



Implementing Servant Leadership at Cleveland Clinic: A Case Study in Organizational Change

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Abstract

In 2008, Cleveland Clinic—one of the world’s premier healthcare institutions—launched an organizational development process with the interrelated goals of significantly increasing employee engagement and improving the overall patient experience. Critical to the success of this process has been “hardwiring” the concept of Servant Leadership into the culture. Supporting elements in the process have included enterprise-wide initiatives focused on the concept of “We are all caregivers”—caregiver wellness, and caregiver recognition. Results have included dramatic improvements in both engagement, as measured by the Gallup Q¹² survey, and patient satisfaction, as measured by the federal “HCAHPS” survey (Hospital Consumer Assessment of Healthcare Providers Systems).

Keywords: Servant Leadership, Serving Leadership, Cleveland Clinic, Employee Engagement, Healthcare

Renowned for its many clinical “firsts,” effective management practices, and innovative use of technology, Cleveland Clinic is perennially ranked among the nation’s best healthcare providers. In 2013, for example, the annual U.S. News & World Report survey of U.S. hospitals ranked Cleveland Clinic #4 overall; 15 of its specialties were rated among the nation’s best, including cardiac care, which was rated #1 for the 19th consecutive year.

Cleveland Clinic is a large, complex healthcare delivery system. Its locations include the 167-acre, 44-building main campus in Cleveland; eight regional hospitals; 16 family health and ambulatory surgery centers; and facilities in Florida, Nevada, Canada, and Abu Dhabi. The Clinic has over 44,000 employees, including 3100 physicians and scientists, and 11,000 nurses.

But in early 2008, despite its well-deserved reputation for excellence, the Clinic faced an array of challenges, including an increasingly strong sense that its overall patient experience was not on par with its clinical results. In the words of the CEO, Dr. Delos Cosgrove, “Patients were coming to us for the clinical excellence, but they did not like us very much.” In March 2008, the first publicly reported results of the Hospital Consumer Assessment of Healthcare Providers Systems (HCAHPS) attached hard numbers to this concern.

HCAHPS is the first national, standardized, publicly reported survey of patients' perceptions of hospital care. Developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), two agencies in the federal Department of Health and Human Services, the HCAHPS survey instrument was approved for use in 2005. Public reporting of the results began in 2008.

The HCAHPS survey asks discharged patients 27 questions about their recent hospital stay. For each participating hospital, ten composite measures are publicly reported. When those first HCAHPS results were published (and widely publicized in the local media), the Clinic's rating was just average overall, and well below average in virtually every individual measure of the patient experience, from staff responsiveness and the communication skills of physicians and nurses to room cleanliness and noise levels during the night. “Below average” performance in any domain is anathema at a premier institution like Cleveland Clinic. Add to that the fact that beginning in 2012, HCAHPS scores would affect a hospital's Medicare reimbursement levels, and it is no surprise that the Clinic's leadership team viewed these results as unacceptable.

Employee Engagement at Cleveland Clinic

In the fourth quarter of 2007, the Clinic had conducted a search for a new Chief Human Resources Officer (CHRO). During the interview process, the Chief Executive Officer (CEO) and other members of the senior leadership team had indicated to the eventual appointee that the Clinic's organizational culture might need to change. Upon coming aboard in December, the new CHRO conducted an informal “walking around” assessment, speaking with senior leaders, middle managers, unit supervisors, and staff in a wide variety of clinical, business, technical, and support roles across the enterprise. These conversations suggested that significant numbers of people at the Clinic felt unappreciated and undervalued. The question was how widespread such feelings might be, and how they might be affecting the Clinic's overall performance, including the quality of its patient experience.

To provide some answers, Gallup was commissioned to conduct an enterprise-wide employee engagement survey. Employee engagement can be defined as: “...a heightened emotional and intellectual connection that an employee has for his/her job, organization,

manager, or co-workers that, in turn, influences him/her to apply additional discretionary effort to his/her work” (Gibbons, 2006).

With regard to its relationship to organizational performance, engagement has been shown to correlate positively with such diverse metrics as customer loyalty, profitability, productivity, turnover, safety incidents, shrinkage, absenteeism, and quality. In studies of engagement in hospital settings, Gallup has found that higher engagement correlates with fewer malpractice claims and patient safety incidents (Harter, Schmidt, Killham, & Agrawal, 2013). And specifically with respect to patient satisfaction, a Gallup study of 94 hospitals found that “hospitals with higher levels of engagement also register higher HCAHPS domain performance” (Gallup, 2003).

