

Exploring the Organizational Culture of Exemplary Community Health Center Practices

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Background and Objectives: A 1999 precursor to this study, published in *Family Medicine*, suggested that the organizational culture of practices was potentially important to health care providers and patients. In this research, we examined the experiences of people working in exemplary community health center practices to explore the components and maintaining factors of positive medical organizational culture. **Methods:** Two exemplary practices were identified through a process of nominations and selection with respect to a presumptive definition of positive organizational culture. Interpretive categories and themes were developed through qualitative content analysis of semi-structured interviews, along with field observation. **Results:** Categories of culture in these practices included *Community Mission and Values, Leadership and Organizational Dynamics, Relationships, and Physical Space*. Cultural qualities were nurtured by leadership approaches, collaborative staff meetings, and shared values about mission and workplace relationships. Staff consistently indicated that the spirit or culture in their practices was beneficial for employees, patients, and the process of clinical care. **Conclusions:** The positive organizational culture in these practices was substantially characterized and cultivated by specific values, attitudes, behaviors, and relationships of employees. Further work is indicated in approaches to assessment and intervention with organizational culture in medical settings and in evaluating associations with medical outcomes.

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The exploration of organizational culture has been a subject of interest for many years. Management literature¹⁻⁵ suggests that many factors contribute to creating cultural values and norms that are linked to the well-being (sometimes also referred to as the “spirit” or “soul”) of organizations. These include individual factors (eg, employees’ personal experiences of meaning and purpose), certain qualities of leadership style, and factors pertaining to the vision and collaboration within the work community. This literature further suggests that positive qualities of culture in organizations are directly associated with worker productivity and parameters of organizational success.

In the health care arena, several recent articles⁶⁻⁸ and books^{9,10} offer reflections and give examples of processes that contribute to a positive organizational culture and spirit. A particularly comprehensive program of research on medical organizations explores exem-

plary clinical microsystems and idealized design.¹¹⁻¹⁴ This research reveals high-performing medical teams whose organizational cultures are value driven, patient centered, continuously adaptive, and have a high regard for the satisfaction and joy of employees.

In the context of family medicine, several physician subjects in a 1999 qualitative study¹⁵ expressed the opinion that the organizational culture of their practices affected the well-being of patients and staff and the process of healing. Content analysis grouped these opinions into several themes: overall organizational culture or spirit (“The atmosphere in the office sets a foundation for healing.” “There is an amazing spirit here in spite of the fact that everybody feels stretched with the workload.”), shared understanding of organizational mission and values, support and caring within the work community, and valuing and empowering of staff in collaborative work relationships.

In this research, we sought to explore in greater depth the ideas suggested in the 1999 study. We used a qualitative methodology to systematically investigate the organizational culture of exemplary community health

center practices. We examined the experiences of people working in such practices to better understand (1) the components or qualities of organizational culture in exemplary practices and (2) the factors that may foster the qualities of culture that we observed.

Methods

Practice Selection

We identified exemplary practices through a process of nomination and selection using a presumptive definition of “spirited practices” with “a positive climate.” This definition was developed by extracting themes from the literature about organizational culture and reviewing a succession of drafts with eight family physicians in academic/clinical settings and two business professors from four regions of the country. The final version of our definition is presented in Table 1.

We then conducted a process of nominations and interviews that led to the identification of exemplary practices. We circulated our definition of spirited/positive-climate practices to a total of 26 people, representing a cross section of health care providers, health care administrators, academic faculty, hospital staff, and public health professionals. We received nominations for 23 different practices in two states. Among the mix of nominations, four practices received multiple recommendations. Of these, two practices received two recommendations each, and two other practices received three and four recommendations, respectively. We then conducted interviews with the individuals who nominated the four practices (one physician and four people from the public health/ambulatory care administration arena). Based on the strength of these interviews, along with the number of recommendations, we chose to study the two practices that received three and four nominations. Both study practices were public, nonprofit community health centers affiliated with the same health center network. We identified a third community health center practice from the same network as a site for pilot study. We approached the physicians and the office managers of the practices, and they agreed to participate.

Pilot Study

The first author and a research associate made more than a dozen visits to the pilot practice over the course of a summer, interviewing all of the staff and generating field notes about interactions and the environment. A template for subsequent staff interviews in the two research practices was developed through an iterative process from this pilot experience (Table 2).

