Exploring the fit between organizational culture and quality improvement in a home-care environment

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Background: Overseeing the quality of community-based, home-care services is a subject of concern in most jurisdictions confronted with population aging and the rise of chronic conditions. Although various quality management strategies have been used in different health care settings, continuous quality improvement (CQI) is still in the early stages of development among home-care service providers. What is more, some authors have raised questions as to whether CQI is suitable to the unique character of home-care and can be adequately applied to a diverse and varied range of agencies, each featuring a unique organizational culture, professional mix, and mode of operation.

Purposes: The article reports on how differing organizational cultures—as found in a set of public and private home-care providers—appear to affect agency receptivity to CQI during program implementation.

Methodology/Approach: The research methodology is characterized by a qualitative, multiple case study approach. Data were gathered from a purposive sample of four home-care agencies in Quebec, Canada, belonging to the public, private for-profit, and not-for-profit sectors.

Findings and Practice Implications: It is concluded that a core set of cultural attributes play a decisive role in determining agency receptivity to CQI, even when its effect is mediated by several contingent variables. Further, some of the levers and barriers to implementation identified in previous research seem less relevant to home-care agencies. A number of policy/management implications are discussed, which may enhance receptivity to CQI by home-care agencies and prevent implementation failure.

Analysts of continuous quality improvement (CQI) in different fields of activity point out that CQI programs can be a transformational experience, in that they sometimes contribute to a gradual yet substantive change of an organization’s culture (Roberts & Thomson, 1995). Culture and “cultural conversion” are widely regarded in the literature as crucial components of CQI success, particularly when the final goal is making quality an overall organizational commitment (Davies, Nutley, & Mannion, 2000; Scott, Mannion, Davies, & Marshall, 2003a). And when quality interventions fail to produce results, deviate from what was originally planned, or simply die over time, culture is again singled out as one of the main explanatory causes. In such situations, the conclusions drawn are likely to emphasize a misalignment between the two, stating either that the quality efforts were insensitive to the distinctive organizational culture or that the prevalent culture was not congruent with the proposed intervention.

A small but growing body of research concerned with CQI in health care has provided insight into some of the factors that contribute to its implementation in different organizational environments, mostly within hospitals (Carman et al., 1996; Meyer, Silow-Carroll, Kutyla, Stepnick, & Rybowski, 2004; Shortell, Levin, O’Brien, & Hughes, 1995) and long-term care facilities (Lukas...
et al., 2005; Zinn, Weech & Brannon, 1998), where the impetus for CQI began earlier. By comparison, the home-care sector has received considerably less attention, with little being known about what organizational features may impact on quality improvement initiatives and their long-term entrenchment (Wunderlich & Kohler, 2001). Some, however, have raised questions as to whether CQI methods are suitable to the unique character of home-care services and can be adequately applied to a diverse and varied range of agencies, each featuring a unique organizational culture, professional mix, and mode of operation, hence potentially more or less receptive to or capable of introducing this type of initiatives (Coleman, 2000; Kane & Kane, 1988; Kinney, Freedman, & Cook, 1994).

Drawing on a 4-year program of research conducted in Quebec, Canada, this article reports on how differing organizational cultures—as found in a set of public and private home-care providers—appear to affect agency receptivity to a CQI program during implementation. By focusing on receptivity to CQI, the article is more concerned with the readiness of home-care agencies to introduce the tools and techniques characteristic of CQI than with the potential changes to organizational culture resulting from its implementation. Such research perspective is predicated on the assumption, supported by previous work on the subject (Ferlie & Shortell, 2001; Maull, Brown, and Cliffe, 2001), that identifying receptive contexts or assessing beforehand whether an existing organizational culture is congruent with a proposed quality intervention may be a crucial step in determining the likelihood of the intervention being institutionalized.

### Background

The literature on quality improvement acknowledges that the initiation and integration of CQI by health care organizations usually represents a demand, if not uncertain undertaking. In trying to identify what variables act as facilitators or barriers to the introduction of CQI initiatives (Davies, 2002). A contentious issue within this line of inquiry is whether culture can be manipulated to make it more compatible with CQI activities (Brown, 1995; Scott-Findlay & Estabrooks, 2006). Some authors, for instance, contend that culture being a “root metaphor” of what organizations are—as opposed to a set of properties organizations possess—its manipulation may be an unrealistic expectation (Scott et al., 2003a). Others nonetheless suggest some cultural artifacts can be positively “tilted” or influenced by management decisions and hence should be the focus of management attention when implementing quality improvement initiatives (Carroll & Quijada, 2004; Ferlie & Shortell, 2001; Tucker & Edmondson, 2003).

Focusing on the implementation approach used, some studies contend that, of a range of possible strategies, those which follow a stepwise, progressive sequence—consisting on training personnel, undertaking a few highly focused improvement projects, and carefully evaluating them before moving forward—are more likely to increase organizational adherence to the proposed initiative (Garside, 1998; Shortell et al., 1995). Furthermore, several authors suggests that CQI programs that are introduced in a somewhat prescriptive, mechanistic fashion and without regard to the particularities of the organization in which they are applied, are more likely to encounter resistance, and ultimately fail to institutionalize (Blumenthal & Kilo, 1998; Cox, Wilcock, & Young, 1999). Geboers et al. (1999), for example, emphasize that in the case of smaller size practice settings, simultaneous implementation of an all encompassing CQI package may not be appropriate, and facilitation by experts from the outside may oftentimes be required.