The literature on the concept of a service profit chain, developed in the 1990s by researchers at Harvard Business School, also points to the connection between employee engagement, customer satisfaction, and a service-based organization’s performance (Heskett, Jones, Loveman, Sasser, & Schlesinger, 1994). For example, a 2005 study of the service profit chain model in the U.K. retail banking sector notes that there is “...ample evidence to suggest that favourable employee experiences, as reflected by attitudes such as satisfaction and commitment, and by positive evaluations of organizational climate, are associated with elevated levels of customer satisfaction” (Gelade & Young, 2005).

In short, the HCAHPS results made it clear that the Clinic had a patient satisfaction problem, and employee engagement has been shown to correlate directly with patient satisfaction. So where did the Clinic stand with regard to engagement?

The results of the Gallup survey were not encouraging. As measured by Gallup’s proprietary Q¹² instrument, the Clinic ranked only in the 44th percentile in employee engagement when compared to other hospital systems. Perhaps even more telling were the findings with regard to the ratio of engaged to disengaged employees. According to Gallup, which has researched engagement in organizations across the world for more than three decades, in “world class” organizations, the ratio of engaged to actively disengaged employees is 9.5:1 (Gallup, 2012). In the 2008 survey, the Clinic’s ratio of engaged to actively disengaged employees was only 2.57:1—far from world class.

The Clinic’s New People Strategy

In the spring of 2008, with these disappointing HCAHPS and Gallup survey results in hand, the Clinic’s executive leadership team approved a new “people strategy” designed to make the Clinic a “great place to work and grow,” increase engagement, and ultimately improve the patient experience. The strategy was based on a set of high level assumptions about what it takes for employees to become highly engaged—what it takes for them to make that emotional connection with their work that leads to extra effort and ultimately to higher performance. These assumptions were that employees need to feel (1) that their leaders care about them and treat them with respect; (2) that the organization has an important mission, and that the employee’s work is directly connected to that mission; and (3) that the organization offers opportunities for personal and professional development.

These assumptions and the initiatives they have generated at Cleveland Clinic since 2008 are in keeping with the literature on employee engagement and its key drivers. For example, a Towers Perrin (now Towers Watson) study listed these contributors to high engagement: "...senior management's interest in employees' well-being; challenging work; decision-making authority; company focused on customers; career advancement opportunities; ...collaborative work environment; resources to get the job done; input on decision making; and a clear vision from senior management about future success" (Towers Perrin, 2003, p. 1).

A U.K. government review of engagement research and case studies of companies in both the U.S. and U.K. indicated that managers whose organizations demonstrate high levels of engagement provide: "...clarity for what is expected from individual staff, which involves some stretch, and much appreciation and feedback/coaching and training. The second key area is treating their people as individuals, with fairness and respect and concern for the employee's well-being" (MacLeod & Clarke, 2009).

Clearly then, an organization's leaders play a critical role in creating what might be called a "culture of engagement." For senior leaders, this role is manifest primarily in the decisions they make, the policies they approve, and the programs they fund. For managers and supervisors, the role is more direct, in terms of how they actually speak to and behave towards individual employees on a day to day basis.

Servant Leadership at Cleveland Clinic: Introducing the Concept

As indicated above, the Clinic's new people strategy was designed to address several of the key drivers of engagement, as illustrated in Figure 1, and each of the components of this strategy would prove to be critical to improving engagement. But given the critical relationship between leadership and engagement, one of the most important of the Clinic's engagement initiatives has arguably been the on-going effort to implement the concept of Servant Leadership.

Figure 1. Key Drivers of Employee Engagement.



Not atypically for a large, complex organization, Cleveland Clinic is hierarchically structured, and in 2008 the default leadership model tended to be top down, command and control. In and of itself, command and control leadership need not imply that leaders do not value, respect, or listen to those who report to them. Nor does command and control leadership necessarily produce low levels of engagement. Perhaps the best example is the military, where leadership is typically command and control but engagement—that emotional connection to the group and the mission—is often extremely high.

