process should put a premium on identifying who these people are, supporting and holding up their success, and then grooming the next who are in line to follow in their example.



Footnotes

[1] This prior article underscored several 'how-to' lessons for creating and sustaining a culture in the new gig economy of temporary employees and employees who are also consumers in some way– and both in the case of the Fellows who serve as physicians and trainees during their three years in the program. Interested readers can download the article from Denison's Transform landing page or view it directly from the following web address: https://www.denisonconsulting.com/docs/transform/6.pdf

[2] Prashanth Katrapati, M.D., was the Chief Fellow when this work began and is currently an Attending Physician in Interventional Cardiology at the Providence Medical Center in Kansas City. Matthew Konerman, M.D., was the Chief Fellow the following year and is currently a Clinical Lecturer in Cardiology at the University of Michigan. Finally, Dan Alyesh, M.D., was the co-Chief Fellow over this last academic year (2015-2016) and has recently begun a second Fellowship in Cardiac Electrophysiology at the University of Michigan

[3] Dr. Hagan and the Fellows wrote a paper summarizing their culture work, "Better culture, better physicians:Empowering fellows to measure and improve training program culture," which was accepted for oral presentation at the 2016 International Conference on Residency Education (September 30 th) in Niagara Falls, Ontario.

[4] Of course, there are exceptions like political revolutions. It's generally harder to find examples of culture changes within organizations that have risen entirely from the front-lines and were sustained over a long period of time.

[5] One recent example of this scaling is a Fellow-initiated "innovation challenge" that will support and fund one or more winning ideas submitted by employees, patients, and families across the Cardiovascular Center for ways to improve the quality and efficiency of care.