Data Gathering

Interviews and field observation were accomplished in the two study practices over 7 months by the first author. All staff in the two study practices were inter-

Table 1

Definition of Spirited, “Positive Climate” Practices

- Physicians take the lead in creating a positive climate, or spirit, for patients and staff.
 - The practice has a strong reputation in the community for providing compassionate, whole-person care.
 - Physicians and staff have good morale, taking pride and joy in the work they do and their relationships with one another and with patients.
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viewed, with the exception of one person, a receptionist/medical records clerk, who chose not to participate. Staff included physicians/mid-levels (seven), nurses (six), practice managers (two), and support staff (11). Also interviewed were three members of affiliated community health center boards, a consulting psychologist, and the responsible administrative officer of the larger health center network. The first author also generated field notes from time spent in staff meetings, waiting rooms, break rooms, and other practice work areas.

Data Management and Analysis

The methodology for analyzing interview data was based on the phenomenological model described by

Table 2

Template for Staff Interviews

1. Mission
 - What is the primary mission or goal of this organization—what are you trying to do here?
 - How are you doing with this?
 - What do you take particular pride in, as an organization?
 - What helps this come about—what are important ingredients/components?
 2. Individual work experience
 - What is it like to work here? What keeps you here?
 - How would you describe the spirit of this organization from your perspective?
 - What helps to develop/maintain/cultivate this spirit?
 - What gets in the way—and how do people try to deal with these obstacles?
 - What do you see yourself contributing? What do you take particular pride in from your work role? As a result of who you are as a person?
 3. Patient view
 - What do you imagine it is like to be a patient here?
 - How do you think the spirit of this place influences patients' experiences and patient care?
 4. Physical space
 - What does the physical space and environment feel like, and what role does that play?
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Colaizzi¹⁶ and was chosen because it was used in our prior study¹⁵ and several related qualitative investigations.¹⁷⁻²⁰ This methodology is described in detail in our prior study. It has seven steps: (1) reviewing subjects' descriptions, (2) extracting significant statements, (3) creating formulated meanings, (4) aggregating formulated meanings into categories, (5) developing themes within categories, (6) creating a summary narrative description, and (7) returning to subjects for validation. We also jointly reviewed and incorporated observations from field notes.

Results

Subjects

Provider staff included four men and three women. The remainder of the employees were female. The ancillary informants (board members, the consulting psychologist, and the network administrative officer) included three men and two women. All informants were Caucasian. Ages ranged from early 20s to retirement age, with the majority of informants in their 40s and 50s.

Interview Content Analysis

Textual analysis of transcripts of interviews with our 31 informants yielded 871 scorable formulated meaning statements. The iterative process of interpretation yielded five major categories, three of which were further divided into themes. Following are summaries of these categories and themes. We include some sample meaning statements; an extensive compilation of meaning statements is available from the corresponding author.

Category I: Community Mission and Values

Purpose and Mission. Informants consistently described the organizations' missions as providing quality, accessible, and affordable medical care to people in their communities.

Community Connections. Many employees reported personal connections, by birth or residence, with the communities they served. These connections gave them a particular passion (a staff member said "ownership") for the mission.

Pride in Work, Participation in Mission/Values. Many informants expressed pride in their work and in participating with colleagues in addressing the mission. "People stay because of the teamwork and sense of continuity and community . . . because of our mission . . . it isn't for the money." (provider)

Category II: Leadership and Organizational Dynamics

Physician Role. Staff said that physicians contributed significantly to the culture and values of these prac-

tices. They also described physicians' individual relationships with staff as respectful, empathetic, and personally engaged and supportive. "[Our providers] create an atmosphere where everybody counts." (nurse)

Practice Manager Role. Many providers and staff reported that the practice managers were indispensable in the successful functioning of their practices. The practice managers were described as being clear in their expectations, respectful, affirming, forward looking in problem solving, and consistently helping with job tasks when employees were becoming overwhelmed. "You can't just come in an organization and say 'I'm the boss; you've got to respect me.' [Practice manager] leads by chipping in and bending when she can in difficult situations, being that bridge between administration and the patients and others." (provider)

