
*Transforming Healthcare:
Bringing Dialogue to the
Grand Junction Healthcare
Community*

—RESEARCH SUMMARY—
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Transforming Healthcare: Bringing Dialogue to the Grand Junction Healthcare Community

I. Background

In 1992, powerful internal and external forces for change drove the U.S. healthcare environment. Healthcare providers everywhere faced the specter of national government healthcare reform driven by the Clinton administration. In Grand Junction, a medium-sized community nestled in a river valley between high mesas and dramatic cliffs in western Colorado, the CEO and the director of Health Education Services from a large Catholic hospital were searching for an approach to make a cultural shift in their institution that would take the organization into the future. In the summer of that year, they attended a conference on Organizational Learning at Bretton Woods in New Hampshire where they were introduced to the concept of dialogue by Bill Isaacs and colleagues from The Dialogue Project in MIT's Organizational Learning Center.

In conversations with Bill Isaacs and Mitch Saunders, the hospital leaders became very excited about the potential for dialogue to create new capacities for collaboration. Their early talks centered on bringing dialogue to the Catholic hospital alone, but these two visionary women soon realized that they could not begin to make any kind of broad reforms to the healthcare system without considering other people and institutions in the region. They decided to bring together a cross-section of players in the local healthcare community to learn dialogue and develop the communication and collaboration skills that would support a joint effort to design a new integrated healthcare system for the region.

This was a novel undertaking that would involve overcoming many years of entrenched competitiveness and suspicion among the local healthcare providers. Over the years, four institutions had carved out niches of the healthcare market in Grand Junction. Financial success, size, and growth rates maintained a hierarchy of dominance among the three hospitals in the region that put the Catholic hospital at the top of the ladder. Each institution was working hard to improve the quality of service delivery, expand services and simultaneously control costs to gain competitive advantage. Most of these efforts, however, had focused on operational changes within the individual institutions. They were now running up against the limits of what they could do independently to improve the system without complementary improvements in the other institutions. A system-wide approach was going to be necessary to make the next leaps in productivity and quality.

Despite a powerful desire for reform on all sides, many people believed that the historic competitiveness and antagonism between the institutions were intractable barriers to collaborative reform. The leaders from the Catholic hospital realized that some kind of transformation in the way the individuals thought about healthcare delivery and in how the institutions worked together

was going to have to take place for genuine change to occur in Grand Junction's healthcare services. They decided to sponsor a six-month pilot project to bring together healthcare leaders and community representatives to learn and engage in dialogue. They brought in Bill Isaacs, Mitch Saunders, Barbara Coffman, and John Gray of The Dialogue Project in MIT's Organizational Learning Center to facilitate the process. The original participants included representatives from each of the other local healthcare institutions (the CEO and an administrator or board member), the head of the largest employer in the region, the head of the county health department, and the majority leader from the Colorado House of Representatives. In addition, 20 senior managers, physicians, and staff from the Catholic Hospital participated.

Over the first few months of the project, talk about the dialogue group generated a great deal of interest in the community. At the end of the six months, the CEOs agreed to jointly sponsor a second phase to bring in a broader range of participants. In so doing, they took their first step towards establishing a collaborative leadership structure that would carry forward into other initiatives.

Phase Two expanded the dialogue project to a community-wide effort involving other healthcare administrators (including alternative healthcare providers) and representatives from the Independent Physicians' Association, the Veteran's Administration, major businesses and various community organizations. They invited 45 people to join based on their capacity to learn and listen and on the basis of their audience. Thirty-eight of the 45 invitees accepted and committed to spending at least one day a month (in some cases two or more) in dialogue for the period of one year. It was an amazing demonstration of interest and dedication to making a difference in their community.

The purpose for this joint initiative was to establish dialogue as a fundamental change process within the community healthcare system. As the Catholic Hospital's CEO put it, the idea was "to build community and the communications skills to support future healthcare system planning and decisions, and to have a forum for learning to collaborate." The dialogue sessions gave stakeholders in the healthcare system new skills for surfacing and exploring the sources of fragmentation and incoherence in regional services.

Over the course of two years, the healthcare community in Grand Junction has experienced a significant shift in their interpersonal relationships, their inter-organizational transactions, and their beliefs about the structure of the healthcare system. As the Rehabilitation Hospital CEO put it: "The dialogue was an opportunity to make a difference in community thinking. I was interested in forming a solid base for creating an integrated healthcare system. My dream is now on the horizon." Dialogue helped wrought this transformation.

