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ABSTRACT

IDENTIFYING FACTORS THAT ENHANCE OR HINDER THE UTILIZATION OF STRENGTHS BY HEALTHCARE MANAGERS

by

Gene C. Milton

Chair: Erich Baumgartner
ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: IDENTIFYING FACTORS THAT ENHANCE OR HINDER THE UTILIZATION OF STRENGTHS BY HEALTHCARE MANAGERS

Name of researcher: Gene C. Milton

Name and degree of faculty chair: Erich Baumgartner, Ph.D.

Date completed: December 2010

The purpose of this study was to examine perceptions of strengths-use at Hackettstown Regional Medical Center (HRMC), and common factors and conditions that enhanced and hindered strengths-utilization among middle managers at HRMC, a 111-bed acute care facility in Hackettstown, New Jersey. The study identified factors and conditions that can be expanded and improved upon to promote strengths-use at HRMC in the future.

The population for this explorative study was selected from approximately 200 full-time executives, managers, and staff at HRMC who took the StrengthsFinder Profile from January 2007 through June 2009. The vehicle used for data collection was 5 focus groups comprised of 5 volunteers each. Participants were recruited and selected from the larger population of people at HRMC who had taken the Gallup organization’s
StrengthsFinder Profile (SFP). Focus groups were segmented by worker type: executives, clinical and non-clinical managers, and clinical and non-clinical staff. A Pilot Study comprised of a person from each work group was conducted to first test the appropriateness and usefulness of the focus group questions and format.

In order to maintain confidentiality and minimize bias, independent facilitators were hired to conduct and audio-tape each 2-hour focus group session. In addition, a transcriptionist was assigned to transcribe those sessions and remove identifying labels such as a person’s name or department from the data. Gene Milton, hospital President and CEO, organized and managed the data collection process, then completed the encoding and analysis of the data once it had been transcribed. Perceptions of the percentage of time that people were using strengths on the job, and factors and conditions that supported and hindered use, were determined from responses to the focus group questions.

Much of the theoretical framework for this study was rooted in research studies on strengths-use, particularly that of: Buckingham and Clifton, Gebauer and Gorden, and Rath and Harter. Those studies focused on the individual’s role in promoting his or her strengths in the workplace, and the importance of the manager’s role in helping employees to identify and use their strengths at work. In addition, that research focused on people taking responsibility for pushing their personal strengths into an organization. This study went further and examined a range of factors and conditions, including leadership, at HRMC that enhanced or hindered managers’ use of strengths on the job.

Results indicated that while participants were knowledgeable about their own personal strengths-use at HRMC, they often equated strengths with their jobs skills and
duties, rather than with natural talents or passions they bring to the workplace. In addition, participants were less conversant with their manager’s strengths than with their own. On the whole, there did not appear to be an understanding of how strengths-use could contribute at the department level or organization-wide to employee engagement or productivity. HRMC’s leadership did not appear to be encouraging strengths-use organization-wide, nor did they appear to grasp the importance of doing so. On the other hand, findings indicated that there is a foundation in place at HRMC for broader discussions and application of strengths-use at the individual, team, and organizational levels.

This study lays the foundation for my future academic work of teaching and advising other hospital administrators on how to achieve the mission of providing quality and safe patient care to those whom they serve—by building upon the strengths of managers and staff who work in their healthcare organizations.
IDENTIFYING FACTORS THAT ENHANCE OR HINDER THE UTILIZATION OF STRENGTHS BY HEALTHCARE MANAGERS

A Dissertation
Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

by
Gene C. Milton
December 2010
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CHAPTER ONE

INTRODUCTION

Background

The work environment in healthcare, as well as many other industries, is facing many challenges that are putting a strain on workers and their performance. Due to rising costs and the demand for quality products and services at reduced prices, many organizations are expecting a higher level of performance from their employees while at the same time reducing their available resources and support. These and other factors are taking the fun and enjoyment out of work for many people. As additional work and responsibilities are given to employees, it appears that little attention is given to what employees enjoy or do not enjoy doing. If organizations expect to retain employees and have them do more with less, it is extremely important to take a fresh look at our existing manpower.

Management must find ways to better utilize natural talents or strengths of their employees to address this additional workload and responsibility or we may find good people leaving their organizations. Hospitals, like many organizations, must find ways to become more efficient and reduce costs to keep pace with the current declining revenue base, as well as address the likelihood that future reimbursement rates may wane as healthcare costs to patrons are reduced in order to make it more affordable to everyone. According to the Healthcare Financial Management Association (HFMA, 2009), the
single most important factor driving up healthcare costs is growth in labor costs (p. 4, see also HFMA Educational Report, 2007).

In response to these and other increasing financial challenges, organizations are relying more heavily on management to enhance institutions’ performance—especially their excess revenue over expenses. Management personnel are not only critical to the performance of all these tasks, but also vital to the success of an institution; organizations must find ways to meet these increasing requirements without “burning out” its managers. One way to support the best use of managers and minimize staff burnout is to have them spend more of their time in the area(s) of their strengths.

The Gallup Organization, over years of studying employee behavior, cites the important link between managers who encourage employees to use their strengths on the job, and employee engagement. Gallup found that employees with managers who encourage their use of strengths are six times more likely to be engaged and three times more likely to have an excellent quality of life compared to those employees who do not receive that same encouragement (Rath, 2007).

In a study of millions of employees over the past 25 years, the Gallup Organization found that managers matter more than executive team members in lowering employee turnover, enhancing productivity, and increasing customer satisfaction (Wagner & Harter, 2006, p. x). Research also reveals that great managers improve bottom-line results because they understand and better utilize the natural skills and talents of their employees (p. 142). When employees are using their natural skills and talents, more work is done in a more efficient manner, directly affecting an organization’s bottom line. The Harter, Schmidt, and Hayes (2002) study of 198,000 employees found that
while there were many levels for engaging employees, the most effective was having them use their strengths. Hamel (2007) maintains that organizations’ greatest challenge is to reinvent management systems to encourage employees to bring their full capacity to work every day.

Gebauer, Lowman, and Gordon (2008) report that most companies are not fully utilizing the power of employee engagement and four out of every five workers are not delivering their full potential to help their organizations succeed. Similarly, Towers Perrin conducted a 2007-2008 global workforce study of approximately 90,000 employees in large and medium-sized companies in 16 different countries to determine the level of engagement of these employees. The results showed that 71% of workers around the world are not yet engaged or are disengaged. Gary Hamel (2007) calls this a “scandalous waste of human capability” and states that it “helps to explain why so many organizations are less capable than the people who work there” (pp. 57-58).

These studies bear testimony to the proposition that if an organization can create an environment, or make changes to its current culture, to allow managers to spend more time utilizing their natural strengths, the result would be stronger, more efficient and productive management teams to deal with challenges facing hospitals and other organizations. If organizations are going to expect managers to pick up more responsibilities, they must develop better ways to utilize managers’ strengths and talents.

**Statement of the Problem**

The importance of managers to the success of an organization, as well as their influence in enhancing employee satisfaction in the workplace, has been identified in research. The concept of building on “strengths” has been around for many years, but it
was in 2001 that this work became more visible in organizations through Buckingham
and Clifton’s (2001) pioneering work on strengths for the Gallup organization.
Buckingham and Clifton defined strengths as “consistent near perfect performance in an
activity” (p. 28). The tool they created to identify those strengths in the workplace is
called the StrengthsFinder Profile (SFP). They asserted that an individual’s talents,
knowledge, and skills combine to create his or her strengths. Buckingham and Clifton
developed the SFP, an Internet-based product, to provide organizations a tool to identify
the individual strengths of their employees in areas pertaining to: personal motivation
(striving), interpersonal skills (relating), self-presentation (impacting), and learning style
(thinking) (p. 235).

Hackettstown Regional Medical Center (HRMC) began using Gallup’s Q12
employee survey questions in 2006 for its annual employee satisfaction survey because
that survey focuses on identifying and improving employee engagement. In addition,
executives, managers, and staff were encouraged to take Gallup’s internet-based SFP to
understand their own strengths, and how those strengths could be better utilized within
their work.

From 2007 through 2009, over 200 full-time employees (approximately 35% of
the number of full-time staff) took the SFP. However, after 3 years of championing the
use of the SFP, it was unclear to me as the hospital’s CEO whether taking the SFP was
truly making a difference towards the use of strengths within the hospital.

In exploring these matters further, my preliminary review of the strengths-based
literature revealed that even though millions of people have identified their personal
strengths through the SFP, only 17% of workers feel that they use their strengths “most of
the time” while at work. With that data in hand, Buckingham (2007a) declared that to get beyond the first stage of knowing their individual strengths, employees must get to the stage where they move beyond a label and actually put their strengths to work (pp. 10-11). Buckingham went on to emphasize the role of the manager in building strengths-based teams, but he did not address how that could be done in traditionally hierarchical organizations like hospitals.

Rath and Conchie (2008) expanded on Buckingham’s work by elaborating on the importance of managers being aware of their own strengths, investing in others’ strengths, getting people with the right strengths on their team, and understanding and meeting the basic needs of those who look to them for guidance. However, they too placed the emphasis on individuals in promoting strengths-use, and did not seem to look at larger organizational factors that could support or hinder strengths-use.

As a hospital CEO, it seemed unrealistic to me to assume that employees would take the risk of promoting and pushing their own strengths in traditionally hierarchical organizations without the support and encouragement of their middle managers as well as the executive team. Also, it seemed important to consider organizational factors or conditions that could support or hinder peoples’ use of strengths at work.

Consequently, given my interest in implementing strengths-use hospital-wide at HRMC and the current research on the influence and impact that managers have on those who report to them, I decided to investigate these matters further. My research explored both the role and influence of managers in promoting strengths-use at HRMC and those conditions and factors that promoted or hindered managers’ use of strengths at our hospital.
One premise underlying the study was that it is likely that the future success of healthcare will depend on how engaged and committed managers are who lead the day-to-day operational staff. If managers are engaged and using their strengths, the staff may do so as well.

**Purpose of the Study**

The purpose of this study was to identify conditions and factors that seem to enhance or hinder healthcare managers at Hackettstown Regional Medical Center (HRMC) in using their strengths at work. The tool that HRMC implemented to inaugurate the conversation among its employees about using their strengths on the job is an internet-based product called the StrengthsFinder Profile (SFP). Buckingham and Clifton (2001) assisted the Gallup Corporation in the generation of that product.

Because managers are considered part of HRMC’s leadership team, this study explored perceptions of people who took the SFP on whether managers are using their strengths on the job, and those conditions, situations, and factors within HRMC, real or perceived, which appeared to promote or hinder managers in their use of their strengths at work.