Another critical factor singled out in the literature for its role in sustaining CQI practices is leadership (Ferlie & Shortell, 2001; Glickman, Baggett, Krubert, Peterson, & Schulman, 2007). Some authors, concerned with how leadership interfaces with various organizational characteristics and processes, have sought to identify “patterns of leadership” (Westrum, 2004) or “leadership roles” (Quinn, 1991; Quinn & McGrath, 1985), which may facilitate the deployment of quality improvement. Rad (2006), on the other hand, points that some leadership approaches such as “too top down or too laissez faire, superficial knowledge of the implementers of TQM, and lack of a formalized strategic plan for change” are among the key reasons implementation tends to fail. Besides leadership qualities, several studies find that genuine commitment and personal involvement on the part of top management are essential for the sustainability of CQI initiatives (Glickman et al., 2007; Rad, 2006). Levin (2004) and Zbaracki (1998), in particular, hold that when such commitment is ambivalent and CQI is advocated more for its symbolic value than for its actual technical benefits, programs are likely to be ephemeral; their adoption being little more than “myth and ceremony.”

Much of the current literature on CQI implementation, however, while recognizing that CQI encompasses a distinctive way of deciding on and introducing improvements to different organizational settings that require particular leadership skills, underscores the centrality of organizational culture in the success or failure of CQI initiatives (Davies, 2002). A contentious issue within this line of inquiry is whether culture can be manipulated to make it more compatible with CQI activities (Brown, 1995; Scott-Findlay & Estabrooks, 2006). Some authors, for instance, contend that culture being a “root metaphor” of what organizations are—as opposed to a set of properties organizations possess—its manipulation may be an unrealistic expectation (Scott et al., 2003a). Others nonetheless suggest some cultural artifacts can be positively “tilted” or influenced by management decisions and hence should be the focus of management attention when implementing quality improvement initiatives (Carroll & Quijada, 2004; Ferlie & Shortell, 2001; Tucker & Edmondson, 2003).
A related strand of research is less concerned with cultural change per se than with ascertaining whether a given organizational culture may support the introduction of a CQI intervention. The work by Davies and Nutley (2000), Davies et al. (2000), and Kaisi, Kralewski, Curoe, Dowd, and Silversmith (2004), for example, identifies specific cultural traits, indicative of a “learning environment” within organizations, which they suggest are favorable to—that is, aligned with—CQI implementation. Shortell et al. (1995), for their part—based on a typology of four organizational cultures proposed by Quinn and McGrath (1985), known as consensual, ideological, hierarchical, and rational—assert that some types seem more suitable to implement CQI than others. More specifically, they find that in the case of hospitals, “a group-oriented, developmentally oriented culture promotes greater implementation of quality improvement work, [than] larger-size health care organizations, which tend to be more hierarchically and bureaucratically organized” (Shortell et al., 1995, p. 395).

Further, studies also note that environmental forces—such as market competition, accreditation requirements, government regulations, and pressure from funding agencies—by the fact they affect or compel strategic choices, may constitute one of the primary drivers for organizations to embark on formal CQI initiatives and, beyond adoption, influence the conditions under which such initiatives operate (Zinn et al., 1998). Over time, it is suggested that if either incentives or constraints at the base of CQI adoption change or become inconsistent with organizational culture, the stability of such initiatives may be negatively affected (Godiwalla, Batra, Johnston, & Godiwalla, 1997).

All in all, despite existing research, significant gaps remain in our understanding of how CQI implementation and organizational culture—as it impacts on the everyday operations of a health care facility—are associated with one another (Davies et al., 2000). Moreover, culture being a complex construct, any relationship between the two would appear to be contingent on how culture is conceptualized and how its effect is apprehended in light of other internal and external forces. As regards home-care, in particular, although improving service quality is a major theme underlying reform in most jurisdictions, the suitability of CQI as a managing method for a diverse range of agencies, culturally quite distinct from hospitals or other health care settings, has not been established.

**Conceptual Framework and Approach**

The study is informed by a general systems perspective and the theory of “organizational alignment” as developed by Seniier (1997). Organizational alignment centers on the degree of congruence or “systematic agreement” between strategy, structures, and culture within organizations and posits that this agreement, to the extent it favors the development of an appropriate organizational environment, is of paramount importance to the achievement of an organization’s strategic goals. Organizational alignment is thought of as a state rather than a desired outcome, in that it cannot be directly created. Basic cultural values, contends Semler, are formed in a historical process whereby organizations develop and, as a consequence, are highly resistant to change. Leadership, however, is seen as capable of exerting a degree of influence on cultural behavior, including its congruence with strategy, through the selection of an appropriate set of process goals and tactics. Alignment also operates in relation to an organization’s structural aspects, viewed as manifestations of culture. Finally, although alignment theory is mostly concerned with the internal dynamics of an organization, it still recognizes the importance of external, environmental contingencies that may affect the choice of strategy and determine the resources available for the achievement of goals. The environment also plays a role in defining the values and belief systems individual members may hold.

We propose a standard definition of culture as “patterns of basic beliefs and behavior shared by a majority of members of an organization.” Further, we recognize, as does Schein (2004), that culture operates at multiple levels, hence the importance of discriminating underlying assumptions—the core aspect of culture—from espoused beliefs and norms and observable artifacts—seen as a reflection of the former. From an analytical standpoint, Schein suggests that organizational culture may be best deciphered by reflecting on its constitutive components. Several authors, on the other hand, note that out of a broad range of attributes used to define the culture of an organization, some would appear to have a more direct bearing on its quality orientation and disposition (Cameron & Quinn, 2006; Davies et al., 2000). Accordingly, in describing organizations and in making inferences about how their culture interfaces with CQI, our study concentrates on a selective number of cultural attributes that are deemed to be influential in the successful adoption of CQI initiatives. Box 1 identifies these attributes and defines their meaning as used in the context of this study.

In addition, for this article, CQI is loosely defined as a comprehensive, participatory, and ongoing program adopted by a health care organization to provide care that meets or exceeds customer expectations.