II. The Notable Learning

Exploring the Mental Models in Healthcare

The Community Dialogue provided participants with a time and place where they could learn to surface and explore their mental models about healthcare and their roles in the system. In early dialogue sessions their talk ranged over a number of topics that revealed the system of thought held in healthcare. They talked about how the cultural norms in healthcare restrained expressions of their true feelings—the belief that it is essential for treatment that things be kept depersonalized and unemotional. This belief generates tremendous stress for people in the system. A physician who had transferred into administration described how intensely the norm affected him: “I used to have people die in front of me, and I could deny that and go out and talk with the family, then walk right from there directly into my office and take care of somebody with a trivial illness who was mad at me because I was an hour late... and I would keep it together. But I can’t do that anymore because I’ve been away from the craziness and horror that is medicine. Now when I walk into the ICU, I feel sad to see someone on a ventilator. There has been a huge change in me since I left practice.”

These people had gone into healthcare thinking they could provide care and help heal people, and instead found themselves in a system that represses caring. They recognized that the established healthcare system has thwarted their ultimate purpose: “Something that’s come to mind this entire day is that we, sitting in this room working in hospitals and institutions—we are not involved in ‘healthcare.’ We’re in ‘*sick care.*’ ‘Healthcare’ is only what we call it.”

Participants surfaced the incoherence of their highest aspirations for healthcare and the reality of the existing healthcare delivery system. Yet they came to a new understanding that the habits of thought that maintain the norms of the industry are not immutable. Developing skills in identifying and examining mental models was an important step for helping the group to start to think of healthcare in new ways.

These early conversations drew out the potential to re-engage people’s deep commitment to health and healing and the possibility for changing the system. Participants discovered the broad foundation of values and beliefs that they all shared. Some of the most important benefits came in the realm of interpersonal trust and understanding. In one of these sessions, a comment by a woman in hospital administration captured the impact of the learning: “Especially you three men across the room... If I had to work with you on a project, before half an hour ago I would have come to it guarded and careful and trying to sound out where you were, and what would give me credibility with you and I would have been checking your credibility with me. Now, if we were to sit down to work, there wouldn’t be any of that.”

One of the administrators from the Osteopathic Hospital (OH) concluded: “The beauty of this is that I feel more closely bonded with people now. That means when someone asks me some financial question or something about the way the residents are doing, I’m going to be listening better. For one thing, I’m going to

trust them because of this experience. I can see this exponential improvement in understanding.”

The recognition of so many shared feelings and desire to change would help the group through the process of exploring some of the toughest interpersonal and inter-organizational interactions in later dialogue sessions.

Creating Trust in the Process

In February 1994, five months into Phase Two, the group made a major shift in their interactions. The group began to use their new dialogue skills to test each other’s commitment and trustworthiness.

In the February meeting, the CEO of the Rehabilitation Hospital (RH) asked the group if they would be open to exploring his vision and model for an integrated healthcare system. He positioned it as a hypothetical model: “In the midst of the crisis in healthcare cost and quality, I’d like to present a proposal to the healthcare decision makers in the region that we shift ownership of the Rehabilitation Hospital into a centralized facility for the entire region—that we decide the old Rehab Hospital must die in order to see ourselves in a broader role of serving the larger community and region.”

This was an astonishing proposal to most people in the group. A CEO that was proposing to shut down his organization for the good of the community? Furthermore, the CEO had said that in his scenario, his job might disappear. A physician made an inquiry that tested the motivation and genuineness of the RH CEO:

“A cynical person might say to you that you’re not doing this to make yourself disappear, but rather that you’re doing this to expand your dominance further still. What about this assertion?”

“I can say honestly that I don’t get anything out of this scenario except expanded rehabilitation services for the community and higher quality.”

“Why would you want to do this?” asked another participant.

“The issue for us to my mind, is that in the process of designing reforms in healthcare, we may have to lose an organization or make other sacrifices. These are our sacred cows—potential loss of authority or jobs. The question is: Are we willing to step up to do what it takes to design a system for a healthier community?”

This question got to the heart of concerns that had remained implicit in earlier conversations: If I’m going to be asked to give up something in order to create the ideal healthcare system, can I also trust that everyone else will too? Will everyone keep their word to work for the good of the whole? The discovery of the shared values for doing the right thing for the community created a foundation of trust.