**Research Study Questions**

This study addressed two primary research questions. The first was: To what degree have managers who have taken the StrengthsFinder Profile been utilizing their strengths at HRMC? “Degree” here was defined as the percentage of time managers and others who work with them perceive that managers are using their strengths “most of the time” while at work. The second question was: What conditions and factors within
HRMC promote or hinder managers’ use of their strengths on the job? The term “condition” as used in this study was considered to be an existing circumstance in the HRMC work environment that supported or hindered employee use of their strengths at work. A condition could include circumstances out of the control of the manager, which if changed could make a difference to his or her use of strengths on the job (e.g., organizational structure, training, and resources—human, financial, physical). The term “factor” as used in this study referred to a specific circumstance, element, or fact that had some bearing on why people do or do not use their strengths at work (e.g., knowledge or skills on how to apply them, time restraints, incentives or motivation, leadership support).

**Theoretical Framework**

Three major themes pertaining to strengths-use in organizations served as the theoretical framework for this study. The first was strengths-based research, which focused on how individual skills and talents and passion for what they’re doing are necessary, and how their use contributed to the productivity of an organization. The next area was Appreciative Inquiry (AI), which is an organizational approach that seeks to improve organizational effectiveness by highlighting an organization’s strengths, that is, what is already working in organizations, including the employee’s role in making that happen. The third area was Servant Leadership, which explores how executives and managers provide the organizational leadership to create the conditions that can make the greater utilization of strengths a reality. The literature review elaborates upon these themes further.
Significance of the Study

This study has the potential to provide significant benefits to many people and groups. They include the following:

1. The primary beneficiary of this study was myself who as both the researcher and the President and CEO of Hackettstown Regional Medical Center (HRMC) benefits from knowing what the current situation is at HRMC with regard to strengths-use. The study provides a baseline report to continue building from what was done in the past, and what can be done in the future to expand upon strengths-use at HRMC.

2. The next group of beneficiaries is the circle of leaders around me at HRMC including the executives, managers, and staff who participated in this study. They benefit by learning the results of this study, and by being provided with recommendations for moving forward on building strengths-use and employee engagement at HRMC. The summary of findings and recommendations provides HRMC leaders an appraisal of what is supporting or hindering strengths-use, and the importance of their role in using their influence to support and encourage their colleagues’ strengths.

3. Another group that benefits from this study is other hospitals that are struggling with similar questions of how to maximize employee engagement, well-being, and productivity as financial resources become even more constrained.

4. This study also benefits other organizations that are looking for ways to improve employee engagement, well-being, and productivity. It is possible that the results of this study may encourage organizations to look at their organizational culture and structures to better job satisfaction and more fully engage employees, while at the same time meeting the requirements of their industry.
5. The information gained from this study also contributes to a wider understanding beyond what Gallup and others have unearthed in their strengths-use research. It also contributes to research that reports about Servant Leadership practices in organizations. This study drilled down to what was happening in one organization, and raises questions that warrant further investigation. It opens avenues for discussion about the impact of current organizational structures and the leadership mind-set needed to promote organizational change. It invites leaders in hierarchical organizations to examine what in their organizational culture nurtures or represses employee creativity, innovation, and productivity. Furthermore, it raises questions about who in organizations has a vested interest to keep the structure as it is, and what can be done to remove barriers that hinder organizational health and employee well-being.

**Definition of Terms**

**Appreciative Inquiry:** A methodology developed by David Cooperrider (1995) for understanding and enhancing organizational innovations. Its purpose is to examine an organization's success, which is their strengths—what is best and most valuable from the past and to build from that going forward. Appreciative Inquiry is acknowledged by Marcus Buckingham and others in the Gallup organization for its influence on their strengths-building initiatives (Buckingham & Clifton, 2001).

**Conditions:** Existing circumstances in the HRMC work environment that supports or hinders managers’ use of their strengths at work. A condition may include circumstances out of the control of the manager, which if changed could make a difference to his or her use of strengths on the job (e.g., organizational structure, training, and resources—human, financial, physical).
**Direct Reports**: People whose job performance and supervision is a direct responsibility of a given HRMC director, manager, or supervisor.

**Executive Team**: The members of the top executive/administrative team at HRMC, which consists of the Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Chief Nurse Executive (CNE), the Chief Medical Officer (CMO), and the Executive Director for Business Development, and two Administrative Directors.

**Servant Leadership**: A philosophy and practice of management coined and defined by Robert Greenleaf in 1970 (The Robert K. Greenleaf Center, 2008). Its core tenets are that servant-leaders achieve results by giving priority attention to the needs of their colleagues and those they serve and this in turn improves the results of the organization. The servant-leader’s role is to be a humble steward of his or her organization's resources (human, financial, and physical). Servant-leaders demonstrate qualities of listening, commitment to growth, foresight, and building community (http://www.greenleaf.org/whatissl/). Its importance to the strengths-based movement is cited in Marcus Buckingham’s (2007a) work.

**Strengths**: Strengths as described here are viewed as those natural talents and qualities that make individuals perform their best. They are evident in things that people do consistently and nearly perfect every time and also make them feel great about doing them. These are activities that may appear simple for a person, but are areas for which they have an interest to continue to learn and grow, come up with new ideas, and have the best insights. These are the things that people have a passion for doing and that keep individuals interested and focused with almost no effort (Buckingham, 2007a, pp. 73-83).
Research Design

This was an explorative focus-group study of the factors that enhance and hinder strengths-utilization among managers. Focus groups were used with HRMC executives, managers, and other employees. Participants were recruited from the approximately 200 people who took the StrengthsFinder Profile at HRMC from 2007-2009. Separate focus groups were segmented by role (executive, manager, and staff) and clinical or non-clinical functions within the hospital to serve as the principal source of data for this study.

Since the dissertation research was conducted by me, HRMC’s Chief Executive Officer, there was potential for bias in my doing the actual facilitation of the focus groups with executives, managers, and staff who might be influenced in their responses because of my leadership role in the organization. Consequently, although I was the organizer of the study, I was not involved in the groups themselves. Rather, I used impartial facilitators, who were not employees of HRMC, to run the focus groups. However, I both set up and managed the data collection plan and process, and stayed engaged through frequent debriefs with the facilitators and input from an internal Formative Committee, which I had initiated to serve as a quality check on this process.

In addition to those tasks, I organized and conducted the entire data analysis process, and developed codes with qualitative word factors to analyze what enhanced or hindered the use of strengths on the job at HRMC. The data collection and analysis steps that I followed are described in more detail in chapter 3 of this report. Both chapters 3 and 5 describe some of the study’s limitations due to my not being able to directly facilitate the focus groups during the data collection process. In addition, chapter 4 details my findings from the data analysis process.
Summary

Chapter 1 provided an overview of the problem, purpose, research questions, and research design of the study. It described the background of the theoretical framework for the study, and provided an explanation of this study’s significance. The next chapter, the Literature Review, elaborates on the theoretical framework and the major themes underlying this study.
CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study was to identify conditions and factors that seem to enhance or hinder healthcare managers at HRMC in using their strengths at work. This study’s literature review describes three major areas pertinent to building new paradigms for improving employee engagement and productivity in organizations. It presents philosophies, principles, and practices in the areas of Strengths-building, Appreciative Inquiry, and Servant Leadership. All of these areas provide a foundation from which current executives, managers, and employees can learn to maximize each other’s contributions in the workplace.

The first section of this review examines the strengths-building movement championed by Marcus Buckingham and Donald Clifton (2001) of the Gallup organization (pp. 5-10). Strengths-based research addresses the importance of building upon employee strengths, that is, on using those natural talents and those qualities that make individuals perform their best. Much of that research focus has been on assessing whether individuals are taking personal responsibility for promoting and using their strengths on their jobs. This research study expands upon that research by focusing on managers’ use of strengths at work, and examines what in the work environment helps or hinders the use of their strengths.
The second section presents Appreciative Inquiry (AI) and its theoretical framework for how to improve overall organizational performance by emphasizing an organization’s strengths, that is, what is positive and working in an organization. AI research was an influence on the strengths-movement: it emphasized looking at an organization’s strengths by talking with employees and gathering their stories about what is best and most innovative in their organization.

The third and final section of this literature review examines Servant Leadership. Servant Leadership concepts are important to this study because leaders in an organization strongly influence factors that may either support or hinder people’s use of strengths in the work setting. The Servant Leadership literature is of particular interest because it advocates breaking away from traditional hierarchical leadership structures and management paradigms like that of Frederick Taylor (1991); instead, it encourages leaders to foster stewardship via democratic and participative practices in the workplace. Further, it illustrates the important role leaders may play in building consensus for and encouraging change (like strengths-use) for the sake of both individual and organizational growth.

**Strengths Literature**

According to Peter Drucker (2006), “Most people do not know their personal strengths and when questioned respond in terms of subject knowledge, which is the wrong answer” (Buckingham & Clifton, 2001). Drucker (2006) states that those making staffing decisions do not want to build on weaknesses but on strengths. He states that an effective executive knows that he or she has to start with what a person can do rather than what the job requires (p. 83). Influenced by parents, teachers, and others, individuals
spend most of their time trying to fix their weaknesses while their strengths lie dormant and neglected (Buckingham & Clifton, 2001, jacket cover).

Rath (2007) goes on to argue that developing personal strengths is even more important to success than a title, role, or even salary. Jim Judge and Charlice Hurst from the University of Florida found that awareness of one’s strengths increases self-confidence (Rath & Conchie, 2008, pp. 15-16). In a study of 7,660 men and women between 1979 and 2004, they found that those with higher self-confidence in 1979 ended up in 2004 with higher levels of income and career satisfaction. They also found that those with low self-confidence had three times more health problems than those with high self-confidence over the 25 years of the study.

The Strengths Movement

Donald O. Clifton is considered the Father of Strengths Psychology. Before his death in 2003, Clifton was asked about his greatest discovery over his three decades of research. His response was, “What great leaders have in common is that each truly knows his or her strengths and can call on the right strength at the right time. This explains why there is no definitive list of characteristics that describes all leaders” (Rath & Conchie, 2008, p. 13).