That said, the Gallup survey results certainly seemed to indicate that at Cleveland Clinic in 2008, the existing leadership model was part of the engagement problem. The Gallup Q¹² asks employees to rate their organizations on a 5-point scale from 0/strongly disagree to 5/strongly agree. In 2008, Clinic employees gave by far their lowest rating to “I have a best friend at work.” Gallup ties this item directly to leadership style, noting:

“The best managers do not subscribe to the idea that there should be no close friendships at work; instead, they free people to get to know one another, which is a basic human need. This, then, can influence communication, trust, and other outcomes” (Harter et al., 2013).

After “best friend,” the following items—all clearly related to how leaders behave and how employees perceive this behavior—received the next lowest scores on the Clinic’s 2008 engagement survey:

- In the last seven days, I have received recognition or praise for doing good work.
- At work my opinions seem to count.
- There is someone at work who encourages my development.

With all this in mind, the Clinic turned to the concept of servant leadership. Powerfully articulated more than four decades ago by management consultant Robert Greenleaf, servant leadership emphasizes the leader’s role in “making sure that other people’s highest priority needs are being served.” According to Greenleaf, a leader’s effectiveness can at least in part be measured by whether the members of the organization “become healthier, wiser, freer, more autonomous, more likely themselves to become servants” (Greenleaf, 2008, 27). Some 30 years after Greenleaf’s groundbreaking work on the concept, Larry Spears listed these ten characteristics of a servant leader: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community (Spears, 2010).

Over the years, servant leadership principles have been applied in organizations ranging from Southwest Airlines, Marriott, Kaiser Permanente, and Starbucks to the U.S. Army, Air Force, and Marines (Sloan, 2009; Modern Servant Leader, 2015). Nonetheless, the idea of shifting the Clinic’s leadership model in this direction was in many ways a daunting one. Cleveland Clinic has always been a “physician-run organization” and its leadership team was clearly committed to maintaining the Clinic’s core clinical culture—a culture focused first and foremost on clinical excellence and a way of “doing things around here” perceived as leading to the best possible clinical

results. Thus, while some change might be acceptable, any change that could be construed as weakening this clinical focus would be resisted and rejected.

Recognizing the need for some shift in the Clinic's operating culture, the CEO was prepared to approach the idea of servant leadership with an open mind. Noting, however, that the Clinic's leaders could be resistant to mandated change, he advised the CHRO to conduct a soft launch, gradually introducing and "socializing" the idea with individuals and small groups of leaders.

Thus, the initial phase of implementing servant leadership at Cleveland Clinic began with presentations to key members of the executive leadership team in the spring of 2008. As expected, the response was not universally supportive. The then Chief Nursing Officer (CNO) had serious reservations, and the then Chief Operating Officer (COO) was explicit in his feeling that servant leadership "...will never work here," adding "I'm not going to let you [the CHRO] take 40,000 people down this path."

By early summer, however, the groundwork had been laid, and the servant leadership concept was presented before the entire executive leadership team. The discussion was lively, but by the end of the meeting the CEO had expressed his personal support and approval to move forward was obtained.

In the next few months, the servant leader concept was introduced across the enterprise via a series of informal meetings with small groups of leaders. In response, some physicians pointed out that they had been trained to "take charge" and make difficult decisions, that their ability and willingness to do so were critical to outstanding patient care, and that this deeply ingrained training made it natural for them to assume a command and control leadership style. In the words of one surgeon: "Hey, in my OR (Operation Room), I'm in charge. Period. That's the way it has to be, and that's the way it is. And now you expect me to also be a servant leader? Come on."

By and large, however, the reaction to the concept in these initial meetings was generally positive, evoking comments such as "This is a good thing for us to do" and "This idea of serving others is precisely why I went into medicine." As a result, by the fall of 2008, it seemed time to move ahead with implementation.

Implementing the Concept: Building Awareness

In the fall of 2008, an external consultancy—Pittsburgh-based Third Rivers Partners—was retained to assist with implementation. Ken Jennings, the founder of Third Rivers, has infused the servant leader concept with new ideas and language, while creating a set of tools designed to help organizations put the concept into practice. Jennings, for example, speaks not of "servant" leadership, but "serving" leadership—a shift to more active language that may help the take-command type of leader feel more comfortable with the broader concept. (In the following pages, SL refers to serving leadership).

According to Jennings, the serving leader:

- Uponds the pyramid—supporting and serving others in the organization, rather than issuing commands from the top down.