In addition to the trust they built with each other, the group also accomplished a milestone in their use of and trusts in the dialogue process. The Rehabilitation

Hospital CEO noted how the dialogue process was taking hold and helping them do things differently:

“We tried to do this [integrate healthcare services] a year ago and we all dragged our feet and got nowhere. Here we’ve been able to clarify, inquire, and build on each other.”

With the sense of trust they had created, the group went on to list the elements they wanted to have included in any plan for regional healthcare reform. It was one of their first steps toward creating the future they desired.

Surfacing the Undiscussables

People are trained early in life to avoid conflict in work and life, and to withhold their negative inferences about others. Yet this avoidance allows the inference to go on, untested but still influencing interactions negatively. Secret attributions and inferences about other people are probably the most common “undiscussables.” Learning to recognize these opinions and to test them against reality are two crucial skills for collaborative action.

In the healthcare community in Grand Junction, there was a great deal of energy tied up in covering up negative inferences and projections. Underlying beliefs that healthcare providers work out of dedication to saving lives—and not for the money—made money and profit issues undiscussable for the dialogue group. As they learned to drop their defensive routines, participants faced up to the challenge of expressing and listening to each other’s attributions and projections and eventually cleared the historic barriers that blocked the path to a joint future. But it was not an easy process.

Many participants mentioned the meeting in May 1994 as the single most significant event of their dialogue experience. This session dealt with the long-held and untested attributions between the key healthcare leaders that kept them from collaborating. The facilitators opened the session with the question: “*What is at risk for me if I really say what I feel and think?*” The intent was to encourage the group to use dialogue to break past old norms on undiscussable issues. But in this event the conversation rapidly polarized the group and shifted from dialogue to heated discussion.

An attribution by the HMO CEO that the Catholic Hospital’s contracting approach addressed only its own interests precipitated the confrontation. Although clothed in matter-of-fact business terms, the comment contained an implicit accusation that CH was using a subversive approach to support its own competitive advantage at the expense of others. Other participants added fuel to the fire. To maintain the norm against saying something negative, people referred to what they’d heard from *other* people. The conversation continued with one untested attribution after another, with no inquiry or attempt to recognize their own attributions. The leaders from the CH felt that their motivations were being called into question and that they were being unfairly accused of working for their own self interest. Not only that, but their personal and professional integrity was being challenged with the implicit message that

CH was saying one thing about working for the good of the community but then seemed to be acting out of self-interest.

The operations officer at the HMO described the learning that they eventually gained from this experience: “The session brought out negative 'non-facts' and beliefs about what had been done in the past that still influenced our decisions and prevented any cooperation. It was a situation where two hospital CEOs were expressing beliefs they held about each other or their institutions—many of which were inaccurate. Eventually this conversation had a great outcome for the individuals, their institutions and the community: We learned to get past such assumptions.”

Many of the results from the dialogues on undiscussables were in the form of new insights. An administrator from the RH described how he hadn't realized “the degree to which our stories about the other hospitals [i.e., our perceptions of them] color our ability to think openly and be in relation to each other. I no longer believe that CH is out to get the others.” Another participant said, “One of the achievements from dialogue has been a reduction of the baggage that has been carried along. I think there has been a decrease in the number of inferences we make about who someone is. It makes it a lot easier for us to work together.” In sharing these discoveries with the larger community in various conversations, the CEOs spoke powerfully for the value of inquiry. Their new level of mutual understanding and respect was evident in the cooperative interactions they demonstrated.

Learning to Stand in Others' Shoes

Following the very difficult session struggling with the participants' attributions of each other, the facilitators introduced a role-playing exercise called “Standing in Others' Shoes.” The exercise uses inquiry along with role-playing to give participants a way to see another person's perspective. Many of the dialogue members referred to this exercise as one of their most profound experiences in the dialogue group.

The exercise starts with five participants questioning an individual about his or her feelings about their role in healthcare. The interviewers then do a pantomime of what the interviewee seemed to be expressing. In a role-play with the HMO CEO, the interviewers asked how he was trying to move the HMO into the future. Afterward, one of the interviewers in the role-play described her experience: “In a silent drama, we acted out the way it seemed to us that he must feel in the situation he described: I (playing him) tried to head into the future with people hanging on each of my arms and legs—but I could only go *backwards*. There were no words. The look on his face as he watched us portray his situation—it was such a look of pain. The group all saw how he felt. All of our relationships with him changed in that instant. I had never believed him before when he said he was really committed, but I do now and I know I can trust him implicitly.”