Before the strengths movement began, virtually all business and academic inquiry was built on the opposite idea: namely, that a deep understanding of failure leads to an equally deep understanding of excellence. The strengths movement asserts that what people learn from mistakes are the characteristics of mistakes. If one wants to learn about success, one must study successes. The most competitive companies “get their strengths together and make their weaknesses irrelevant” (Buckingham & Coffman, 1999, p. 8).
Watkins and Mohr (2001) state that organizations should focus on their strengths: the things they are doing right and by doing so they will encourage more of it. They warned not to spend time on solely trying to fix what is wrong. Similarly, Thatchenkery (2005) indicates that if this is done, organizations will learn more about the “life giving forces” within them (p. 19). The strengths literature provides critical understanding on ways to increase the amount of time that employees use their strengths, talents, and skills on the job, thereby improving employee engagement and organizational performance. Research indicates that the attitudes and performance of managers directly influence the performance and attitudes of their staff.

Gallup set out to identify a way to measure workplaces that would attract and retain the most productive employees. They surveyed 2,500 business units in 24 different companies and found that managers, not pay, benefits, perks or even executive leaders, were the most critical in building a strong workplace (Buckingham & Coffman, 1999, pp. 31-32). The Gallup Organization found that the engagement of managers relates closely to that of the attitudes of their employees and resulting performance (Wagner & Harter, 2006). Based on their data, Buckingham and Coffman (1999) proposed that if managers become more engaged in their work, this should result in engagement of their entire staff (pp. 197-198).

Other research maintains that in order for managers to have an effective positive impact on their staff, they must be motivated. Finding and working within their personal strengths is a stimulus. This idea emerged during the 1950s when the Nebraska School Study Council supported a statewide research project of approximately 6,000 tenth-graders to identify the relative value of different methods for teaching rapid reading. The
students who read the fastest at the beginning of the study made the greatest gains during the study, and while those who read slower at the beginning also made gains, the gains were small in comparison. Researchers began thinking about a “strength” approach to teaching and management, in which individuals gain more when they build on their natural talents than when they make comparable efforts to improve their areas of weakness (Clifton & Harter, 2003, p. 1, see also Cameron, Dutton, & Quinn, 2003).

Management theorist and educator, Peter Vaill (1996), challenges organizations to build on the natural talents of their employees by promoting continual learning that encourages employees to discover and create new ways to navigate the white water of constant change and chaos in organizations. In his book Learning as a Way of Being, Vaill promotes the use of self-directed, intrinsically motivated learning in organizations where people can develop the learning attitudes of courage, curiosity, self-respect, and respect in their interactions with others, thus invigorating employees to see how their contributions and learning contribute to the whole of the organization (pp. 42-46).

Moreover, Peter Drucker (2006) asserts that, “to achieve results, one has to use all the available strengths—the strengths of associates, the strength of the superiors, and one’s own strength” (p. 71). Drucker’s position can be used as an argument to drive organizations towards identifying and utilizing the natural strengths and talents of managers and employees. Rath (2007) indicates that if organizations will cultivate and find ways to maximize the strengths and talents of their employees, it increases the ability to consistently provide near-perfect performance (p. 20). If this is the case, it may be one way to improve the chances of meeting the challenges facing healthcare as well as other organizations. If knowledge and skills are developed around a person’s natural talents,
the result will be a more productive workforce as well as one that performs more consistently (p. 18). Employees require skills, knowledge, and practice, but for the best results they should be in the areas of their strengths (p. 76).

In the White Paper Series titled, “The Strengths Engagement Track,” Buckingham (2007b) states that when a national sample of the workforce were asked the key to their success, only 37% chose building on strengths. When managers talk to their employees about their performance, only 24% focus on strengths; 36% focus on weaknesses, and 40% don’t talk about either area (p. 6). As Drucker (2006) and Rath (2007) indicated earlier, the best way to achieve greater results in organizational performance and employee engagement is to focus on building employees’ strengths. Given the results of this study, there appears to be a great opportunity for improvement, and with declining revenues and increasing costs, hospitals may take advantage of their staff’s strengths to survive and grow in the future. They must utilize the strengths of the staff already present in an effort to reduce turnover and increase productivity.

Utilizing Natural Strengths

Clifton and Nelson (1992) state that “the Strength’s Theory is based on the premise that every person can do one thing better than any other 10,000 people” (p. 36). Buckingham and Clifton (2001) propose that the things employees do consistently well are those areas that utilize their natural talents or strengths. In order to build lives, personal or professional, around people’s strengths, the following three areas must be understood: talents, knowledge, and skills.

The first area Buckingham addresses is innate talent, or natural recurring patterns of thought, feeling, or behavior—patterns created within the brain at a very early age,
which, beyond a certain age change very little (Buckingham & Clifton, 2001, p. 49).

Zander and Zander (2000) state that the world comes into an individual’s mind, or consciousness, in the form of a map already drawn or a story already told, and it is through the evolved structure of the brain that people perceive the world (p. 10). There is much written about how patterns are formed very early in the brain and how early childhood experiences assist in finding some connections smoother and easier than others. Rath (2007) maintains that core personality traits are relatively stable throughout adulthood. Talents feel so natural that they seem like common sense. Natural talents are those things that come spontaneously without even thinking because of the pathways already formed in the brain (p. 53). Levine (2002) indicates that many strengths, as well as weaknesses, are inherited from the parents’ genes (p. 38).

The other two areas for building strengths are knowledge and skills, both of which can be learned. Knowledge is built around factual content, and skills are a sequence of steps learned that lead to acceptable performance. Buckingham maintains that when people attach that knowledge and skill building to their natural talents, their outcomes are greater than if they do not. He asserts that each employee has great potential when he or she focuses on what he or she does best; the more a particular strength is exercised, the more integrated and stronger it becomes (Buckingham & Clifton, 2001, pp. 41-47).

Aldwin, Sutton, and Lachman (1996) indicate that identifying and understanding talents can become positive turning points, triggering changes in how people view themselves in the context of the world around them. Substantial predictive validities have been established between structured interview measures of manager “talents” and future manager performance (Clifton & Harter, 2003, p. 4).
In a study of more than 2,000 managers in the Gallup database, researchers looked at the responses of managers to open-ended questions related to management of individual talents versus weaknesses. In comparison to poor-performing managers, top-performing managers were more likely to indicate that they spend time with high producers, match talents to tasks, and emphasize individual strengths versus seniority in making personnel decisions. Probability of success was 1.9 times greater for managers with a “strengths versus non-strengths” approach. Managers with a strengths-based approach nearly doubled their likelihood of success (Clifton & Harter, 2003, p. 5).

Studies Citing Strengths-Based Interventions

A study was completed in healthcare (Black, 2001) in which nine hospitals were assigned various strengths-based interventions over a 3-year period, and then compared to a control group of 151 hospitals. Black asserts that hospitals using the talent identification and strengths developmental interventions grew in employee engagement over those that did not (pp. 10-12).

The Save the Children organization found an innovative way to help poor rural Vietnamese people reduce childhood malnutrition, a serious public health challenge. Save the Children studied poor Vietnamese families who had managed to avoid malnutrition. Using what they learned, Save the Children encouraged others in the community to emulate what was working for those families whose children were not suffering from malnourishment. By building from what they learned, and on the strengths of that positive example, Save the Children estimated that 80% of the children were no longer malnourished (Sternin & Choo, 2000, pp. 14-15).
The Save the Children study is a good example of how to apply both a strengths-based and AI approach to solving a problem. It was when Save the Children researchers looked at the strengths of those families whose children were thriving rather than those who were malnourished, that they found ways to copy what the others were doing, and this problem was solved. Appreciative Inquiry is described in more depth later on in this chapter.

Strengths-use and Employee Success

In a Gallup organization study (Harter et al., 2002) of 198,000 employees from 36 companies, when asked whether they had the chance to use their strengths every day, findings were that employees who strongly agreed were 50% more likely to work in teams with lower employee turnover, 38% more likely to work in more productive teams, and 44% more likely to work in teams with higher customer satisfaction scores (Buckingham & Clifton, 2001, p. 5). In another study of 10,885 work units (308,798 employees) in 51 companies, those work units that scored above the median on the statement, “At work, I have the opportunity to do what I do best every day,” had 1.4 times higher probability of success on customer loyalty and employee retention, and 1.4 times higher probability of success on productivity measures. Success is defined as exceeding the median performance within one’s own company across work units. The difference in probability of success can amount to millions of dollars to organizations (Clifton & Harter, 2003, p. 5).
Strengths Data and Healthcare Organizations

The strengths research data send a clear message to healthcare organizations: By utilizing employees’ natural talents and skills there is a strong likelihood that they will increase employee engagement and retention, and increase productivity and customer loyalty as well. This is an important learning, particularly given today’s global mind-set where consumers have more choices regarding where to get their healthcare needs met. Indeed, Friedman (2005) indicates that the world is shrinking, and other countries in the worldwide economy offer quality services, including healthcare, much less expensively. This is due in part to a highly trained workforce that lives where wages and cost of living are much lower (pp. 14-15).

Given these challenges, it is almost impossible for American healthcare organizations to provide services at the lower costs which other countries can provide. Since U.S. healthcare organizations cannot compete with this discounted knowledgeable overseas workforce (where the labor force is very highly trained, but the cost of living and wages are so much less), the U.S. healthcare focus must be on something else. That focus has to be on promoting those skills or traits that are more “high touch” as well as high tech, to keep the healthcare consumer population from seeking services elsewhere (Pink, 2005, p. 51). One way to do this is to discover and utilize those skills and talents within existing employees that bring passion and excitement to their jobs. Over a period of 30 years, the Gallup Organization interviewed approximately 2 million people in a wide range of industries and discovered that people’s talents are the greatest opportunities for success (Clifton & Harter, 2003). They defined talents as naturally recurring patterns of thought, feeling, or behavior that can be productively applied. By refining dominant
talents with skill and knowledge, organizations can create strength, or the ability to provide consistent, near-perfect performance in a given activity (p. 1).

Collins (2001) found that one of the three key dimensions of great companies was that employees had a passion for what they did. It was “not to stimulate passion but to discover what makes you passionate” (p. 96). This concept also applies to healthcare employees; if a hospital’s executives and management team can identify and utilize more of employees’ natural strengths or passions, the result is that they will likely become not only good employees, but great employees.

To summarize, strengths-based literature and the work of the Gallup organization and others in this area, served as the primary stream of thought fueling this study. That literature is important to my study because it focuses on the many contributions people can make to organizations if they are allowed to bring their own natural talents and skills to bear in the workplace. The strengths literature also asserts the importance of managers in encouraging strengths-use among those with whom they work. My study builds from this and goes a step further: It closely examined one hospital to identify specific factors that helped or hindered people in using their strengths.