**Methods**

The methodology is characterized by a qualitative, multiple case study approach (Yin, 2002). Information was gathered from a purposive sample of four home-care...
agencies participating in the implementation of a CQI program. The agencies, which are described in detail in the following section, belong to the public, private for-profit, and not-for-profit sectors and reflect distinctive organizational types. All agencies were located in the same Regional Health Authority’s territory in a metropolitan area, and their participation was voluntary. Four criteria were used to recruit agencies: (1) the presence within the same regional authority of all categories of agencies targeted by the research project, (2) management willingness to participate in the project and to allocate some of the necessary resources, (3) the absence of ongoing labor conflicts within the agencies, and (4) the main characteristics of the client population served. Agencies belonging to three Regional authorities were contacted, and the project’s main objectives were presented to each of them before making a decision. The participating agencies’ names have been withheld for confidentiality reasons.

By implementation of the CQI, we refer to the set of practices and activities introduced by the participating agencies in the course of the project, with the support of the research team—the project specifics are described below. Receptivity to the CQI, on the other hand, was assessed by comparing organizations with regard to (1) the breath of work undertaken by CQI teams, (2) the ease with which teams learned and performed improvement-related tools and methods, and (3) the assessment provided by team members of the project’s usefulness and performance.

Various methods were used for gathering data. First, written documentation was collected from each participating organization pertaining to their mode of operation, statutes, service delivery processes and standards, policies, and any past or ongoing quality improvement activity they were engaged on. Second, a member of the research team (and sometimes two) attended all CQI meetings as a participant observer, gathering field notes where relevant. An average of 300 hours of observation per organization was performed during a 9-month period. Observation helped in gaining an intimate understanding of the organizations’ way of operating and practices, including the insight on the climate of team meetings, the interaction dynamics among team members, the manner in which CQI tools were used, the members’ attitudes toward quality problems, and the members’ perceptions of the project or its suitability for their organization. Third, minutes from CQI team meetings recording all the issues discussed, the activities accomplished, and the decisions made were taken by a member of the team after each meeting. Minutes and field notes were the basis for discussions at regular meetings with members of the research team and management from each organization to assess the accuracy of findings and their implication for the project’s development. Fourth, semistructured written assessments were completed by all CQI team members at three strategic moments during the implementation of the CQI program, namely, after the examination of quality problems, once the identification of improvement activities was completed, and after improvement activities had been tested. Such assessments centered on how CQI team members perceived the accomplishment of a given activity, the team’s strengths and weaknesses, the obstacles encountered, or
the key changes to be made in future CQI cycles. Lastly, focus groups were organized with CQI team members at the end of the project to review and to evaluate the CQI program. Typical questions addressed during focus groups were as follows: What were your expectations at the beginning of the project? Did the CQI team activities fulfill your expectations? How did you feel about being a CQI team member? Where the CQI teams an appropriate way of tackling quality problems within your organization? Looking back, what could have been done differently! How would you evaluate the CQI project’s outcome?

Different qualitative techniques were used for data analysis depending on their source. All written materials were subject to content documentary analysis. Relevant sections from documents were indexed, extracted, and organized according to whether they provided information on quality-related activities, structural dimensions, or cultural aspects of the organization. On the other hand, field notes, written assessments, and focus group interviews were coded and analysed in a two-step process and in an iterative manner. A first step consisted in identifying information that could help in characterizing various cultural aspects of the participating organizations and complete what was already available from the analysis of documentation. At this stage, a coding template was developed first inductively, by relying on our theoretical framework and a scan of the relevant literature on the subject, and then inductively, as the analysis of data progressed. A second step aimed at analyzing how team members evaluated the CQI project and team performance. Team members’ opinions were categorized into three major themes (as suggested by Harber, Ashkanasy, & Callan, 1997; Zbaracki, 1998): attitudes (i.e., how they felt about the CQI project), appreciation (i.e., how well they thought it was used), and valuation (i.e., how useful they found it). Notes and transcripts were read and reread several times to identify emerging categories within themes and to redefine them if necessary. Careful, iterative reading and analysis of data also helped in verifying the trustworthiness of coding and related findings.

Participating agencies were compared in terms of their cultural attributes on the basis of a 5-point Likert-type scale (ranging from very high = ++++++, to very low = +). The score/weighing of cultural attributes was done by the principal investigator and a research assistant according to a three-step process. First, on the basis of the information collected, a short monograph, describing each agency, their mode of operation, and main cultural characteristics, was drafted and used as the basis for analysis. Second, each analyst independently proceeded to score agencies on each of their cultural attributes. Third, the scores attributed by the two analysts were compared and, where necessary, adjusted to achieve consistency of results. Discrepancies in scoring were resolved by discussion and clarification between raters until consensus was reached. Discrepancies related, for the most part, to differences in the meaning of cultural dimensions, differences in their weighing by each rater, or problems with the mutual exclusivity of certain dimensions. Computing of agreement indices to measure interrater reliability (percentage of agreement or kappa statistics) was not deemed pertinent.

### Organizational Settings and Their Environment

The four participating agencies typify the home-care sector in Quebec while exhibiting different organizational characteristics and histories. The first agency, a local community services center (known in French as CLSC), is a well-established public service organization mandated to provide primary health care and social support services to the local community. Home-care is organized as a separate programmatic branch within the agency, with a user base of about 3,500 people, mostly elderly. The CLSC acts as a single-entry door for people requiring public services in its territory and coordinates admissions to residential institutions. It uses a wide range of professionals from the health and social services fields, including physicians, nurses, social workers, physiotherapists, home-care workers, and others.

The second agency is a not-for-profit social economy enterprise (known in French as EESAD), founded in the mid-1990s by two community organizers in an effort to augment service provision at an affordable cost in the region. The EESAD is mandated to provide home cleaning and meal preparation services and has expanded considerably over the years. Services to elderly users or to people referred by a CLSC are partially covered by the government. When the CQI project began, the ESSAD had 72 full-time employees on its payroll.