- Builds on strengths—recognizing and leveraging the strengths of others.
- Raises the bar—confirming a commitment to greater goals and empowering others to succeed in reaching them.
- Blazes the trail—teaching and coaching others, enabling them to go beyond their past limits.
- Runs to great purpose—creating a compelling vision that engages others in striving to achieve it. (Jennings & Stahl-Wert, 2003).

Using the Third Rivers model and tools, the first stage of implementation was designed to build awareness of SL across the leaders of all units and functions within the Cleveland Clinic system. The activities in this phase included serving leader-focused coaching of the Clinic’s executive leadership team—which includes the 30+ leaders of all key business and clinical functions—and the broader Strategic Council, consisting of some 65 clinical and non-clinical executives. In early 2009, the next leadership tier, consisting of 400+ Directors, participated in a one-day serving leader initiation program. SL principles were also introduced into the mentoring program for physicians.

Developing Serving Leader Skills

Since 2009, the Clinic has implemented an array of initiatives designed to ensure that serving leader principles are embedded throughout the culture, and that leaders at every level obtain the skills necessary to be effective serving leaders. These initiatives include developing:

- *Serving Leader competencies*, appropriate to each leadership level, from supervisor to senior executive; these competency families include: Leading through Mission & Values; Performance Management; Empowerment & Delegation; Building Healthcare Talent; and Building Work Relationships.

The SL competencies have been embedded into the curriculum and specific courses offered as part of the Clinic’s new leadership development strategy.

- *Serving Leader training*, for supervisors and managers; first piloted in several of the Clinic’s institutes and one of its regional hospitals, this program has since been implemented enterprise-wide.
- *Cohorts of Serving Leader Advisors*, tasked with being champions of SL and providing SL coaching/support in their own units; more than 100 SL Advisors have participated in the 8-day development program, and received on-going SL coaching from Third Rivers staff.
- *SL in a Box* and the *SL Toolkit*, resources designed to assist leaders in integrating SL into the everyday working environment of their units.
- *SL metrics*, embedded into the Clinic’s performance management system for leaders at all levels.
- *A SL Community of Practice*, consisting of leaders from across the Clinic who are involved with projects using SL principles. The group meets on a quarterly basis to discuss SL, compare project results, and share best practices.

- *Executive Rounding*, jointly initiated by the Office of Patient Experience and Human Resources, deploys the Clinic’s top 200 leaders in small groups on quarterly “rounds” throughout the system. The purpose is to recognize caregivers at the unit level, and most importantly, to listen deeply to both caregivers and patients.

SL and Other Engagement Initiatives

It should not be forgotten that Cleveland Clinic’s drive to implement SL was motivated by the goal of increasing employee engagement and ultimately improving patient satisfaction. In other words, SL was not necessarily seen as a good in and of itself. Given this, it is worth commenting on the relationship between SL and other engagement-focused initiatives at the Clinic.

We Are All Caregivers: Recognizing the Contribution of All Employees

In 2008, at the same time that the concept of SL was being introduced, a “Cultural Development Work Group” that included the CHRO, Chief Medical Officer (CMO), Chief Patient Experience Officer (CPEO), Executive Director for Continuous Improvement (EDCI), and other senior leaders met to discuss the issue of cultural change at the Clinic. What emerged from these discussions was a simple but powerful idea: “We are all caregivers... working together to ensure the wellbeing of our patients...and each of us plays a valuable role in fulfilling that mission.”

This idea flowed directly from the realization that patient satisfaction—as defined, for example, in the HCAHPS survey—was based on the total patient experience, and not simply the patient’s clinical results. If factors such as the cleanliness and quietness of the patient’s room, and the quality of discharge information could shape the patient experience, then all Clinic employees—including not just doctors and nurses but also the people working in Facilities or Accounting, Transport or Food Services—played a role in whether that experience was positive or negative. In that sense, they could and should be considered “caregivers.”

Not surprisingly, this idea that “we are all caregivers” encountered at least initial resistance from some members of the clinical staff—and here again, as with the concept of SL, the explicit support of clinical leaders such as the CEO and the CMO was critical to building gradual acceptance. Ultimately, to embed the idea into the broader culture, the term “employee” was changed to “caregiver” on internal and external communications materials, from the website to identification badges. Senior leaders wove the idea into their regular presentations to Clinic audiences. By 2010, the idea was sufficiently well established that the Clinic’s Annual Report for that year was titled “We Are All Caregivers.”