Subsequent sections of this literature review describe two additional streams of research that served as backdrop to the study: Appreciative Inquiry (AI) and Servant Leadership. The first, Appreciative Inquiry, influenced my research approach of examining what is already working at HRMC, the strengths of the people who work there, and whether HRMC is finding ways to go deeper into building on its successes by encouraging employees to be creative and innovative and “think outside the box” in their work. The second, Servant Leadership, provided me an approach to exploring the
attitudes and values of HRMC’s leadership. I wanted to determine whether those in
HRMC’s leadership positions were promoting employees’ use of their natural talents and
skills in the workplace, and if they were fostering democratic, collaborative, and
participative practices to do so.

**Appreciative Inquiry (AI)**

Appreciative Inquiry was developed by David Cooperrider (1995) of Case
Western Reserve University to examine what is best and most valuable in an
organization’s past, and to use that learning to build upon going forward. AI emphasizes
that rather than trying to fix what doesn’t work in an organization, its leaders should start
with an examination of what is working well, and promote organizational learning and
employees’ use of their talents and skills to bring about innovation in the workplace.

AI literature describes how to engage individuals in change and focused
performance rather than trying to control employees in a way that stifles innovation and
creativity. It diverges from traditional industrial management models like that of
Frederick Taylor (1991), and promotes more positive and collaborative practices in the
workplace. In order to understand AI’s contribution to management practice, it is helpful
to look at what preceded it: Frederick Taylor’s approach to scientific management, which
still dominates in many organizations today.

Taylor (1991) maintained that influence occurs as a direct result of force exerted
from one person to another (Wheatley, 1994). His scientific management theories,
developed in the late 19th century and published in *The Principles of Scientific
Management* in 1911, resulted in a high level of managerial control over employee work
strategies. The tendency in such hierarchical environments is that when something goes
wrong, management looks backwards to try to fix it, often blaming employees for what happened. Consequently, much management time is spent on trying to identify and fix individual weaknesses rather than on fostering what is positive and working well in an organization (Watkins & Mohr, 2001, p. 4).

AI promotes shifting the organizational view from Taylor’s (1991) rigid top-down managerial control of workers, to one of heightening awareness of the value, strengths, and potential of individuals: building upon those capacities by looking at what is “right” in an organization (Lord, 2005). The AI supposition is that forward movement toward the ideal provides the greatest value. The greatest value comes from embracing what works (Watkins & Mohr, 2001, p. 11).

Appreciative Inquiry Defined

Watkins and Mohr (2001) state that AI is a way of seeing and being in the world. They note that the word “appreciate” comes from the idea that when something increases in value, it appreciates. “Inquiry” means the process of seeking to understand through asking questions. David Cooperrider states that, “AI involves, in a central way, the art and practice of asking questions that strengthen a system’s capacity to appreciate, anticipate and heighten positive potential” (Watkins & Mohr, 2001, p. 14). AI seeks out the best of “what is” to help ignite the collective imagination of “what might be.” Consequently, AI asks questions about what people are doing right: focusing on their strengths and not on their weaknesses. It helps to implement vision in ways that successfully translate images of possibilities into reality and belief into practice (Cooperrider, Whitney, & Stavros, 2005, p. xiii).
Cooperrider’s Contribution

In 1980, David Cooperrider (1995), a young doctoral student at Case Western Reserve University, was helping a colleague, Al Jensen, do his dissertation on physician leadership at the Cleveland Clinic. They asked physicians to tell stories of their biggest successes and greatest failures. Cooperrider was drawn to the success stories and was amazed at the cooperation and innovation that took place in these success stories. With the encouragement of his advisor, Suresh Srivastva, and the permission of the clinic chairperson, Cooperrider decided to look at the data only in search of the positives. In a report to the board, Cooperrider and Srivastva (1995) called their method Appreciative Inquiry (AI). The result of this study was so powerful that the board requested this AI method be used at all levels of the 8,000-person clinic. This became the basis for conducting an organizational analysis using AI principles that were still in their formative stage (Cooperrider et al., 2005, p. xxiv).

Cooperrider (1995), still at Western, went on to write his dissertation on his work at the Cleveland Clinic. He created a scholarly logic for this new form of action research which is called Appreciative Inquiry. Cooperrider’s theory and methodology of human development refined the paradigm of how to look at change. Rather than using more traditional approaches to defining, analyzing, and solving a problem, Cooperrider proposed that managers look for what is working in an organization.

In 1986, Cooperrider (1995) completed his dissertation titled “Appreciative Inquiry: Toward a Methodology for Understanding and Enhancing Organization Innovations.” In that study, he proposed moving beyond the traditional theory of change management and the traditional question regarding change which asked, “What problems
are you having?” He felt that this approach leads people to look at the problem, perform a diagnosis, and decide on a solution. The result was a rather one-dimensional approach that emphasized deficiencies. This view of change management saw people and human systems as machines and as parts that are interchangeable. With the emergence of AI the question changed to, “What is working around here?” The AI focus is based on examining in organizations what is best and most valuable from the past (Watkins & Mohr, 2001, p. 11).

Cooperrider and Srivastva described in their 1995 publication, “Appreciative Inquiry in Organization Life,” the value of using AI for “discovering, understanding, and fostering innovations in social-organizations” (p. 6). As a result of Cooperrider and those who built upon his work, practical tools including trainers’ guidebooks and other planning and action instruments have been developed to foster the use of AI in a variety of organizational settings. Since 2000, the theoretical foundation of AI has been applied to action-research work that expands the use of democratic, participative, and collaborative techniques (not unlike those proposed by Servant Leadership advocates) to build on individual and collective interests and strengths in fostering innovation, organizational learning, and positive growth in organizations.

Appreciative Inquiry proponents assert that for organizations to grow they must shift the focus from thinking about what is wrong or not working, to what is working well. AI postulates that operating under traditional management theories will not optimize innovation or promote the creative human performance needed for organizational growth. Cooperrider (1995) states that "the questions we ask, the things that we choose to focus on, and the topics that we choose determine what we find. What
we find becomes the data and the story out of which we dialogue about and envision the future” (Watkins & Mohr, 2001, p. 28).

The first step in the AI process is selecting the positive as the focus of inquiry, because what is studied becomes reality. The future is consciously constructed upon the positive core strengths of an organization. Employees are one of the greatest, yet least utilized, resources in the change management field today. Linking the energy of this employee positive core directly to any change agenda suddenly and democratically creates and mobilizes topics never before thought possible (Cooperrider et al., 2005, pp. 29-30).

In the practice of AI, language matters. Hammond (1996) reflects that the language people use creates their reality, and Joseph Jaworski states, “It is through language that we create the world, because it’s nothing until we describe it. To put it another way, we do not describe the world we see, but we see the world we describe” (Watkins & Mohr, 2001, p. 13).

To summarize, as a backdrop to this study AI provided a mind-set that is in harmony with the strengths-based ideas proposed by Buckingham (2007a) and others. Like those approaches, AI seeks to heighten awareness of the strengths and potential of individuals in an organization, and to build upon those capacities by promoting innovation and creativity among people who work there. If HRMC is to tap into that positive core, people must spend more time appreciating and talking about the good things that are happening there. AI can help HRMC assess and create this mind-set to more fully engage employees’ strengths.
The next and final section of this literature review discusses Servant Leadership, the third stream of thought that served as backdrop to this study. It too is a positive approach to employee engagement because, like AI and other strengths-based practices, Servant Leadership nourishes positive attitudes and practices to promote what is best in people and in organizations. Servant Leadership emphasizes that leaders must make it one of their primary goals to nurture employees’ natural talents and skills by encouraging democratic, participative, and collaborative engagement in the workplace. Where Appreciative Inquiry served as a backdrop to the study, Servant Leadership became the venue from which I was able to explore what was happening among HRMC leaders regarding strengths-use in our hospital.

**Servant Leadership**

Much of healthcare has been embedded in the old approach of top-down management, in which employee focus is on trying to please a superior instead of taking care of the customer. Organizations must change this mentality and develop a culture of trust between managers and employees. Covey (2006) indicates that the first job of a great manager is to inspire trust. Covey maintains that when there is a high level of trust in organizations, employees do not need close supervision or control to become motivated (p. 319). Further, he asserts that trust brings out the best in employees and these companies become great places to work.

Gallup conducted a study from 2005 to 2008 to understand employees’ opinions about management (Rath & Conchie, 2008). People were asked to identify words that best described the most influential manager in their work experience. The number one word used by this group was “trust.” Gallup’s research on trust found that there is a very
close relationship between trust and employee engagement. The likelihood of employees being engaged at work when they do not trust their managers is a ratio of 1 to 12 (1 representing those who are engaged without trust, and 12 those who are not). This was quite different when compared to a ratio of 1 to 2 when trust exists (p. 83).

Covey (2006) states that financial success comes from success in the market place, and this comes from success in the workplace. He maintains that the heart and soul of all of this is trust, and trust is the ultimate source of managers’ influence (p. xxiv). One element of trust is a sense that employees feel that their managers are not only interested in the organization’s goals but also their own personal well-being. A global survey by Towers Perrin reports that only 38% of employees feel senior management is sincerely interested in their well-being (Gebauer et al., 2008, p. 16).

In addition, the research of Rath and Harter (2010) on well-being in organizations reinforces the importance of the manager’s role. They noted, “The most disengaged group of workers we have ever studied is those who have a manager who is simply not paying attention. If your manager ignores you, there is a 40% chance that you will be actively disengaged or filled with hostility about your job. If the manager is paying attention, even if he is focusing on your weaknesses—the chances of your being actively disengaged go down to 22%. But if your manager is primarily focusing on your strengths, the chance of your being actively disengaged is just 1%, or 1 in 100 (p. 26).

Block (1996) maintains that failing companies must focus on quality and service before the financial situation will change. He claims that for many people to make these necessary changes, a different kind of management is required. For Block, stewardship offers reform that puts management in the background. When people choose service over
self-interest they become accountable without controlling the world around them (pp. 5-6).

Gary Hamel (2007) argues that management has changed very little during the past several generations. He notes that hierarchies may have gotten flatter, and employees may be smarter, but they are still expected to obediently follow executive orders (p. 4). Hamel recommends “management innovation” as the way to change what managers currently do. One way to accomplish this may be to use the principles of Servant Leadership.

Servant Leadership Defined

Servant Leadership is a philosophy and practice of management, coined and defined by Robert Greenleaf in 1970, and supported by many leadership and management writers since then (The Robert K. Greenleaf Center, 2008). Greenleaf’s (1996) position was that servant-leaders achieve results for their organizations by giving priority attention to the needs of their colleagues and those they serve. Servant-leaders are often seen as humble stewards of their organization’s resources (human, financial, and physical). Greenleaf’s work emphasizes the need for this new management model where serving others—employees, customers, and community—becomes the number one priority (Spears & Lawrence, 2002, p. 3).