Staff Meetings. Both practices had weekly staff meetings that were described as safe places where employees could raise issues and receive respectful, collaborative, problem-solving responses. "The longer people are here, the more they say in staff meeting because they can feel the sense of safety and openness and interest—that other people are willing to hear them." (nurse)

Office Design. The larger of the study practices had undergone an extensive process that redesigned provider-nurse relationships and patient flow. With the new design, nurses worked consistently with particular physicians, together seeing consistent panels of patients. Nurses provided consistent phone triage for patients within their panels and met with patients at the conclusion of office visits, answering questions and scheduling follow-up and referrals from the privacy of the exam room. Nurses reported increased professional satisfaction from these arrangements. Providers appreciated the teamwork of collaboration with particular nurses. Front office staff were relieved of the awkwardness of trying to conduct confidential conversations in a public place. Many staff expressed the opinion that the redesign supported their practice value of patient centeredness.

Relationships With the Larger Organization. The practices related to larger systems primarily at two levels. Community boards had been involved in the inception of the practices but were no longer involved in practice management. They maintained the facilities, acted as links with the community, raised money for special projects, and were perceived as being committed and affirming. The larger organization of which the two practices are a part provided services in operations, finances, and recruitment. Some practice functions (such as productivity measurement and billing) were standardized by the larger organization, while individual practices had autonomy in many other aspects of

practice management. Staff perceived the larger organization as accessible, committed to the mission, and providing links to subsidies for low-income people. Some onerous administrative requirements associated with regulatory oversight were generally outweighed by a sense of partnership among local staff and colleagues at the larger level.

Category III: Relationships

Shared Responsibilities/Collaboration. Practice cultures emphasized teamwork relationships; employees were attentive to ways of helping coworkers, creating what one physician called “giving relationships, rather than demanding or adversarial relationships.” “This is not a cushy job; it’s a hard job, it’s demanding. But one of the things that keeps us here is that everybody works hard, and we help each other out . . . It’s very rare that people go home until everybody else is done. At the end of the day, you hear people saying ‘Can I give you a hand, is there anything I can do to help you?’ . . . that would be a nurse talking to a receptionist, or a provider talking to a nurse, or anybody.” (provider)

Caring Relationships. Several informants used the metaphors of “community” and “family” to describe organizational qualities of caring and personal regard. Like many families, they reported having what a staff member called “our ups and downs,” and they varied in how much they met socially. Almost everyone reported valuing their personal relationships, however, and supporting individual colleagues who were having difficulties. “We know each other really well and work well together. You can read if someone’s having a bad day without even asking. You touch them on the back and say ‘You doing ok?’ That kind of stuff happens often, and that’s what makes it a wonderful place to work.” (staff)

Egalitarianism. Although roles varied among employees, there was clearly a shared understanding that everyone worked hard, everyone was important to the mission, and everyone’s opinions were valued. “It doesn’t feel here like anyone is higher up in their role or better than somebody else . . . everybody is treated as equal. I’ve never been in a job situation like that before.” (nurse)

Dealing With Conflict and Stress. Many informants felt that their workplaces were as hectic and stressful as any other medical practices. However, they consistently described responding to conflict and stress with out-on-the-table problem solving and personal affirmation. “We really work together to understand why problems are happening and what we can do to make situations better. Nobody gets attacked, and everybody is included in the problem solving.” (nurse)

Humor/Joy/Celebration. Staff work hard, but they laugh. They celebrate the milestones in one another’s lives.

Compatibility/Fitting In. Several informants indicated that the cultures of their practices were not for everyone. Many employees value the freedom, responsibility, and relative intimacy of the work environment . . . and tend to stay long-term. Occasionally employees fit less well with the work environments and tend to leave.

Category IV: Effect on Outcomes

Informants consistently expressed the observations that the spirit or atmosphere in the practice (1) is easily apparent from being there, (2) affects the emotional reaction of patients receiving care, and (3) probably has some effect on patients’ quality of care. “The atmosphere is contagious. If patients see us being happy and helping each other out, they feel good and welcome in coming here.” (staff)

Category V: Physical Space

Both practices had histories of buildings with inadequate space, which were described as the boon (“It brought us together, literally”) and the bane (“Not enough work space”) of their existence. They both had moved or were moving to more appropriate space and were optimistic about this change. Several people also indicated that the freedom to personalize and decorate their practice space was important in creating a pleasant and hospitable atmosphere for themselves and patients.