To reinforce the “we are all caregivers” concept, the Clinic launched the Cleveland Clinic Experience initiative. Over a six month period in 2010-2011, all 43,000+ caregivers at the Clinic participated in this program focused on how to respond with greater empathy to both colleagues and patients. Working in groups of 8-10, individuals from different levels and functions—executives, managers, physicians, nurses, and non-clinical staff from every department—came together to learn how to respond to colleagues and patients with “HEART.” This acronym stands for the ability to listen

closely and really *hear* the other person, *empathize* with the other person's situation, *apologize* when something has gone wrong, *respond* appropriately and with *respect* to the other person's concerns, and, finally, to say *thank you* and really mean it.

Since 2011, every new hire at the Clinic has gone through this same program, and line managers have received follow-up training in how to support and sustain the HEART skill set in their own units. As with the “we are all caregivers” initiative, the Cleveland Clinic Experience program has reinforced and been reinforced by the principles of SL.

Rewarding Caregiver Behavior

SL at the Clinic is closely tied to another key engagement initiative, the Caregiver Celebrations program. As the name implies, Caregiver Celebrations, which was launched in 2010, provides a consistent way for managers, peers, and patients to recognize caregivers who manifest the Clinic's core values. Awards range from simple thank you notes and certificates of recognition to cash awards ranging from \$10 to \$2000. An annual award of \$10,000 is presented by the CEO to one individual caregiver and one team.

The Caregiver Celebrations program has been highly successful, as measured by its high rates of utilization, by positive anecdotal feedback from both managers and caregivers, and as discussed below, by data from the Clinic's annual engagement survey.

SL and the Other Engagement Initiatives

Individually and together, the We Are All Caregivers, Cleveland Clinic Experience, and Caregiver Celebrations initiatives have served to reinforce the core SL principles of recognizing and building on the strengths of every member of the organization to achieve a greater good. That goal was to make Cleveland Clinic a great place to work and grow, thereby achieving a significantly higher level of employee/caregiver engagement and ultimately delivering a more satisfactory overall patient experience. Have these results been achieved?

RESULTS

To assess the success of Cleveland Clinic's serving leader initiative, two questions must be considered: (1) Has SL become embedded in the Clinic's operating culture? (2) Has SL increased the Clinic's employee engagement and improved its patient experience/satisfaction?

The fact that all of the Clinic's managers and leaders have experienced serving leader (SL) training, that serving leader metrics have been embedded in their formal performance evaluation, and that senior-level serving leader advisors have been trained and deployed across the enterprise—all of this tells us something, but not enough. A better indication of how much SL has taken root in the Clinic's culture is the fact that, in the words of one manager, “It [SL] has gone viral.” What he meant by this is that all across the enterprise, at the institute, hospital, department, and unit level, SL is being explicitly applied in a wide variety of performance improvement projects. For example:

- The IT department has incorporated SL tools into an ongoing re-design of its operating structure.
- A “Silence Kills” initiative is applying SL principles to “create an environment within the ICUs at Cleveland Clinic where all caregivers feel empowered and have the courage to speak up when they observe unsafe practices or behaviors.”
- The new head of the Pharmacy division is using SL principles to improve the division’s ability to meet patients’ and fellow caregivers’ needs much more effectively and efficiently.
- Leaders at one regional hospital have participated in cohort training to improve their serving leader practices. Leaders at another regional hospital are redesigning their management councils to “reflect a serving leader meeting format.”
- The Regional Operations Institute has “...used serving leader practices to develop a strategy and actions to take the Family Health Centers to the next level of performance.”
- The Medicine Institute is using “...the serving leader change management methodology and providing serving leader coaching for site physicians” in development of a new “Patient Centered Medical Home” care delivery model.
- The Continuous Improvement (CI) group has “integrated serving leader practices into the CI methodology and tools.”

These and other such projects suggest strongly that SL has become widely accepted and practiced at Cleveland Clinic—which raises the question, “To what effect?” The most direct answer to this question lies in the specific Gallup Q¹² items previously discussed as being the most obviously related to leadership style:

- I have a best friend at work.
- In the last seven days, I have received recognition or praise for doing good work.
- At work my opinions seem to count.
- There is someone at work who encourages my development.