Servant-leader advocates maintain that the old concept of top-down management, in which those at the top carry the responsibility for the success of the organization, must change. James C. Hunter (1998) states that there are two ways to lead people: by power or authority. Power is the ability to force people to do their work and authority is the skill of influencing people, through example, to willingly do their work. There are a number of
examples of people using positive influence or authority over power to support this position. Jesus had all the power of heaven to assist Him but instead He used His personal life and influence—and, subsequently, people followed Him. The Reverend Martin Luther King, Jr. and Mother Teresa of Calcutta did not have any power over people, but through their personal example they both had a tremendous positive effect upon millions of people’s lives.

On the other hand, to make the changes necessary to achieve Servant Leadership, many organizations may require a new type of manager. The foundation for this change is presented in the philosophy and practice of Robert K. Greenleaf’s (1996) work. Greenleaf’s reading of Hermann Hesse’s *Journey to the East* precipitated his concept of what servant-leaders are and what they do. The Hesse story spoke to a belief that great leaders are seen as servants first, and this simple fact is the key to their greatness (Greenleaf, 1996). Greenleaf proposed that a new moral principle was needed where the only authority deserving allegiance was that to which the allegiance was freely given (Spears & Lawrence, 2002). Greenleaf (1996) assumed that people will freely respond only to those leaders who are proven and trusted as servants (pp. 3-4).

**Role of the Manager**

Stephen Covey (2006) contends that the role of the manager must change from one of outside-driven results to one who is a Servant-leader: one who draws out, inspires, and develops the best and greatest within each employee from the inside out (Spears, 1998, p. xii). Robert K. Greenleaf stated that the best test of Servant Leadership is whether “those served grow as persons; do they while being served become healthier,
wiser, freer, more autonomous, more likely themselves to become servants?” (Spears & Lawrence, 2002, p. 1).

Peter Drucker (2004) states that management’s job is not to change employees, but rather to grow them. Just as the Bible teaches in the Parable of the Talents (Matt 25:14-30), managers can multiply the performance capacity of each employee by utilizing their strengths (Drucker, 2004, pp. 98-99). Blanchard and O’Connor (1997) note that, in the past, managers have emphasized judgment, criticism, and evaluation rather than providing the support and encouragement that people need to be their best. Gary Hamel (2007) indicates that the challenge is to reinvent the management system. Hamel notes that current management systems in organizations often result in employees who use only a fraction of their capabilities. These organizations systematically under-utilize and under-perform the potential of their employees. Hamel maintains that this has to be changed to inspire employees to bring all of their abilities to work every day (p. 58).

Servant Leadership Principles in Practice

Examples of these principles in practice are found within the literature on Servant Leadership. Wallace and Graves (1995) cite their studies of public school systems and note that, because each student is an individual, comparing one student to the “average” student did not help but, rather, hindered their learning. One of the characteristics of Servant Leadership is commitment to growth of each and every individual within his or her institution (Spears & Lawrence, 2002, pp. 7-8). Wallace proposes instead that schools evaluate students on their progress toward goals rather than on how they compare to other students (Wallace & Graves, 1995, p. 23).
Zander and Zander (2000) agree that we cannot change people as it relates to the world of measurement, where people and things are fixed in character, but argue that in the universe of possibility, people can change. They state that managers have to stop demanding that it be “their” terms or conditions that dominate the workplace. It would be better for managers to remain open to the possibility that what they seek may already be in front of them. Benjamin Zander noted that after many years of being the conductor of the Boston Philharmonic Orchestra, he suddenly realized he did not make a sound. He said that the true power was derived from his ability to make other people powerful (p. 68).

Similarly, the lessons learned from Wallace and Graves (1995) and Zander and Zander (2000) apply to healthcare organizations. Hospitals like HRMC benefit when individuals come together and use their strengths to build committed teams working with each other to provide the very best possible services to its customers in a compassionate and efficient manner. Those who have the most impact and influence on these customers everyday are staff individuals. Therefore, it is the responsibility of current management to listen to staff and to champion Servant Leadership principles and practices. This requires that hospital management promote the contribution of each individual, and develop the collaborative work relationships that serve their customers compassionately and well, even given the current turbulent times.

In summary, the literature on Servant Leadership provides insight on how to lead healthcare and other organizations through the challenges that lie ahead. Healthcare is provided by many individuals, and if management does not shift away from trying to control and force people into a machine-like world of doing things the same way over
and over as they have been done for years, hospitals will not meet their potential for the future. The future should be a world where creative self-expression and embracing systems of relationships are the focus and there is no such thing as separate individuals (Spears, 1998, pp. 343-344). Servant Leadership literature provides a mind-set to organizations like HRMC on how to develop trust in the workplace, practice and promote stewardship of resources, and function in a way that is more democratic in order to nurture employee engagement. These practices can help hospitals to survive and excel in the current and future healthcare environment.

Summary

Strengths-building, Appreciative Inquiry, and Servant Leadership literature offer both unique and often complementary perspectives on how individuals and organizations can improve workplace satisfaction, productivity, and customer satisfaction and loyalty. They come together in my study by informing the research questions, data collection, and analysis processes I used. Key points from this literature that underlie the successive stages of the study include (a) the need for greater self-awareness and knowledge of one’s own strengths and passions and how using them can have a positive influence on others and can contribute to organizational growth; (b) the role of managers in promoting people’s strengths so that employees may be more engaged, satisfied, and motivated at work; and (c) the importance of leaders in valuing employees and developing new paradigms for organizations that emphasize individual self-awareness and management responsibility in building trust and reaffirming what is positive and working in an organization.
Although the literature on Appreciative Inquiry and Servant Leadership initially served as backdrop to my more concentrated focus on strength-use at HRMC, Servant Leadership moved more to the forefront in my examination of how HRMC leaders’ attitudes and values affected the promotion of strengths-use and employee well-being at HRMC. I wanted to know whether managers saw their leadership responsibility as serving those with whom they work, or if they viewed themselves as part of a more traditional hierarchical ladder that they had to climb in order to achieve leadership rank at HRMC.

Chapter 3 of the study elaborates further on the links between the research questions, the literature, and the data collection methods.
CHAPTER THREE

METHODOLOGY

This study explored managers’ use of strengths factors which supported or hindered their use at Hackettstown Regional Medical Center (HRMC) in Hackettstown, New Jersey. The strengths referred to in this study are those dominant strengths identified by Buckingham and Clifton (2001) in their StrengthsFinder Profile tool, a multimillion-dollar effort developed from over 25 years of study and research (Appendix A).

Strengths-use was chosen as the focus of this study for several reasons. One reason was that HRMC’s executive team had supported implementation of the StrengthsFinder Profile (SFP) for several years prior to the study, and I as CEO had often discussed with them the Gallup supposition that if people are building on their natural passions, talents, and skills at work, their colleagues and the organization would benefit as well.

Gallup’s research on strengths building indicates that if an organization can increase the amount of time employees use their strengths on the job, the result can be increased productivity, customer satisfaction, reduced employee turnover, and increased bottom line profitability (Buckingham & Clifton, 2001). I had chosen the SFP tool developed by Clifton and Buckingham as a starting point from which to provide hospital executives, managers, and staff an opportunity to identify and build on their personal strengths in the workplace.
Specifically, this study focused on HRMC managers, and examined the degree to which they were currently using their strengths on the job, and those conditions and factors that supported or hindered the use of their identified strengths. Managers were chosen as a focus of this study because throughout the healthcare sector, managers are shouldering more responsibility with fewer resources. Management may find themselves moving into roles and taking on tasks that they are not suited to undertake. By identifying and capitalizing on strengths, managers may have greater likelihood of seeking opportunities in their organization that are good matches for their talents and skills.

As both Gallup and Appreciative Inquiry literature indicate, successful managers do not focus on fixing employee weaknesses; instead, they concentrate upon looking at what is working in an organization and improving areas of strength. In addition, just as the Servant Leadership literature emphasizes the role of the manager in building trust and working collaboratively with colleagues to promote innovative ideas and practices, other research contends that managers have more of an impact on improving areas like employee satisfaction and productivity than the executive team does (Wagner & Harter, 2006).

This chapter describes the theoretical framework for the qualitative research methods I used in the study, the sample and instrumentation, my data collection strategies, and the approach to data analysis that I used in this study.

**HRMC and the StrengthsFinder Initiative**

Since 2007, more than 200 HRMC employees have identified their strengths using the StrengthsFinder Profile. This is approximately 35% of full-time staff at HRMC. People across multiple levels in the organization (executives, managers, and staff) and
within both clinical and non-clinical departments at HRMC have participated. A number of retreats, workshops, and coaching sessions with hospital groups and departments were conducted to follow up with some of those who took the StrengthsFinder Profile.

Buckingham’s (2007a) research indicates that while over 2 million people have taken the StrengthsFinder Profile in organizations, when asked, “What Percentage of a typical day do you spend playing to your strengths?” only 17% respond “most of the time” (p. 11). Simply put, identifying strengths does not appear to substantially increase the amount of time they are used. I wanted to examine whether this was or was not the case at HRMC.

Furthermore, research exists on how managers and others can increase the use of strengths by taking personal responsibility for pushing them forward in the workplace; however, less is written about conditions or factors in the work environment that support or hinder the use of strengths. I was interested in investigating if and how managers were using their strengths at HRMC, and if not, why not. The goal of this study was to explore what was going on with regard to managers’ strengths-use at HRMC.

**Research Design**

This section introduces the theoretical background of the research design, an explanation of why I selected qualitative research methods using a case study and focus groups, the setting and population for this study, and a discussion of the instrumentation I used and of the Pilot Study that was conducted. In addition, this section describes the data collection process, including how participants were recruited and selected, and how the data collection proceeded.
Theoretical Background

This study used a qualitative research design utilizing a single case study with focus groups for data collection. The unit of study for this dissertation research was Hackettstown Regional Medical Center in Hackettstown, New Jersey, a rural acute care facility.

The study’s design was built from Creswell’s (2003) recommendation that a qualitative study should address one or two central research questions followed by no more than five to seven sub-questions. It also followed Creswell’s suggestion of posing research questions consistent with the emerging methodology of qualitative research so as to not constrict the inquiry (pp. 105-107).

Consequently, the two primary research questions the study addressed were: “To what degree have managers who have taken the StrengthsFinder Profile been utilizing their strengths at HRMC?” “Degree” here was initially defined as percentage of time managers and others are using their strengths “most of the time” while at work. The second question was, “What conditions and factors within HRMC promote or hinder managers’ use of their strengths on the job?” The term “condition” as used in this study was considered to be an existing circumstance in the HRMC work environment that supported or hindered employee use of their strengths at work.