In another round of the exercise, a manager from RH interviewed the senior administrator from the Catholic Hospital about his experience there. He said: "I was one of the questioners in the 'Standing in Other's Shoes' exercise with the senior administrator from CH. I'd never met him before and he was silent in the dialogues. As we queried him, people began to see him as a whole person, especially when we asked him, 'What creates the most stress for you?'" In a post-project interview, the CH administrator explained his experience of this exercise as interviewee: "I dealt with my concern about how adversarial other institutions are with CH—when every nickel from us goes back into the community, when nuns died and served this community—how can CH be such a monster with this history? I described how every time we try to do something, it is seen as predatory—all negative attributions are put on our actions. It was easy to speak from my heart, just to let it come out."

The exercise gave participants another chance to become aware of their attributions of each other and learn to test them through inquiry. In recalling the event in a post-project interview, a hospital board member described how, "The drama created a genuine shift in the group. I never realized before that other people were doing things for a reason—that they have real rational reasons for doing what they do, and they are not just a bunch of assholes. This is when I really got into the process and began seeing things differently." One of the physicians said, "I've come to understand how drastically different people's perspectives can be, but that there is still some logic behind them. In the past, I wouldn't inquire into others' conclusions and assumptions. I learned here that people aren't stupid—you have to interpret them from their own perspective."

Challenging the Alliance Model

About six months into Phase Two, the group underwent a serious test of its capacity to move beyond their old fragmenting and competitive approaches. In the few first sessions, the group had talked about the tension between those participants who wanted to push things to action and those who felt the group should first build some shared understanding. In early Spring 1994, this tension came to a head. A few participants who were frustrated with the slow pace and "lack of action" in the dialogue sessions formed the Western Colorado Healthcare Alliance. The Alliance gathered together representatives from 21 regional hospitals to develop a vision, strategic plan and model for an organized delivery system (ODS) for healthcare in the western region. It was led by one of the participants in the dialogue project and involved several other participants as well.

One facilitator described the formation of the Alliance as a typical avoidance move: "People thought that by forming a separate group they could bypass the conflict in the dialogue group. They saw it as a way to release the tension of the two different approaches to change, when in fact it perpetuated the fragmentation. Such moves only exacerbate conflict since there is no time or place to resolve it."

In April 1994, the leader of the Alliance (a physician) presented a hypothetical model of an organized delivery system developed by the Alliance to the dialogue group. The presentation spotlighted the group's lack of consensus and diversity of opinions. Old habits of advocacy and defensive routines reappeared as the group emphasized their differences more than their shared values. For the presenter, this intense reaction to the model felt like a frontal attack: "My presentation of a model developed by the Alliance resulted in an inquisition. I felt beat-up." Another participant described the event as being like "the group just ran the presenter out on a rail." The underlying issues, which once again remained undiscussable, were about who might lose money or power. The regression into old defensive routines reproduced the same old pattern of unintended and ineffective outcomes.

In reflecting on the session, people recognized the pattern they had fallen into and the problems it caused. According to a manager from the HMO: "This was one of the most eventful sessions because it forced us to acknowledge and be aware of what can happen if we don't do appropriate inquiry and keep people involved." After a period of time, the presenter of the Alliance model was able to look back at what he had learned from the experience and said: "I hear myself and others making judgments now and I have learned to stop and ask. I have more empathy for everyone else around me now. Dialogue is about getting *me* to understand the other person better."

One of the lessons from these experiences was that the status quo is very powerful. Our cultural and institutional structures draw out our propensities for making implicit inferences and being competitive. We encounter these structures in the system again and again. There isn't any "fix" for these problems. It calls for a reiterative process as the system moves towards structural change.

To deal with the misunderstandings and contention the group had experienced in their last couple of sessions, in August 1994 the facilitators designed an exercise to help the group look at healthcare from a broad systems perspective. The exercise had the group look at a hypothetical model of Grand Junction's healthcare system from the perspective of five different constituents: the HMO, hospitals, independent physicians, local employers, and patients. The exercise helped the group notice that, indeed, they had made a significant shift from their old paradigms of healthcare. It highlighted the new ideas about different possible structures and patterns of relationships the group had developed over time.