The third organization is a small for-profit private agency established in the late 1990s. Most of the agency’s clientele are referred by the local CLSC on a contractual basis—in which case services are covered as when delivered directly by the CLSC. The agency specializes in providing personal care and respite services and, to a lesser extent, nursing and rehabilitation services. It is run as a family business, with the help of two administrative employees. The agency’s staff is made up of about 30 full-time employees, a large majority of whom are low-skilled, home-care attendants. Employees manage a heavy caseload, and working conditions are rather poor.

The fourth participating agency is a nonprofit community organization set up in the late 1980s. The organization runs several home support programs—including meals-on-wheels, befriending, telephone security checks, and special transportation—and is also involved in...
managing a small residential care unit. The community organization relies almost entirely on volunteers, most of whom work part time and on an occasional basis. Management is assured by an executive director, with the help of two part-time employees who fulfill an important role in sustaining all activities, including the raising of funds. Most of its funding comes from government sources, and the organization works in close collaboration with the CLSC.

Within the regional authority where agencies were recruited, service provision is organized into four separate territories, each led by a CLSC, comparable in size and volume of population served. A small number of private for-profit agencies (five to eight) subcontract services with the CLSCs, and most of them are family-run, small-size organizations, in many respects similar to the one recruited for the study. Likewise, about 10 community, not-for-profit organizations provide various types of services to seniors within the region and interact with the CLSCs. Only one EESAD exists in the region, although its size and organizational characteristics reflect those of most EESADs operating within the same metropolitan area.

At the time of the project’s commencement, neither agency had a specific policy for quality management or a measurement system to monitor quality problems. Only the CLSC collected some information on organizational and employee performance. In addition, all participating agencies were interdependent with one another in the ways they worked and related at the local level, mostly through service contracts, with the CLSC assuming a steering, dominant role. Noteworthy, home-care agencies in Quebec are poorly regulated, and certification is not a requirement for entering contracts with the public sector. Also, these contracts are generally awarded on a discretionary basis. However, government’s increased reliance on home-care to provide posthospital and long-term care has contributed to expanding the agencies’ client base at the same time it has put pressure on them to better coordinate their activities, reduce costs, and ultimately improve the quality of services.

### Organizational Culture Attributes Compared

As indicated, the agencies’ organizational cultures are quite dissimilar in a number of ways. Table 1 below compares agencies on the basis of their most prominent cultural characteristics.

The CLSC appears as the organization where collegiality and teamwork is most clearly embraced. Care services at the CLSC are typically delivered by interdisciplinary teams, in charge of client evaluation, service allocation decisions, and follow-up. Teams are also organized by individual professional groups, such as registered nurses or home-care workers, and employees often take part in various administrative committees. Collegiality is an important feature of the EESAD and the community organization as well, although it is less prominent than at the CLSC. In the case of the ESSAD, for example, employees are assigned to a service team, headed by a frontline supervisor. Management at the ESSAD has also set up a special internal committee for employees to identify and to deal with problems in

| Table 1 | Home-care agencies culture attributes |
|---|---|---|---|
| **CLSC** | **EESAD** | **Private agency** | **Community organization** |
| Collegiality and teamwork | ++++ | +++ | + | +++ |
| Personnel organizational commitment | ++++ | +++ | + | ++ |
| Personnel organizational involvement | ++++ | +++ | + | ++ |
| Degree of professionalization | ++++ | ++ | +++ | + |
| Formalization of work | ++++ | +++ | +++ | + |
| Centralization of decision making | ++ | +++ | ++++ | ++++ |
| Reward orientation | ++ | ++ | + | + |
| Organizational progressiveness | ++++ | +++ | + | +++ |
| Customer focus | ++++ | +++ | +++ | ++++ |

Note. ++++ = “very high.”
++++ = “high.”
+++ = “moderately high.”
++ = “low.”
+ = “very low.”

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service provision. By contrast, the private agency is the organization where team work is the least developed and valued. In fact, employees at the private agency have very limited contact with each other and rarely frequent its premises; most of their communicating with management is usually done by telephone or fax.

Organizational commitment among employees is stronger at the CLSC, where working conditions are comparatively better, employees manifest a greater emotional attachment to their jobs, and people are more likely to remain on the payroll for longer periods. Personnel at the ESSAD and volunteers from the community organization also express an affinity with their organizations—both of which place a high value on the quality of work life and embrace the principles of social entrepreneurship. However, employee turnover and volunteer retention are critical problems faced by both of them. Organizational commitment within the private agency contrasts with the others in that it is the weakest. Noteworthy, for many home-care attendants, working at the private agency is viewed as a temporary job and a way of acquiring some experience before applying for a position with a CLSC or other public facility.

In addition, the CLSC and the EESAD are the organizations where personnel involvement in a range of paraprofessional activities is most widespread. Involvement relates to employer-sponsored projects such as training, topical conferences, peer review, administrative committees, and others. By comparison, employees from the community organization and private agency have far less possibilities to participate in similar activities. Even when given the opportunity, they still appear less motivated to get involved than members from the two other participating organizations.

The four organizations also differ with regard to their employee’s qualifications and standardization of practices, a dimension we label degree of professionalization. Here again, the CLSC stands out as the organization where professionalization is the most pronounced. All professionals working at the CLSC are regulated by a relevant trade association that determines licensure requirements and practice standards. By comparison, the private agency and, to a lesser extent, the EESAD are much less professionalized. For instance, many home-care workers employed by the private agency do not possess a vocational studies diploma and are not members of the provincial home-care attendants association.