A condition included circumstances out of the control of the manager, which if changed could make a difference to his or her use of strengths on the job (e.g., organizational structure, training, and resources—human, financial, physical). The term “factor” as used in this study referred to a specific circumstance, element, or fact that had some bearing on why people did or did not use their strengths at work (e.g., knowledge or
skills on how to apply them, time restraints, incentives or motivation, leadership support).

The sub-questions developed for this study are located in Appendix E.

**Qualitative Research Methods**

The rationale for the use of qualitative methods in this study was grounded in research practice. Miles and Huberman (1994) stated that in most qualitative studies the researcher has an idea of the parts of the phenomenon that are not well understood and knows where to look for these things as well as some initial ideas about how to gather the information (p. 17). They describe several recurring features of qualitative research, as follows:

1. Qualitative research methods handle an inquiry where the researcher wants to gain a systemic, encompassing, integrated overview of what is being studied.

2. Prolonged researcher contact occurs with a typical or normal life situation reflective of the everyday life of individuals, groups and organizations.

3. There is a situation where the researcher wants to capture data on the perceptions of local actors from the “inside” through a process of attentiveness, empathy and bracketing of preconceptions about the topic under discussion. (p. 6)

In addition, other researchers maintain that qualitative research is oriented toward exploring, describing, and explaining something. Creswell (2003) proposed that qualitative research is a form of inquiry in which the researcher makes an interpretation of what he or she sees, hears, and understands. He supported collecting data in the field where the participants experience the issues under study. As Creswell proposes, I focused on learning the meaning that the participants in my study held about the matter that I was studying (pp. 175-176).

Krathwohl (1998) maintains that qualitative researchers typically view participants whom they observe or interview as collaborators or teachers from whom they
learn. Similarly, one of my key practices throughout this study was to focus on understanding strengths-use from the participants’ perspectives, not that of the researcher (p. 4). I looked closely at the verbal descriptions people used to portray strengths-use at HRMC; qualitative inquiry techniques were what I used to interpret what others were saying.

Case Study and Focus Groups Methods

Robert K. Yin (1984) defines the case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between a phenomenon and context are not clearly evident (p. 23). Furthermore, Berman and McLaughlin (1978) avow that to examine a change, researchers should consider how it was adapted within each setting. Louis and Miles (1990) support this notion by stating that a case study is a way to explicate the ways that people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations (p. 6). Fullan (1993) adds that conducting analysis on a case-by-case basis will help researchers to better understand the factors at work in individual settings, and that understanding can result in better practices.

Sharan B. Merriam (1998) contends that qualitative inquiry is an attempt to understand a situation or behavior as a part of a particular context. This understanding is not to predict what is causing a particular situation, but more to understand why the situation is occurring. McMillan and Schumacher (1997) maintain that case studies are appropriate for exploratory and discovery-oriented research. They also relay that qualitative research using a case study approach means the data analysis focuses on one
phenomenon and tries to understand it in depth, “regardless of the number of sites, participants, or documents for a study” (p. 393).

Consequently, this dissertation study employed a case study approach to examine the context in which HRMC managers work in order to better understand why they were or were not using their strengths at work. Focus groups were the primary vehicle for collecting the data. The advantage of focus groups over other qualitative techniques, such as participant observation or individual interviews, was that group interactions allowed me to collect a large amount of data on the topic of interest in a limited amount of time. Furthermore, focus groups permitted me to learn participants’ attitudes and opinions on my research topic (Morgan, 1997, pp. 7-21).

Site Selection Procedure

Hackettstown Regional Medical Center was selected because HRMC has been doing a large-scale implementation of the SFP tool for over 3 years. HRMC’s executive team is committed to ongoing employee use of the SFP and I, as President and CEO at HRMC, had access to the pertinent records on who had taken the SFP, thus ensuring greater feasibility of completing this study.

Population

The population for this study was comprised of the full-time executives, managers, and staff from HRMC who took the SFP from January 2007 through June 2009. The identified population consisted of 200 possible participants, approximately 35% of the number of full-time staff. That was narrowed down based on the number of those people still working at HRMC, the number of volunteers who self-selected to be
part of the study, the number of focus groups and participants that research suggested as reasonable for a qualitative study of this nature, and time and resource constraints for conducting the study.

Because this was a qualitative study, purposive sampling was used. That is, the entire population of people who took the SFP at HRMC, and who had knowledge or experience with the area being investigated, were considered potential participants for the focus group sessions. The detailed procedures for inviting volunteers, segmenting them into focus groups by targeted work categories, and selecting and notifying people are described in detail in the Data Collection section of this chapter.

**Instrumentation**

A Focus Group Facilitator Guide contained the study’s initial sub-questions which linked back to the dissertation’s two general research questions (see Appendices B–E). At the beginning of each session, participants were asked to sign an Informed Consent Form that they had previously received (Appendix C). In addition, they were to provide some brief demographic information before the session began (Appendix D). Beyond that, Focus Group questions were sectioned by focus group worker type: employee, manager, and executive (Appendix E). Those questions addressed where and when managers appear to be using their identified strengths on the job, and asked for observations on conditions that support or hinder managers’ use of strengths at HRMC.

Group sessions were audio-taped, and transcription was done by a project assistant as backup to the audiotape in the event any mechanical problem occurred. Like the participants, the project assistant signed a confidentiality agreement (Appendix F), and removed from the transcripts any personal or departmental identifiers to maintain the
confidentiality of the participants. With the names removed, I was able to read about what happened in each session without attributing it to a particular person. Once transcribed, I encoded and analyzed the data.

Prior to the focus groups, a Formative Committee was invited to meet and confer with me on the appropriateness, usefulness, and precision of the focus group questions I had developed. The Formative Committee members consisted of people representing each of the study’s focus groups: an executive, a clinical staff person who also represented the clinical manager role, one non-clinical manager, and one non-clinical staff person. All members had been at HRMC for at least a year, had taken the SFP, and had demonstrated an interest in its use at HRMC. Formative Committee members did not participate in the actual focus groups. They also signed a Confidentiality Agreement to assure that they would keep the focus group sessions and verbal and written material confidential and not share it within HRMC or elsewhere outside of the context of this dissertation study (Appendix G).

Prior to the Pilot Study, I met with professional consultants I had hired through Adventist Healthcare’s Education Institute (E.I.) to discuss their role in facilitating the Pilot Study and focus groups. The consultants also met with me after each focus group session to debrief on the interview questions and the process for conducting the focus groups. They too signed a Confidentiality Agreement (Appendices B–E, H). The independent consultants were professionals with advanced graduate degrees who had conducted focus groups in the past; they were familiar with the SFP tool and Buckingham’s (2007a) work.
As mentioned previously in chapter 1, because I am the President and CEO of HRMC, the use of these consultants allowed me to be in charge of organizing the data collection phase of the study and to get regular progress reports. In addition, using consultants maintained the confidentiality of the participants’ comments. This also helped me control for bias in my data analysis.

It must be noted that, consistent with the emerging methodology of qualitative research, some of the focus group questions changed in a manner consistent with the assumptions of an emerging process. Therefore, my debriefs with the facilitators provided me with information on key messages from the groups and insight on whether further reformulation of the questions was necessary to support my study’s goal and the two primary research questions. In addition, I kept a log documenting the debrief sessions, thus recording my responses to what I had heard in the debrief sessions and what I had read in the review of each group’s transcript. This is reported on further in subsequent sections of this chapter.

**Pilot Study**

Designing a good instrument involved testing my questions to ensure they could be asked and answered in a form to obtain the information I was studying (Fowler, 1993, p. 115). Consequently, the focus group questions were pilot tested under my direction by the two independent facilitators I had hired. Prior to conducting the Pilot Study I met with my Formative Committee to discuss the purpose of the study, the focus group format and questions, and the schedule for running the focus groups.

Several changes were made to the questions as a result of the committee members’ recommendations. The first recommendation they made pertained to the
question asking employees about their managers’ strengths-use. A committee member felt that the staff may not know what their managers’ strengths are as defined by Gallup, or feel comfortable estimating percentage of use. Members felt it was important that staff not get caught up in “Gallup verbiage” but rather that they understood and could speak to the concept of strengths. As a result, I provided more precise guidance in the Facilitator Guide on this matter. I also agreed to provide instructions to the facilitators on how to gather the information I was looking for prior to their conducting the Pilot Study.

Another recommendation the committee made was to change wording in one of the questions in order to invite a more open-ended response. That change was also made. Further, I followed up on another suggestion to add a question to the demographic data information sheet asking people if they had taken any training on the SFP beyond learning their SFP results. Finally, a committee member proposed asking people directly how much time they spend using their own strengths at work, both to get people engaged early on and to see if people are thinking in terms of percentage of use.

That change was made and resulted in a modification to the definition “degree” of use as originally proposed in this study’s research questions. The original research question was: To what degree have managers who have taken the StrengthsFinder Profile been utilizing their strengths at HRMC? “Degree” was defined as percentage of time managers and others who work with them perceive that managers are using their strengths “most of the time” while at work. In the revised question, the definition of “Degree” was changed to the percentage of time managers perceive that they are using their strengths “most of the time” while at work.
Conducting the Pilot Study

Since the scope of this study and time and resource constraints did not warrant more than one Pilot Study, I made the decision to do one Pilot Study with participants from each of the categories of participants making up the study’s homogenous focus groups. Therefore, the Pilot Study participants consisted of a non-clinical staff person, a non-clinical manager, an executive, one clinical staff member, and a clinical manager.

The Pilot Study was conducted by the two facilitators hired to conduct the five focus group sessions. This allowed both facilitators to practice using the Facilitator Guide and focus group questions, and to interact with participants similar to those whom they were likely to meet in their focus groups.

Pilot Study Feedback

Overall, participants responded favorably to the Pilot Study format and questions (Appendix B–E). In their feedback participants noted that they were aware that their group makeup was more heterogeneous than the typical groups in this study, and commented that while they were not uncomfortable with each other, their comfort level was likely due to the fact that they were not in reporting relationships to each other. One person stated that if her boss were there, she was uncertain if she would have been as candid. Pilot study participants agreed that a homogenous makeup of the groups would probably elicit more open responses than if the groups were mixed across worker types.