By the end of the dialogue project, a hospital CEO felt that: "The group's perspective on the structure of healthcare moved over time from the old institutional-centered model where each institution had competitive strategies, to a patient- and community-centered model." The experience they had gained over the period of the dialogues came through in these last exercises and conversations. One participant commented, "People gave up their professional roles and we weren't worried about preserving our specific institutions as much as we were looking at how could we build this healthcare delivery system."

III. The Business Results

Collaborating on Joint Initiatives

Six months into the Phase Two sessions, the dialogue group generated a list of potential collaborative initiatives that would put their ideas into action where they could be tested. The list included ideas for several projects that would involve multiple institutions in jointly providing healthcare services to the community. These potential projects offered the possibility to offer entirely new services or to make current services more efficient and effective by coordinating the offering. Over the next few months, participants from the healthcare institutions designed and implemented a number of experiments based on the ideas generated in the dialogue sessions.

The Community Health Assessment Task Force

The dialogue participants determined that the first step should be an assessment of community healthcare needs. "We decided to look to the community for guidance on what they felt they needed. We wanted the needs assessment process itself to be about empowering people in the community," said one participant.

In March 1994, they formed a joint Community Health Assessment Task Force with people from each of the healthcare institutions plus representatives from the local school district, county planning agency, and the general community. The CH CEO described the outcome at the time of our six-month follow-up interviews in mid-1995: "The Task Force has just published their report, *Mesa County: Our Picture of Health*. The assessment looked at housing, crime, the economy, education, transportation, drug use, teen pregnancy—the whole range of factors that contribute to or detract from the quality of life in our region. The task force found 14 areas of concern in the community and identified five priorities for healthcare to target, in particular recreation, mental health, immunization, drugs, and teen pregnancy. The task force has produced a video as well as the written report and is now in the process of setting up meetings with a variety of community groups, churches, service clubs and so on to share the findings. The task force will be asking for assistance from these community groups to join in the design and to implement the plans for these initiatives."

Cross-Organizational Dialogue Training

The Director of Educational Services at the Catholic Hospital joined with dialogue participants from the HMO and the Rehabilitation Hospital to pick up the idea for on-going dialogue training and facilitation. Each of these individuals developed their own expertise in dialogue and began to offer dialogue training to groups in their institutions and others in the community. This cross-organizational team has since offered dialogue training to a joint group of supervisors from all three of the local hospitals. They continue to offer dialogue training and facilitation to various groups in the regional healthcare system and throughout the community and serve as a key resource for diffusing dialogue.

Cross-Organizational Quality Education

Each of the major hospitals had been running independent programs for quality management according to their own organizational strategies. Given the number of interfaces where the institutions had to interact, however, they recognized that coordinating their quality approaches could create some leverage for all. The CH CEO described their experience with the collaborative initiative they designed: "We're now at the point of working jointly across institutions. The CH/RH Transfer Team is working together already to improve quality. We also have the first community-wide healthcare quality project with quality directors from each institution who meet regularly to focus on quality education issues."

Over the previous six months, a cross-organizational quality team had developed protocols and quality standards for treatment of a common urinary track ailment. In the course of doing this experimental joint project, the team ran into old defensive responses from doctors who feared that their treatment and patient results would be exposed to comparison and criticism. The team worked through the resistance in this trial project. The project director reported: "It will take some time to begin to see the impact of the new standards in patient outcomes. We want to allow time to gather the data on this pilot project and show people the benefits. We think the outcomes will win further cooperation for other quality initiatives."

Consolidating the Hospices

In one of the earliest collaborative initiatives, CH involved the HMO and Osteopathic Hospital in talks about consolidating their hospices. Their historically competitive system had been producing minimal—if any—returns to the institutions. In a dialogue session speaking to the group, the financial administrator at CH described the experience with the hospices: "The thing that I find intriguing that I haven't figured out yet is that we were developing hospice services for 15 years and each one of those years had a negative bottom line. Just when we started putting together a new, single hospice program is the first time the operation went into the black. Why did that happen? Was it just the opportunity to do something better for the community? I don't know but it's kind of scary when you work for 15 years and do everything you can to come up with a black bottom line, and it only happens when you give it away..."