Field Observations and Practice Documents

Review of field notes and practice documents added emphasis to several interpretive categories and themes from the interview content analysis but did not reveal additional interpretive categories.

Returning to Subjects for Validation

The first author met with practice staff to present preliminary findings and solicit feedback. Comments indicated that the analysis captured accurately the organizational life of the practices.

Associated Practice Data

There were some limited data about clinical and operational variables available for these practices. The network administrative officer indicated that these practices are consistent leaders in patient satisfaction and productivity/financial parameters within the comparison group of the larger network of community health centers. They also have the highest level of staff retention for 10 years or longer within the larger organization—82% and 50%, compared with an average of 20% for the comparison practices.

Discussion

Through iterative processes, we developed a presumptive definition of “spirited practices” with “a positive climate” and identified two community health centers that were considered to be exemplary with respect to this definition. We used a qualitative methodology to systematically investigate the organizational culture of these practices. We examined the experiences of people working in these practices to better understand (1) the components of organizational culture in exemplary practices and (2) the factors that may foster the qualities of culture that we observed.

Key findings are presented in the summary narrative description:

Two exemplary practices in the present study were deeply rooted in their communities and showed enthusiastic engagement of staff with a meaningful mission. Providers and practice managers played key roles in exercising leadership by example and by relating to staff with openness and respect. Regular staff meetings provided a setting for affirmation, community building, and problem solving. The organizational culture reflected a strong spirit of egalitarianism, hard work, collaboration, joy, and personal investment and caring. The level of work was demanding, and there was stress and conflict, but difficulties were dealt with above board and without personal accusation. Qualities of organizational culture/spirit were valued by employees and believed to beneficially affect the experience of patients.

We note the similarity between our definition and the categorical and thematic findings of this study. In the cases of these two practices, what “makes it work” is consistent with observations from the management literature and from our pre-study informants about organizational culture. The most notable departure of our findings from the definition concerned the presumptive statement that “Physicians take the lead in creating a positive climate, or spirit, for patients and staff.” Clearly, the physicians in these practices were leaders in cultivating organizational climate, but leadership was not limited to them. The practice managers played key roles in maintaining organizational climate, and there was widespread agreement that all employees had the opportunity and the responsibility to participate in this, as well.

Our results also suggest that there are multiple linguistic and conceptual approaches to the qualities we are exploring. We believe that a variety of words appearing in the organizational literature and in our interviews (“culture,” “spirit,” “climate,” “tone,” “atmosphere,” etc) probably converge on the same transcendent qualities of organizational life. This research suggests that it is probably important to be inclusive in using language to refer to these qualities in organizational development, research, and clinical settings.

Limitations

There are several interpretive cautions in this research. First, it is unclear how generalizable these results are to other practices or clinical microsystems. One physician informant specifically mentioned, for instance, that the organizational culture of community health centers might be different from private practices because of their focus on mission and service and their nonprofit status. It may be that health centers have these qualities more than other practices, or it may be that our nominators were more familiar with health centers (which are probably more accessible to outsiders) than other practices.

Second, we do not have corroborating data from patients. It was not within the scope of this research to examine patients’ perspectives, and our principal focus was on the perspectives of employees. There was, however, a consistent observation from staff that qualities of the climate or culture for employees clearly affect the experience for patients. Limited patient satisfaction data further suggest that the experience for patients in these practices is very positive. In terms of busyness and productivity, moreover, it cannot be argued that these practices are great places to work or to be a patient because the pace is slow and relaxed.

Third, we have no comparison interview or observational data from less well-functioning practices. Finally, this is descriptive research, and it remains a question for further research to explore how—or whether—interventions supporting the factors we have identified would make a difference in practices or microsystems with a less positive climate or culture.

Future Directions

Further research may (1) further explore pieces of these findings in a descriptive way, (2) pursue measure development (adapting existing measures of organizational culture from the management literature or developing new instruments), (3) examine more thoroughly the association of various parameters of organizational culture and outcomes for employees, patients, and practices, and (4) create and evaluate practice interventions linked to these findings.

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