Other feedback included the suggestion that facilitators should place more emphasis at the beginning of the session on the study’s goals; although they were stated, participants said they would have appreciated knowing more about how the focus groups fit into the larger reasons for the study.
Pilot Study Debrief

The two facilitators who conducted the Pilot Study noted that while participants were engaged in the discussion of strengths-use, they didn’t seem to get beyond strengths as identified in their SFP results. One facilitator commented that although people were comfortable talking about their own strengths, they were less comfortable in discussing managers’ strengths, nor did they seem to grasp the larger implications of strengths-use for the wider organization. Another point that was addressed was that Pilot Study participants rated their own strengths-use quite high (from 75-90%) in comparison with what Buckingham’s (2007a) research noted at 17% of use “most of the time.” This was of concern to me: I was curious about the disparity between the Pilot Study participants’ perceptions of their strengths-use findings versus Buckingham’s findings. As a result, I decided to closely observe the percentage of strengths-use responses in the focus groups. I also modified the focus group questions somewhat based on the feedback I received from the Pilot Study (Appendix E).

Data Collection

This section describes the data collection process which included the recruitment and selection of volunteers from the people who took the SFP at HRMC, an explanation of the sampling strategy, a discussion of how focus groups were conducted to collect the data, and information on the data analysis procedure. Additional details on the work plan for this study are supplied in Appendix I.
Recruitment and Selection Process

An introductory letter with return response deadline was sent via email to all who took the SFP to explain the purpose and timeframe of this project. It stated that although I was the researcher conducting this study, in order to avoid my influencing their candor or responses because of my role as President and CEO of HRMC, study participants would not be directly interacting with me. The letter asked if they were interested in participating and told them that they could indicate their interest via their reply to the email.

Once responses were received, a follow-up email was sent to those who indicated an interest in participating. It restated the purpose of the project, explained the risks and benefits of the project, gave the timeframe for when the groups would meet, and described how confidentiality of responses would be maintained. With that email, volunteers received a copy of the Demographic Data form and the Informed Consent form that they were expected to sign; it was witnessed by the facilitator before a focus group discussion began. Participants also received a list of their strengths from their SFP results.

Furthermore, participants were told that in order to protect participant confidentiality, each focus group would be facilitated by an independent consultant and audio-taped with a note-taker present to ensure accuracy in recalling and transcribing that data for my analysis. Participants were assured that all identifying information (such as their name or department) would be removed from the transcripts that I received.

The selection process segmented participants into homogeneous work groups. Homogeneous groups were defined as groups that were sorted into one of five worker
types: executives, clinical staff, non-clinical staff, clinical managers, and non-clinical managers. This decision was based on Morgan’s (1997) recommendation that segmentation of study participants into homogenous groups typically allows for more free-flowing conversations among participants about the topic, and participants feel more comfortable in speaking to each other. In addition, homogenous group data facilitate analyses that examine differences in perspective between groups (p. 35).

It must be noted that my goal in the selection process was homogeneity in worker type, not homogeneity in attitude, gender, or race. Once participants were identified, it was also important for me to determine the likelihood of a particular group of participants being able to comfortably discuss the topic in ways that were useful to my study (Morgan, 1997, p. 38).

I followed Morgan’s (1997) rule of thumb for focus groups in a project like mine that there should be three to five groups, comprised on average of three to seven people per group, because there is a saturation point at which additional data collection no longer generates new understanding (p. 43). Morgan also noted that the degree of homogeneity among groups (e.g., as in this study by worker types), the degree of structure of the interviews, and the sheer availability of participants affects the amount and quality of data (pp. 44-45).

Subsequently, this study had five separate focus groups, each group segmented by worker type. Furthermore, another goal of my selection process for focus group composition was to get participants from as many of the hospital departments as possible. I also took into consideration that some departments may have had fewer or larger numbers of participants take the Profile in proportion to their staff size in the
Conducting the Data Collection

Each focus group met for approximately 2 hours with an independent facilitator. Facilitators reported that all five members of each focus group appeared on time, and stayed for their entire session. The initial Facilitator Guide and focus group questions that were used are appended (Appendices B–E). As described earlier, to control for potential bias in the study, independent consultants were employed and managed by me. Those consultants conducted the focus groups as well as the Pilot Study. A project assistant recorded meetings and typed the transcription for all the groups. During two of the five focus groups some problems occurred in taping the sessions; the project assistant captured the discussion via note taking. The audio files that were recorded were transcribed in a way that did not identify any individual and were given to me. The focus group schedule took into consideration the work hours and rotation schedules of the clinical staff.

The First Focus Group: Non-Clinical Staff

After the first focus group with non-clinical staff, I held a debrief session with the facilitator and learned that similar to the Pilot Study participants, non-clinical staff participants described their strengths-use at higher levels than Buckingham’s (2007a) research indicated. Also, like the Pilot Test participants, non-clinical staff talked about strengths-use mostly in terms of their job tasks and skills. It was unclear to me whether
their responses were influenced by the group discussion or the questions being asked, or whether the facilitators’ did not fully understand what I was looking for. However, because of the compressed time period between the first and second focus groups, the transcripts of the sessions were not ready for me to review to determine what was going on prior to going on to the next session. Therefore, I made a decision to build more emphasis on strengths as natural passions and talents into a subsequent and final set of focus group questions (Appendix E). I also asked facilitators to reiterate that emphasis not just at the beginning of each session, but also throughout their entire focus group discussions. Eventually, all questions for the remaining focus group sessions were broken out by group type (i.e., employee, manager, executive) to minimize any possible confusion for facilitators on those questions that were specific to each group they were conducting (Appendix E).

Furthermore, that revised set of questions asked respondents in all of the four remaining groups about their “Degree” of strengths-use. Because I was still wondering why participants were assessing their strengths-use at such high levels, I decided to ask participants from all subsequent groups (the clinical staff and executive groups, as well as the clinical and non-clinical manager groups) to complete an anonymous self-report question regarding their strengths-use at the end of their focus group. My thinking was that people might rate themselves differently if the question about degree of strengths-use was asked separately from their larger group conversation. Moreover, I wanted to see if participants’ degree of use self-reports reflected a hospital-wide pattern, and if so, why this might be happening. After that, no further changes were made to the focus group questions.
Data Analysis and Interpretation

Data analysis began once the first focus group audio file was transcribed. Creswell (2003) described a process for data analysis that I followed: preparing the data for analysis, moving deeper and deeper into understanding the data, representing the data, and making an interpretation of the larger meaning of the data (p. 190). I first examined each transcript to get an overall impression of what was being said and the general ideas that seemed to be emerging. Then my data analysis entailed encoding the transcripts of each focus group and reviewing my notes from the post-focus group debrief session I held with the facilitator. After that I developed a coding process that allowed me to conduct a more detailed analysis to go deeper into the transcript data and examine participants’ perspectives across topics, within a group, and across groups.

Coding the Data

The following section describes the stages of data collection and analysis. This includes my review of transcripts, the debrief sessions, and changes made to the focus group questions and format. Also described here are the processes I used for coding the transcript information and the themes that emerged from the coding process.

As discussions evolved from my initial Formative Committee session through the post-Pilot debrief session on how best to frame and facilitate the Focus Group questions, it became clear that implementation of strengths-use at HRMC involved a change process, that is, a practice that is perceived as new by an individual or another unit of adoption (Rogers, 1983, p. 11). I subsequently reviewed material that summarized 10 years of research on conditions that support or hinder change in organizations.
(Ely, 1990; see also Surry & Ely, 2001). Ely’s synthesis then became a vehicle for me to think about what supports or hinders strengths-use at HRMC.

Ely’s (1990) synthesis of research cited eight key conditions, important to implementing change in organizations. They are (a) Dissatisfaction With the Status Quo; (b) Knowledge and Skills Exist; (c) Participation is Expected and Encouraged; (d) Resources are Available; (e) Rewards and Incentives Exist; (f) Commitment; (g) Leadership is Evident; and (h) Time. These conditions appear to hold true for both technological and non-technological changes, and traverse institutional and cultural boundaries. Although my study was not specifically examining the SFP in the context of a larger adoption-diffusion process, I found Ely’s conditions helpful as an initial filter for developing codes and assessing focus group comments on factors and conditions that supported or hindered strengths-use.

Codes

Many of Ely’s (1990) conditions appeared in the Pilot Study transcripts. Initially, all eight conditions were coded, and other codes were also developed to account for activities, perspectives, relationships, and the work environment and culture (Creswell, 2003, pp. 179-199). The resulting 45 codes were then applied to analysis of the non-clinical staff and non-clinical managers’ transcripts. Definitions were ascribed to each code.

Based on Miles and Huberman’s (1994) suggestion that “definitions get sharper when two researchers code the same data set and discuss their initial difficulties” (pp. 60-61), I invited a colleague from the Education Institute, who had some background in qualitative research, to join me in the coding exercise. The outcomes of the double-
coding exercise identified a number of codes that were either redundant or supplied little information.

Consequently, I combined some of the codes and refined their definitions so that they could be used consistently across the remaining groups. This resulted in 21 codes that were used for the other three focus groups; also, I re-coded the non-clinical staff and non-clinical managers’ groups to assure consistency in my coding across all five groups. Among the remaining 21 codes, six of the original conditions cited by Ely (1990) were retained. Eventually, the 21 codes were reduced even further according to the larger theme patterns that emerged in the analysis (Appendix J).

Counting and Displaying the Results

Morgan (1997) proposed that quantitative uses of coding are “both obvious and useful in analyzing transcripts from focus groups” (p. 61). He also asserted that “coding that is truly at the group level often requires judgments beyond aggregating codes,” and that he often presents “simple counts of codes without performing any statistical tests” (pp. 60, 61).

Following Morgan’s (1997) approach, I decided to develop an Excel spreadsheet with separate worksheets for each focus group in order to be better able to count and visually compare and contrast the coding results within a given group and across groups. I did not want to overemphasize this numerical count, but rather to use it as a way to look for response patterns within a group and across groups. Therefore, I transposed the narrative text from the transcripts into columns on each group’s worksheet and standardized the format in the chronological order that information occurred in a discussion. Columns were labeled by the following:
1. The order a comment appeared chronologically in the transcript
2. Group name (e.g., non-clinical staff)
3. The unique identifier assigned to each person in the group (e.g., P1, P2-P5)
4. The page where a given comment appeared in the transcript
5. The specific comment
6. My researcher notes copied from the transcript
7. A column for other notes on any recurring themes or patterns that seemed to be emerging in the group
8. Separate columns for each of the 21 codes used for labeling the comments in the transcript.

I was then able to sort by person, comment, and code to look at patterns that were emerging about strengths-use at HRMC, and about factors and conditions that supported or hindered strengths-use. After that, I tabulated each separate code on each worksheet by focus group and then summarized total usage by code across groups.