The experience with integrating the hospices also provided some valuable lessons in how long it can take to put even a single initiative in place. "It's taken almost two years on a simple, very contained project. And there is still lots of work to be done," reported one of the CEOs. Never the less, people credit the hospice project as one of the most successful joint initiatives, both in terms of collaborative management and in terms of economic success. In a six-month follow-up interview, the senior administrator at the HMO described the progress they had made: "Our collaboration to integrate the hospice operations has been very successful—it's been a cooperative, energetic, positive experience. We are now ready to let the hospice establish its own identity in the community. This has been a conscious, planned process that will allow the hospice to seek

financial support from a broader range of organizations. We all agreed it was the right thing to do.”

The Health Information Network

As with all hospital functions, each institution had maintained its own independent practices for maintaining patient records. Given the significant numbers of patient transfers between institutions in the Grand Junction region, the potential benefits from re-designing and integrating their electronic records systems made this a high-priority project for the dialogue participants. At the time of our six-month follow-up interviews, however, this initiative had experienced a breakdown in communications and was entangled in sorting out two competing proposals for a health information network. Once again, people had allowed dissension to fragment the group and had fallen back into old, ineffective defensive routines.

A disagreement between the physicians and the information systems people on the steering committee for the project led the physicians to split off from the joint Health Information Network to develop their own proposal for electronic record sharing. By setting up a competitive situation, the independent physicians reverted to a win/lose strategy that may cost them their say in how the system gets developed. One of the steering committee members from CH described the situation: “Old issues in power and control came up in our meetings and the whole thing has gotten very messy right now. I actually believe that we are all trying to accomplish the same thing. The problem is that we still act as if money, control, and power are undiscussable and it keeps us from moving forward collaboratively. It’s going to take some time for this issue to settle out so we can move ahead.”

Part of the challenge for dialogue participants as they go into other initiatives is that, unfortunately, certain situations pull very hard to re-engage ineffective defensive routines. Even people skilled in dialogue find that a group is likely to go through all the stages of group evolution many times—from instability to trust and safety, through chaos and more instability, and then finally on to genuine inquiry and creativity. Dialogue is an iterative process that must be sustained in each event and situation.

Coordinated Physician Recruiting

The potential for physician recruiting to become a collaborative decision process came up very early in the dialogue sessions. Physician recruiting practices were a long-standing sore point between the hospitals. The nature of the system was such that physicians might work at one or more of the institutions, eroding the competitive and economic advantage for the recruiting institution. In addition, as the head of the physicians’ association explained, “Having too many physicians is not good for our system. When there are too many doctors, what we see in response to the “shortage” of patients is that a doctor may go beyond what is necessary for the patient and start satisfying ‘wants’ instead of needs and healthcare costs skyrocket. Too few physicians is a healthcare problem; too many physicians is a *big* healthcare problem.”

The healthcare leaders continue to deal with the ghosts of competition in physician recruiting. Their goal remains to meet the needs and economic effectiveness for medical services community-wide, rather than losing money with competitive strategies that merely provide unnecessary and unprofitable duplicate resources. But given the current realities in the regional system, they have had to move just one step at a time towards the goal of an integrated healthcare system. Even at our six-month follow-up, little progress had been made on reforming physician recruiting practices. The initiatives that will flow out of the Community Healthcare Needs Assessment may bring the institutions to the point of readiness to jointly plan physician recruitment based on the needs of the community.

Diffusing Dialogue to the Workplace

As their skills developed, the Community Dialogue participants looked for ways to diffuse their new insights and norms throughout their workplaces and into the wider community. Initially many of these efforts were spontaneous and informal. Dialogue participants would practice their inquiry skills with coworkers or at home and in essence be acting simply as role models for open communications and inquiry. Later, the group also formed more organized approaches for disseminating dialogue practices.

The Impact on Hospital Leadership

The Phase Two Community Dialogue included several directors from the hospital boards as well as each of the CEOs and they took their new dialogue skills into their board meetings. According to one of the Board members at the Catholic Hospital: "There's been a significant impact on CH's board meetings—there's a slower pace, more listening, more suspension of ideas, more inquiry, and less discussion. Before, ideas presented with advocacy would escalate; now someone will say, 'In dialogic fashion, I would like to ask a question,' or someone will have an opinion and say, 'I would like to suspend this idea,' and then there's a shift in the group's tone." CH also provided dialogue training to its Executive Committee and continues to apply dialogue in several of its various leadership forums: "We're using dialogue processes in our Medical Staff Leadership Development program, the monthly meeting with Medical Directors, and in our new forum for joint meetings of the Medical Directors and Administration Directors where we are trying to rebalance the voices in the organization," said the CH CEO.