Further, although practice guidelines for service provision are established by all agencies, it is at the CLSC that work is more formalized and systematized. Service delivery, for example, is not only more intricate at the CLSC but is also structured around a sequence of clearly delineated stages, from intake to discharge. Institutional rules are employed at the CLSC to prioritize recipients, and a standard home-care instrument is applied for evaluating clients, determining levels of assistance, establishing service plans, and defining care activities. Standards of practice are also used at the EESAD and at the private agency, but the service delivery process is not as organized and complex as in the CLSC. The community organization, on the other hand, is comparatively the place where activities are more poorly formalized.

Decision making, however, is least centralized at the CLSC, where the home-care program executive director is allowed considerable latitude in determining objectives and approaches to problem solving. At the same time, authority for many organizational decisions is delegated to lower ranking personnel, whereas professionals exercise a high degree of clinical discretion. In comparison to the CLSC, decision making at the private agency is quite hierarchical and concentrated in the hands of the owners, who keep a tight control over all aspects of the agency’s operation and service delivery, including employee performance. The ESSAD and the community organization rank somewhere between the latter two agencies with regard to their decision-making practices; although their managing directors, particularly in the case of the ESSAD, can be very insular in making many of the day-to-day operating decisions.

None of the organizations had explicit policies to reward employee performance, although at the CLSC and, to a lesser extent, at the EESAD, employees would sometimes receive a symbolic recognition for their work. Differences among participating agencies are also evident with regard to a dimension we termed organizational progressiveness. The CLSC and the EESAD are the two organizations that most clearly foster a work environment conducive to professional development and encourage staff contributions in a number of managerial and clinical activities. Within the private agency and the community organization, on the other hand, investment in training and employee/volunteer development activities are much more limited and do not constitute a distinctive organizational orientation.

If we now look at customer focus, the contrasts among the four agencies are less marked. All agencies embrace the idea that promoting the role of users and meeting their needs constitute fundamental dimensions of service provision and consider user satisfaction to be a key indicator of service quality. However, and perhaps more than is the case with other values, the significance of customer focuses in shaping each of the agency’s behavior is to be understood in relation to their (sometimes competing) strategic goals and external constraints. The CLSC, for example, advocates a client entitlement, needs-based approach to service delivery characteristic of a publicly run health organization; however, given limited resources, such principles are generally tempered by considerations on the “efficiency” of
interventions, including a rather strict interpretation of needs and the targeting of support. In the case of the private agency, the user centeredness of service provision is qualified by the owners’ imperative of profit making and the importance of providing “good value for services” in a competitive environment. Likewise, the EESAD places a value on “personalized services” at the same time it emphasizes innovation and the importance of a rewarding working environment. An increasing demand for services combined with financial uncertainty has nevertheless, over the years, driven the ESSAD to accentuate the importance of “sustainability” and to incorporate some managerial principles characteristic of the for-profit sector at the expense of its focus on users. Balancing the demand and supply of services has represented an equally important challenge for the community organization that, confronted with the difficulties of volunteer recruitment and burnout, has become ever less able to fulfill the expectations of volunteers at the same time it responds adequately to an increasing demand for services. In addition, although maintaining a steady stream of funding is important, a central stake for the community organization is demonstrating to government that services affect users and that monies have been efficiently used.

Working and Performance of the CQI Program Among the Participating Agencies

The CQI initiative began in the four agencies concurrently. Its implementation was done in stages, in accordance with the so-called analyzer approach (Miles & Snow, 1978), which the literature on the subject suggests is associated with a greater degree of implementation success (Shortell et al., 1995). As applied, it involved, first, building awareness in management about the CQI project objectives, its relevancy, and expected results; second, conducting an overall scan of quality problems in each organization; third, setting up CQI teams; fourth, training concerned personnel; and fifth, running CQI teams, applying corrective measures, and evaluating them.

CQI team members were recruited on a voluntary basis from agency personnel interested in participating on the project, although efforts were made at ensuring an adequate representation of all personnel categories and professions from each agency and of personnel most directly affected by a particular quality problem. Only one team, of eight members on average, was created per agency—teams, however, were slightly larger at the CLSC and smaller at the private agency to take into account differences in agency size, personnel mix, and variety of services provided. All teams received an initial crash training course focused on quality improvement tools and their application and were led by an agency member with decision-making authority (i.e., mid-manager, owner, or director) with the help of a facilitator.

The CQI activities entailed a sequential problem-solving process—derived from the “plan-do-check-act” cycle—that was used in the same manner in all places, with minor adjustments to account for agency characteristics and differences in available resources. A variety of CQI tools and instruments were used by CQI teams depending on the improvement process step and objectives pursued, including nominal groups, small surveys, flowcharts, brainstorming, affinity diagrams, fishbone diagrams, Pareto analysis, and so forth. Table 2 presents these tools according to the CQI stages and activities in which they were applied.

The quality problems identified in the course of the project were diverse and specific to each organization. Typical problems addressed by quality teams concerned

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high turnover of home-care workers (CLSC), inconsistency in client follow-up (CLSC), delimiting of professional responsibilities (EESAD, private agency), variation in task/work routines (EESAD, community organization), unsystematic reassessment of intervention plans (CLSC), and so forth. The intensity of work invested by CQI teams to correct these problems varied from one place to another depending on their nature and degree of complexity (see Table 3).

Each problem-solving cycle entailed an average of seven meetings, with a higher frequency at the CLSC (nine meetings) and a lower one at the EESAD and at the community organization (five meetings). CQI cycles were repeated at the CLSC and the EESAD, which allowed team members to better experiment and improve their mastering of CQI techniques. The number of solutions tested and implemented at the CLSC and at the EESAD was also higher than at the other organizations. Further, at the CLSC in particular, the evaluation activities selected to monitor the implementation of corrective measures were far more thorough and robust than elsewhere.