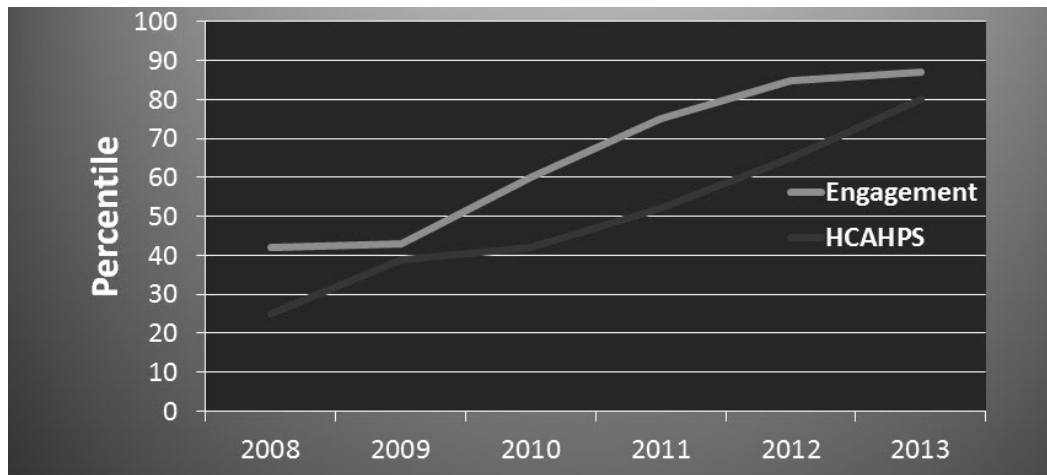
As previously indicated, in the 2008 survey these items were rated the lowest of all the engagement metrics by Clinic employees. On subsequent Q¹² surveys, from 2009 through 2013, these items had the greatest increase in their mean ratings across the enterprise. Judging by these results, it seems reasonable to conclude that SL is having a significant, positive effect.

In terms of the Clinic’s overall engagement, it is not possible to tease out the effect of SL from that of other factors, including other engagement-related initiatives such as the Wellness program and Caregiver Celebrations. It is clear, however, that the Clinic has achieved a dramatic improvement in employee/caregiver engagement since 2008. When

compared to other hospital systems in the Gallup database, the Clinic ranked only in the 43rd percentile in 2008; in 2013, it ranked in the 87th percentile. In terms of the ratio of engaged to actively disengaged employees, in 2008 the Clinic's ratio was only 2.57 to 1. By 2013, that ratio had risen to 10.2:1, above Gallup's designated "world class" figure of 9.57:1.

With respect to the patient experience, again it is impossible to separate the effect of SL from that of other initiatives, but it is clear that the Clinic's overall patient satisfaction has improved dramatically. And as shown in Figure 2, this improvement, as measured by the HCAHPS results, maps directly to the improvement in engagement.

Figure 2. Patient Satisfaction and Engagement.



DISCUSSION

Since 2008, Cleveland Clinic has successfully implanted servant leader (to revert to Greenleaf's original terminology) principles into its leadership model, despite considerable initial resistance to this cultural shift. While they may not have abandoned their traditional command and control operating style, it seems clear that at least some of the time the Clinic's leaders, from supervisor to executive team level, behave as servant leaders. In doing so, they have enabled and reinforced a variety of initiatives specifically aimed at increasing caregiver engagement. As indicated by the results of an ongoing Gallup survey, they have demonstrated in ways not previously apparent that the Clinic as an organization cares about, respects, and values all of its employees—all of its caregivers. The results—in terms of both higher engagement and greatly improved patient satisfaction—indicate that this significant cultural change effort has been well worth the effort.

Limitations

This paper does not report the results of a formal research study. Rather it describes how servant leadership was implemented as one of a whole set of initiatives at Cleveland Clinic designed to raise the Clinic's engagement level and patient satisfaction. The data reported in the paper, taken from the Gallup Q¹² engagement survey and the HCAHPS survey, do not directly address the causative effect of the servant leadership initiative on the increase in engagement and patient satisfaction that has occurred. As indicated above, it is not possible to separate the effects of the servant leader initiative from the Clinic's other engagement-related programs.

More formally structured, empirical studies would be extremely valuable in establishing how the implementation of servant leadership in hospital environments may directly affect employee engagement and the patient experience. Perhaps this paper will stimulate others to undertake such research.

In the meantime this paper will hopefully encourage other healthcare organizations to consider implementing servant leadership as they seek to provide a better working environment and deliver higher levels of patient satisfaction.

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