The management team at the HMO also credits use of dialogue with helping them move forward in implementing their strategic plan: "Our CEO wanted to make an already strong company even better. When things get tough, dialogue can get to what someone really thinks and their assumptions and it was assumptions about each other that made our management team dysfunctional—each of us had different and inaccurate ideas of the others. Dialogue helped us develop smoother and healthier interactions and get our differences out on the table honestly."

The CEO at the Rehabilitation Hospital reported on the use and impact of dialogue on RH's leadership team and their ability to move ahead with their vision and strategy: "We are using the dialogue process as an integrated part of our Leadership meetings. We sit in a circle and use the dialogue tools to talk about issues in the organization. We have had only three month's experience with this so far. We're working on learning the dialogue process and dealing with hospital issues simultaneously."

Not all of the leaders felt that further training and development of dialogue in their organizations would be worthwhile. The CEO of the Osteopathic Hospital felt that, "Expanding dialogue at OH is not likely. People felt like they already knew how to do this." The operations officer at OH explained, "Some of the supervisors saw the brief introduction they got to dialogue as good, some saw no benefit." Today, the OH is the only major healthcare institution in Grand Junction not actively using dialogue in their management team or diffusing dialogue across the organization.

The Impact in the Workplace

Several of the independent and staff physicians in the dialogue described how they were actively transferring dialogue techniques into their own units and workplaces. A department head at Catholic Hospital described the results of training the Radiology staff in some of the concepts and techniques she and her boss had learned in the CD: "The way we deal with people in work settings is different now. There's been a change in the way things are communicated. We're able to support each other and be accountable. People seem to be able to voice problems with higher-ups." The Lab Director added: "We had to do a lot of work at first to help people get past some resistance to the process. I think it was a natural reaction to being asked to do something different. We talked a lot about the myth we hold of being in control. We had to help people go through the fear that loss of this myth brings on." In a follow-up interview he reported that: "Dialogue has become deeply rooted here. The process is flourishing."

By the summer of 1994, Community Dialogue members from many of the institutions were trying out their new skills in their workplaces in interactions with their co-workers or employees. "I recently coached a breakdown between two people and helped them to get stuff out—to disclose their thoughts and inferences to each other and clear up the source of a recurring problem," said an administrator at RH to describe how he had used his learning in an event at work. Another person reported: "I have become much more patient at work. I've tried to invite all voices to speak and inquire into their thinking. I know when I have asked the right question because the tension shifts. The key is to ask the question that has hung unspoken."

Participants also have experienced some real challenges in transferring dialogue beyond the dialogue group, especially in using dialogue techniques with people who are unfamiliar with the concepts: "When I use the techniques with other associates at work, especially inquiring more deeply, sometimes people get a little suspicious. I need to learn how to form my inquiries better—to put the

questions so they don't compete with the other person's ideas," said one of the HMO's Board members.

At some point in the process of diffusing dialogue across an organization, the process will surface the incoherence among many parts of the system. People find that dialogue touches the entire range of the organizational culture, from interpersonal interactions to operational processes to strategy. Not all people will be comfortable with the degree or type of change that dialogue can engender.

Besides the use of dialogue in the workplace, in post-project interviews dialogue participants also talked about the effect dialogue has had on their personal lives. Nearly every one of the 20 people interviewed for this report had a story about the profound impact their experience in dialogue had on them personally. A number of people referred to the way their new skills and understanding have helped them develop deeper relationships with their families as well as their co-workers.

Stepping up to Shared Governance

An unexpected event provided an opening for the group to take their first major step towards shared governance of an integrated healthcare system. Leaders from competing organizations had been learning to re-think their old, habitual beliefs and assumptions and had developed some trust by this point. So when an unsolicited buyout offer from a large out-of-state organization for the HMO gave rise to the opportunity to buy out the HMO, the leaders were ready and willing to consider taking on a risky joint venture.

The HMO Buy-Out Opportunity

The dialogue group now had a concrete opportunity to use their new skills and ideas about integrating structures and systems in healthcare to fulfill a common vision. In the dialogue sessions, they began to develop a concept for a new, locally owned 'Physician/Hospital Organization' (PHO), as they came to conceive of it. By early Fall 1994, the healthcare leaders had formed a multi-organizational committee to develop a plan for jointly acquiring the HMO and were taking the first steps towards creating an integrated system for the region. This initiative was just getting underway about the time the facilitated dialogue sessions ended in October 1994.