Besides differences in the type of quality problems tackled and the intensity of work accomplished, the organizations also diverged with regard to the ease with which CQI teams learned and internalized the various quality improvement techniques introduced in the course of the project. In this regard, although before the initial crash course most of the techniques were new to members of either organization, at the CLSC and at the EESAD participants seemed comparatively more apt at using them with limited external help. By contrast, in the two other agencies, the involvement required from members of the research team was consistently higher. In fact, at the private agency and the community organization, several improvement activities had to be accomplished by a research assistant outside of the CQI meetings together with the team leaders.

The CQI teams operated for a total of 9 months on average—including 4 months for the analysis of problems and identification of solutions and 5 months for their implementation. At the end of the research, management from all of the participating agencies pledged to continue with the CQI project and establish it as a permanent organizational feature. At the community organization and at the private agency, however, ongoing external financial support was seen as essential to its long-term sustainability. At the CLSC, on the other hand, the home-care experience was consolidated and extended to other service programs as part of an agency-wide quality strategy. A full description of the CQI project, including an evaluation of its implementation process and outcomes, is available elsewhere (Firbank et al., 2005).

### Team Members’ Assessment of CQI Activities

Data on team members’ assessment of the project, gathered at critical stages of its development, heighten our understanding of agency receptivity to CQI principles and methods.

If we first concentrate on the attitudes of CQI team members toward the project and related activities, opinions were mixed but mostly positive in all four agencies. With minor nuances from one organization to another, the undertaking was variously described as “creative,” “fun,” “quite interesting and new,” “a break from everyday activities,” and so forth. Furthermore, participants felt CQI teams were helpful and offered a valid instrument to reflect on their working premises and practices. Particular aspects of the initiative were nevertheless considered “arduous” and at times “stressful.” For instance, some participants felt “rushed through the experience,” argued it “demanded considerable time and energy” and involved an added responsibility to their “already overburdened caseload” or, in the case of the private agency, were “apprehensive about how results might be used, or influence [their] practice.” But even when concerns were raised, perceptions appear to have evolved in a favorable way as the project moved forward.

As regards the appreciation or perceived utility of the project, members recognized its worth both for personal and for technical reasons. At a personal level, members emphasized the “possibility of exercising a certain power over the work problems [they] usually

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**Table 3**

<table>
<thead>
<tr>
<th></th>
<th>CLSC</th>
<th>EESAD</th>
<th>Private agency</th>
<th>Community organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. problems tackled</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No. solutions implemented</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total No. CQI team meetings</td>
<td>19</td>
<td>16</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Average No. CQI team meetings per problem</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

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encounter," the “opportunity of distancing [themselves] from daily routines” and “of reflecting on [their] practice.” Being able to “rely on a methodology to get through all of the [CQI] stages […] and find practical solutions” and to “use tools [which] helped in structuring discussions” were two recurrent technical aspects valued by participants. Regardless of the organization, the limitations most noted relate to the time requirements of the project and, in the case of the CLSC and the private agency, the difficulty in implementing and applying some of the corrective measures identified by CQI teams. At the private agency, participants regretted the “lack of continuity in team activities” and the “limited involvement of several team members.”

Finally, participants’ valuation or perceived outcome of the project related as much to CQI team activities as to the results to be expected from the corrective measures implemented in each place. Here differences between organizations are more noticeable. For instance, participants from the CLSC expressed their satisfaction with the methods used, but some pointed that “more quality problems could have been tackled.” Several people also highlighted that although “the solutions found were durable,” their “effect could only be measured over a longer period of time.” At the EESAD, members valued the fact “concrete solutions were found” but emphasized that even if “solutions were not readily effective, just addressing them” in the context of the project was seen as positive. At the private agency, members appreciated the results but noted the paucity of elements to promote “a quality improvement mindset” beyond the activities undertaken by the CQI team and the “unknown of whether the project would continue into the future.”

Making Inferences About Culture and CQI

Overall, the comparative evaluation of how CQI teams operated indicates that the project performed better and benefited from a more sustained support at the CLSC and the EESAD than at the private agency and the community organization. Further, at the end of the experience, the quality improvement project seemed better established at the former two agencies, hence stood a better chance of being institutionalized in full. This section aims to look more closely at whether the differing results can be attributed to the degree of congruence or alignment between the CQI initiative and the organizational culture of each home-care provider.

If we return to the cultural makeup of agencies, a first aspect to be highlighted is collegiality and teamwork, which, particularly in the cases of the CLSC and the EESAD, represented an important leverage for the establishing of CQI teams. In both these agencies, the principles of joint work were already embedded in routine practices, which provided the common ground needed for the introduction of interactive, group problem-solving activities characteristic of the quality improvement initiative. At the private agency and community organization, by contrast, before CQI teams being introduced, personnel were not as connected with one another or familiar with cooperative working arrangements. As a result, participants had to adjust to working in teams and required more time before creating synergy between them and being able to organize around the project goals. Some of the principles of effective collaboration, however, such as information sharing, engagement in discussions, and recognizing the value of collective problem solving, were not always forthcoming. In this regard, it could be said that although CQI teams were introduced in the latter two agencies and generated some valuable results, these teams relied on an “appearance of teamwork” more so than on a truly collaborative ethic.

The ability of teams to learn and to effectively apply various quality improvement techniques is another dimension that differentiates organizations and helps understanding their uneven performance. Although all teams received the same training at the beginning of the project and were assisted by a research assistant in completing a range of activities, their technical capabilities to assimilate some of the techniques were sometimes inconsistent if not inadequate, in large part an expression of the degree of professionalization of each place. Upon completion of the project, teams at the CLSC and at the EESAD appeared more confident and capable of carrying on with the project on their own than was the case elsewhere. Likewise, differences in the organizational involvement and commitment of personnel translated into members being more or less conscientious about and engaged in the process of problem solving. Team members’ willingness to participate in discussions and to assume responsibilities directly affected team performance. Again, at the CLSC and EESAD, such cultural characteristics meant that task delegation was relatively easier and participants were more accepting of taking on new duties tied to the project.