By our June 1995 follow-up interviews, the business environment and collaborative initiatives in Grand Junction had evolved significantly. The joint work assessing the potential buy-out of the HMO brought to light another, grander possibility: to merge the services of the Rehabilitation Hospital under the umbrella of the Catholic Hospital. The idea for the HMO buyout was set aside—the threat of an outside takeover had evaporated and the HMO was seeing some success with the new strategies it had been putting into place over the last year. The idea of a merger of the RH and CH held much greater potential for integrating healthcare delivery. One of the administrators at the Rehabilitation Hospital described the dramatic evolution they had undergone: "The dialogue had created so much energy and enthusiasm that we skipped

some of the trial projects we had planned to do as practice fields and we went straight for the big deal.”

Much of the thinking and planning that led to the merger decision took place in a committee called The Mesa County Providers’ Group formed in late 1994. Members included the CEOs in the dialogue group and others from the western region of Colorado, as well as the leader of the physicians’ association and several physicians from each of the hospitals who had participated in the dialogue sessions. Their objective was to move forward to develop and design a legal entity that would establish a community-wide Physician/Hospital Organization. The CEO from the Rehabilitation Hospital described the group’s experience: “The way this group related and behaved right from the start was a testimony to dialogue. After many—sometimes-difficult—conversations, when we got to the point of actually designing a structure for a PHO, we determined that we still weren’t all entirely ready for this. Usually people would have thought of this outcome as a failure. But the group hasn’t felt that way this time. We recognized the need for all to be ready, that we couldn’t force the issue, and that we did not have to label it a failure.”

The decision to evaluate and negotiate the merger of the two hospitals shifted the priorities in the healthcare community. Some of the proposed collaborative initiatives became irrelevant or redundant with the prospect of the two hospitals merging, such as the collaborative quality work between CH and RH in progress. Other pilot initiatives of the dialogue group have been postponed until the merger is implemented and new procedures and practices are designed. A hospital administrator explained: “Although it seems disappointing that some of these good ideas haven’t been accomplished, I think people see them as the practical realities of the impending merger, not as failures to follow through.”

The Rehabilitation Hospital Acquisition

A long-standing vision held by people at the Rehabilitation Hospital was to focus on community-based and residential services. In an offsite retreat in December 1994, RH board members and senior managers reiterated this vision as their personal and organizational goal. This renewed commitment set the context for divestiture of the rehabilitation center of RH. The RH CEO related his experience with the evolution of events: “The plans we are making right now are the fruition of ideas I first proposed to the local healthcare community in 1987. But until we learned dialogue, we never had the capabilities or skills to stay at the table and work through the conflicts. Knowing how to maintain dialogue through rough water made the difference.”

The leaders of the Catholic Hospital and the Rehabilitation Hospital announced the conclusion of the deal in June 1995. CH has acquired outright the rehabilitation facilities and services of RH, including skilled nursing, home healthcare, and occupational rehabilitation. The RH retained the community-based services for youth and the elderly, such as residential services for head injuries, social service referrals to youth, work with youth offenders, shelters, and services for retirement and assisted living.

Not surprisingly, hearing about this level of impending change aroused multiple reactions among the entire healthcare community. Managers at both hospitals have made conscious efforts to provide people with information and give them appropriate times and places to come together to talk about their concerns. RH and CH jointly held a meeting of about 60 representatives from a cross-section of the healthcare community to talk about the acquisition and the implications it held for other healthcare institutions. One of the RH managers reported: "There have been some understandable reactions from people who will be affected by this move. But for the most part, people have been wonderfully supportive. People at OH and the HMO have expressed their concerns at the prospect of CH becoming a 'bigger bear' and the possibility that competition might increase, but these comments have been made openly and constructively. Everyone acknowledges that this is the best first step for Grand Junction towards integration and service to the larger community."

Over the six months following the dialogue project, participants have continued to apply what they learned and to practice their skills. The sentiments of many of the dialogue members was captured in these remarks at the close of the project: "The greatest value of the dialogue was in bringing members of healthcare together to talk about what is important to us. Trust was built. There have been positive steps in sharing information and clarifying assumptions and building regard for each other. It has better prepared us to go out and serve our community."