A further distinctive cultural aspect that played a role in the project’s implementation is the extent to which agencies foster staff development and encourage employee contributions—a feature we termed organizational progressiveness. Although the nature and complexity of problems tackled by quality teams were not comparable, where organizational progressiveness was higher teams appeared more at ease with proposing corrective measures which may challenge traditional assumptions or sometimes entail significant changes. Both at the private agency and, to a lesser extent, at the community organization, such “creative thinking” was more inhibited. In the case of the private agency, in particular,
suspending the corporate hierarchy in teams was not always easy, which created barriers for communication and the generating of innovative ideas.

In addition, the agencies that enforced hierarchies and centralized decisions the least were also the ones that provided CQI teams with more latitude for decision making and the development of a range of corrective measures. Such “empowering” of teams contributed to members developing a sense of appropriation of the quality improvement initiative. It also gave them authority to decide and act within certain parameters, including frontline supervisors’ ability to undertake changes when testing some of the corrective measures identified by teams. All of this helped in creating confidence and openness among team members.

As indicated before, none of the participating agencies had a reward system for employees on the basis of performance or quality work. The contribution made by CQI team members was sometimes symbolically recognized though. In the case of the CLSC and, to a lesser extent, at the EESAD, participants were formally praised by management for their efforts and team achievements highlighted in local newsletters. In both cases, participation to the CQI activities also allowed employees to have a reduced work load and more flexibility in determining their work schedule. The overall impact of such recognition, however, appears limited relative to other cultural factors.

Along a similar line, customer focus, often identified as a key ingredient of quality improvement programs, did not have a visible effect on how teams performed. The fact all agencies embraced such value likely contributed to keeping the quality initiative centered on users—as opposed, for instance, on employees/volunteers’ working conditions—and to viewing users’ experience with services as an essential measure of improvement outcome. However, as stated earlier in the article, customer focus should be considered in context and its impact measured against other related constructs and strategic goals, most notably the agencies’ way of dealing with an increasing demand for services while keeping costs down.

### The Influence of Other Contingent Factors

More generally, in ascertaining how organizational culture affected the introduction and operation of CQI, the influence of various contingent factors, operating differently in each case, should not be overlooked. For instance, although all agencies were readily interested in participating in the project, their motivations differed, partially explaining how the implementation process evolved. In the case of the private agency, although not explicitly stated, it seems the owners’ initial decision to be part of the research project was based less on a drive toward improved quality than on the perception that the CQI initiative would improve the agency’s market image, including its chances of obtaining service contracts from public sector facilities. Likewise, as regards the community organization, gaining “external legitimacy” from the CLSC, their main source of client referrals and a primary force behind the project in the region, can be seen as a major driver on their decision to experiment with CQI. In both these organizations, an indecisive commitment to improve quality contributed to management being less involved in the initiative and less inclined to promote its full implementation.

The resource capabilities to implement the project differed considerably as well. In this regard, the CLSC clearly contrasts with the other participating agencies, in that being a relatively large and well-established public organization, it could tap on a much larger pool of resources. Interestingly enough, although the resources invested by each of the three other agencies were not equivalent, this depended as much on their financial position as on their commitment to the CQI project. At the EESAD, for example, management was generally more disposed to free-up employees from their usual responsibilities to participate in the project and to allow work time for team meetings.

Most important, leadership style and ability to steer the project were not comparable either. Here again, the contrast between, on the one hand, the CLSC and the EESAD and, on the other hand, the private agency and the community organization was quite apparent. In the first two cases, managers exhibited better communication skills and competencies when running team meetings and seemed more capable of favorably influencing personnel with regard to the project. At the private agency and the community organization, management was not only less dedicated but at times perceived the project as being too ambitious and overburdening. Further, in the context of CQI meetings, particularly at the private agency, management appeared more concerned with the tasks and the formal hierarchy than with the creativity and fulfillment of workers. Such leadership qualities surely played a part in determining the project’s uneven performance across the four organizations.

Consistent with the principles of organizational alignment, these factors intervened not just individually but also in combination with one another. Crucially, they complemented as well as reinforced the manner in which culture affected, positively or negatively, the receptivity to CQI among the participating organizations. However, their impact appears to have been secondary to the primary influence of culture. In this respect, although adjustments were made to the CQI project so that the intensity of work will correspond to each agency’s position as on their commitment to the CQI project. At the private agency and the community organization, management was not only less dedicated but at times perceived the project as being too ambitious and overburdening. Further, in the context of CQI meetings, particularly at the private agency, management appeared more concerned with the tasks and the formal hierarchy than with the creativity and fulfillment of workers. Such leadership qualities surely played a part in determining the project’s uneven performance across the four organizations.

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the process of running team meetings or accomplishing various improvement activities, such adjustments, despite their utility, appear to have not fundamentally altered its carrying out and outcome. Again, the extent of fit or alignment between the CQI initiative and a core set of cultural attributes characteristic of each place seems to reflect much of the overall variance in results among the participating agencies.

**Conclusion**

In many respects, the conclusions to be drawn from this study are coloured by its methodology and the conditions under which the CQI program was implemented. One potential constraint relates to the use of a case study approach that, by virtue of its reliance on “theoretical generalization,” may limit the extrapolation of results to a wider sample of home-care agencies (Yin, 2002). Also, the observational and subjective measures adopted to determine agency receptivity to the CQI intervention are more open to bias than if standard, validated instruments had been used. Furthermore, the experimental manner in which the CQI program was introduced and operated, coached by a research team, is atypical and quite different from the normal circumstances home-care agencies may encounter when adopting a similar program. Such caveats aside, the qualitative, observational method allowed nonetheless for an intimate knowledge of how agencies experienced the process of establishing a CQI program, how their cultural characteristics impinged on their everyday operations, and how both appear to have interfaced. The experimental circumstances of the project also minimized variability with regard to the type of CQI program adopted and provided for uniformity and flexibility in the implementation process.

Our examination of the CQI/organizational culture nexus in a set of home-care agencies confirms the widely held premise that culture, by establishing a “patterned way of doing things” that permeates most aspects of organizational life, is paramount to the understanding of variance in receptivity to CQI programs during implementation. Further, the research also provides support for Maull, Brown, and Cliffe’s (2001) observation that in trying to capture how culture affects implementation decisions, the categorical measurement of cultural attributes may be insufficient; instead, what is of critical importance is a ground-based examination of the way such attributes interact with the introduction and practical operation of a CQI program.

In line with findings on CQI implementation in other health care facilities (Davies et al., 2000; Shortell et al., 1995), the study shows that among the four participating home-care agencies, a core set of cultural attributes—namely a team oriented culture, organizational commitment and involvement of personnel, decentralized decision making, and organizational progressiveness—played a decisive role in determining agency receptivity to CQI. Some of the levers and barriers to implementation identified in previous research, however, seem less relevant to the reality of the agencies under study. For instance, the mobilization of all categories of personnel around the quality program—a common problem encountered in hospitals, particularly with regard to physicians, and a primary factor for CQI sustainability (Shortell, 1995)—was not a major challenge for either of the participating agencies—even when at the private agency participants were comparatively less involved and motivated than elsewhere. Likewise, the recognition and rewarding of CQI team members for their innovative efforts, although mostly symbolic and informal in the case of two agencies, only had a limited effect on member’s attitudes and performance. Customer focus, an attribute often recognized in the literature as critical to quality management (Jablonski, 1992), appears to have not had a great influence on the program’s trajectory either.

As suggested by organizational alignment theory, the effect of culture on the CQI initiative was mediated by the incidence of several contingent variables though. Three factors in particular, agency motivation to embark on CQI, commitment of financial resources, and leadership style and competencies, seem to have been most important at facilitating (or hindering) the program’s implementation. In addition, although their impact varied across the four agencies, these factors tended to operate in such a way as to reinforce one another. Hence, where agency culture was the least receptive to CQI, management appeared likewise less able to carry the program through, their motivation to quality improvement was more ambivalent, and the resources allocated were also comparatively less significant. Conversely, where receptivity was higher, the opposite was the case.

Moreover, nothing intrinsic to home-care—such as the type of services provided, the skills and qualifications of personnel, or “the uncontrolled nature of the home as a venue for service provision” (Kinney et al., 1994)—appears to have prevented the use of CQI methods and techniques, thus negatively affecting the program’s implementation. Compared with hospitals, however, the home-care agencies’ resources, both financial and in terms of the competencies needed to manage a CQI program, were rather limited. In fact, before the program being introduced, the management from either of the participating agencies was quite unfamiliar with CQI methods and techniques. On the other hand, the participating agencies were fairly small and rather non-bureaucratic; therefore, implementing a CQI program was at first sight not as complicated or “politically charged” as is typically the case in hospital settings (Blumenthal & Kilo, 1998).
All things considered, the results of the study reveal that the extent of receptivity to CQI among the four home-care providers was variable, and this is despite the different service quality accomplishments made in all of the participating agencies. At one end of the spectrum, the CLSC, followed by the EESAD, appear as the agencies most suited to the introduction of CQI, whereas at the other end, the community organization and, even more, the private agency seem the least compatible with this type of intervention. It can be speculated that under different circumstances, such as the use of an alternative implementation approach or a more generous set of incentives, the outcome for the latter two agencies would have been different. The limited effect some of the adjustments to the program had on facilitating its implementation in these agencies, however, led us to believe that such changes might not significantly affect their overall receptivity to CQI. In addition, too significant a change in the manner CQI is applied and operates may run the risk of “denaturalizing” or undermining its strengths as a methodology for quality management.

What emerges has noteworthy implications for management and government initiatives geared at promoting CQI in the home-care sector in Canada as elsewhere. A first one relates to the fact the home-care providers that might be most in need of monitoring and improving the quality of services—such as for-profit private agencies and providers whose activities are little regulated—due to their un receptive culture are paradoxically also the ones least likely to voluntarily adopt and institutionalize CQI. For this category of agencies, other strategies for quality management, either less ambitious or more centered on oversight and compliance with care standards, would be required. A second policy implication of the study is that although in many jurisdictions CQI is promoted as an across-the-board strategy to improve health care services, a preliminary assessment or “cultural audit” of facilities to determine their readiness and ability to introduce a CQI program might be needed as a way of minimizing implementation failure. Such an assessment would also constitute a useful means to identify the program’s adjustments to be made on a case-by-case basis and, where possible, the organizational changes to be introduced ahead of its implementation.

A cultural assessment of this kind, however, would necessitate an in-depth examination of organizational features that goes beyond the descriptive, typological approach often used in standardized culture surveys (Scott, Mannion, Davies, & Marshall, 2003b). More research would be needed to specify the content and format of cultural audits geared at different home-care agencies and establish their effectiveness. A third and last policy-related conclusion points to the pivotal role a public or quasi-public entity plays in the introduction of CQI among home-care agencies of various types and cultural orientation within a given area. In the context of this research, for example, the CLSC together with the research team, where instrumental not only in promoting the CQI project at the local level but also in providing the necessary resources and support to all participating agencies. Whether it be directly or by delegation responsibility to a provider organization, active government assistance, particularly in the initial stages, may be paramount if CQI implementation efforts are to be successful and deliver their intended results.

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