I then combined codes that seemed to have some overlapping implications into three major clusters so that I could look more closely at what was happening within and across groups. This was done “to separate out the topics or themes that were more important from those that are less important” (Morgan, 1997, p. 64) and then develop a portrayal of themes that seemed most important in answering the research questions (Appendix J).

Separating Out the Themes

The first cluster of codes represented 31% of the data and pertained to the first theme Foundation in Place. It related to satisfaction and dissatisfaction with the status
quo and whether knowledge and skills existed to support strengths-use. These four codes were used to assess the following: (a) Strengths-use among the respondents to determine if they knew what their individual strengths were, (b) if they did, whether they were using them in their job and/or in the broader work setting, and (c) whether they thought that strengths-use was necessary at the individual, team (department or unit), and corporate levels in their organization.

Subsequently, the larger theme pertaining to participant perceptions of strengths-use at HRMC emerged.

The second combination of codes accounted for 20% of the coded data and pertained to whether leadership and commitment existed in supporting use of strengths on the job. Leadership was defined here as being both the executive and manager levels, particularly because at HRMC managers and directors are viewed as part of the leadership team. Commitment was defined and coded as leaders showing visible support for strengths-use; simple verbal endorsement of using strengths did not constitute commitment. This combination of data led to the larger theme of Leadership Role in Strengths-use.

The final combination of codes accounted for 34% of the coded data. Those codes covered work-related demands that may hinder use of strengths like multiple initiatives, competing priorities, and short- versus long-term planning. The combination also included participant perceptions of resource constraints, that is, the perception that finances, personnel, and materials needed to successfully carry the use of strengths on the job are not available or easily accessed. Time was another factor within the indicators of work-related demands, and was coded as such when participants felt that there is no time
to learn more or use their strengths, either from the organizational end or the person’s own willingness to do so.

The largest category in this cluster was given the code name ECO, and pertained to work environment (working conditions), work culture (the meanings and behaviors groups of people develop and share over time), and organizational support (the extent to which people perceive that their contributions are valued by their organization and that the organization cares about their well-being. This combination of data comprised the larger theme of *Environment, Culture, and Organizational Support for Strengths-use*.

There were seven additional codes that accounted for the remaining 15% of the data. Since they didn’t fit into one of the three major categories or combine to create any overarching theme, if there were comments that bore some relevance to one of the three major themes they were incorporated into the appropriate theme sections of the findings.

**Limitations of the Study**

This study was limited to the staff and management team of Hackettstown Regional Medical Center, a 111-bed acute-care hospital in New Jersey. Different hospitals may have a different management structure and philosophy, issues, and challenges; therefore, the findings cannot be generalized to other organizations.

A limitation of the study was the need to control for a possible Hawthorne effect: that is, the impact of my being the researcher and the hospital’s President and CEO on the study participants or setting, notably in changing their behavior. As cited both in chapter 1 and earlier in this chapter, I recognized that in many qualitative studies the self as instrument is integral to the study. However, that was not the case in my study: I was not
able to be instrumental in the actual focus group data collection process due to the need to lessen the potential for bias by maintaining participant confidentiality.

While I did organize and monitor the entire data collection process, I was very much aware of the implications of not being able to hear firsthand what participants had to say. On the one hand, I recognized that because of my role as CEO, if I had personally facilitated these groups, I might have had people parroting back things they heard from me in the past. On the other hand, as I read the focus group transcripts I realized that if I had been able to facilitate the groups, I could have drilled down further in some areas where I felt the questioning had not gone far enough to get to the heart of the matter at hand.

There was another limitation with regard to the use of volunteers who may have shown bias in choosing to take part in the study. To minimize this effect, advance communications to potential volunteers alerted them that the President and CEO would not be conducting the focus sessions. Communications also conveyed that anonymity of responses would be maintained, and that there were no tangible rewards or other incentives to participate. Another limitation of the study related to volunteers was that participants of the study had first volunteered to take the StrengthsFinder Profile survey and then these volunteers made a second decision to participate in a focus group. This purposive methodology limited the possibility of random participation and thus made generalization to the entire population problematic if not impossible. However, the data from focus groups is by nature not generalizable, so this is a minor limitation of the study. The purpose of the study was to determine the impact of taking the StrengthsFinder Profile survey on the individual’s utilization of personal strengths.
Construct validity, that is, where a test or measure behaves as the definition of the construct predicts that it should, may also have been a limitation of this study. This could apply to how individuals interpreted the meaning of the focus group questions, particularly the use and interpretation of the terminology pertaining to strengths. To lessen this effect the goal was to use consistent communication with potential volunteers in describing what is being studied. Furthermore, the Formative Committee work, the pre-sessions with the facilitators, and the Pilot Study helped foster consistency of the construct language.

A final limitation of the study was its dependence on the StrengthsFinder instrument. Again as a purposive study, the intent is to measure and record the effectiveness of the StrengthFinder Profile tool on individuals at a particular place and time in its utilization. This study will not measure the effectiveness of all tools used to increase performance or engagement of employees; it is a single study of a specific instrument. However, there is vigor in the study as it establishes a methodology of case study for assessing such instruments, whether it is the StrengthFinders Profile or another model or tool.

**Institutional Review Board**

All protocol requirements by the Institutional Review Board (IRB) of Andrews University were followed in this study. I submitted the Application for Approval of Research Involving Human Subjects Form before starting the study and included a research protocol, participant engagement protocol, and an informed consent that were reviewed and signed by each participant of the study. I verbally reinforced that participation in the study was strictly voluntary and participants could drop out of the
study at anytime without penalties or loss of benefits to which they were entitled. There also was no implied liability or invasion of volunteers’ privacy.

**Summary**

This section reported on the background of the HRMC StrengthsFinder initiative, the research design, and the theoretical basis I used for the qualitative approach I took in this study. It described the setting, population, and instruments used. Further, it presented the Pilot Study process and results to confirm the appropriateness of the study questions, and a description of further changes made to the group questions after the non-clinical staff focus group was conducted. In addition, this chapter explained ways I used debrief sessions and kept a log to stay abreast of what happened in the focus groups.

This chapter also described the procedures I used for the recruitment and selection of participants from the larger population at HRMC who took the SFP. It introduced my approach for coding the collected data, and the three major themes that emerged based on the research questions, the coded data, and energy that certain topics seemed to generate among the participants. Finally, this chapter detailed some of the limitations of the study and provides information on what I sent to the Internal Review Board (IRB) at Andrews University.

Chapter 4 reports my findings given the demographic information and percentage of strengths-use data I collected in this study. In addition, the three major themes that emerged from the focus groups are explored further in chapter 4. My interpretation and reflection on what was learned are then described in chapter 5.
CHAPTER FOUR

RESULTS

This chapter contains information gathered from the five groups participating in the study at Hackettstown Regional Medical Center (HRMC) in Hackettstown, New Jersey. Information was collected from the five homogenous facilitator-led focus groups comprised of non-clinical staff, non-clinical managers, clinical staff, clinical managers, and HRMC executives. The research questions underlying this study were: “To what degree have managers who have taken the StrengthsFinder Profile been utilizing their strengths at HRMC?” and, “What conditions and factors within HRMC promote or hinder managers’ use of their strengths on the job?”

The first section opens with demographic information about each group and participant responses to questions pertaining to the degree of use of strengths at HRMC. The following three sections elaborate on three major themes that link to the study’s original research questions and the demographic information and perceptions on the degree of strengths-use at HRMC. The theme sections provide a lens for more closely examining what people said in response to questions regarding what supports or hinders strengths-use at HRMC. Themes are reflected upon by me in light of the theoretical framework discussed in chapter 3.

The first theme, *Foundation in Place*, describes staff, manager, and executive knowledge and use of their individual strengths at HRMC. The second theme, *Leadership*
Role in Strengths-use, provides insight on how leaders promote and hinder strengths-use at HRMC. Both the executive level and clinical and non-clinical managers comprise the HRMC leadership team. The third and final theme of this chapter, Work Environment, Culture and Organizational Support, describes other factors and conditions which participants said affected their use of strengths.

**Demographic Information**

Participants were asked at the beginning of their focus group session to complete a demographic information sheet which included their name and current title, the department or unit they are affiliated with and their current role, whether their work is designated as clinical or non-clinical within the hospital, the length of time in their current department, the overall number of years of service at HRMC, the year they took the SFP, and whether they had any additional training on the SFP.

**Years of Service at HRMC**

Tables 1 and 2 reflect what focus group participants reported as their years of service at HRMC, and the amount of time they had been in their current department. A discussion of the results follows.

Three out of the five non-clinical staff had fewer than 5 years of experience at HRMC, with four out of five having 10 years or less experience at HRMC. One person was in the middle range; no one in the non-clinical staff group had more than 11.5 years of experience working at HRMC. All of the non-clinical staff data seem to indicate that the staff is currently working in the department/unit where they started.
Table 1

*Years of Experience at HRMC*

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Years</th>
<th>Non-clinical staff</th>
<th>Non-clinical managers</th>
<th>Clinical staff</th>
<th>Clinical managers</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-5</td>
<td>6-10</td>
<td>11-15</td>
<td>16-20</td>
<td>21+</td>
<td>Average</td>
</tr>
<tr>
<td>Non-clinical staff</td>
<td>1.8</td>
<td>7.0</td>
<td>11.5</td>
<td>20.0</td>
<td>11.5</td>
<td>5.54</td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-clinical managers</td>
<td>4.0</td>
<td>5.5</td>
<td>20.0</td>
<td>32</td>
<td>27.40</td>
<td>8.30</td>
</tr>
<tr>
<td></td>
<td>2.0</td>
<td>10.0</td>
<td></td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical staff</td>
<td>3.0</td>
<td>8.0</td>
<td>20.0</td>
<td>21</td>
<td>12.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical managers</td>
<td></td>
<td></td>
<td></td>
<td>20.0</td>
<td>32</td>
<td>27.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executives</td>
<td>5.0</td>
<td>7.0</td>
<td>12.0</td>
<td>15.5</td>
<td>10.70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2

*Years in Current Department at HRMC*

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Years</th>
<th>Non-clinical staff</th>
<th>Non-clinical managers</th>
<th>Clinical staff</th>
<th>Clinical managers</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-5</td>
<td>6-10</td>
<td>11-15</td>
<td>16-20</td>
<td>21+</td>
<td>Average</td>
</tr>
<tr>
<td>Non-clinical staff</td>
<td>1.8</td>
<td>7.0</td>
<td>11.5</td>
<td>20.0</td>
<td>11.5</td>
<td>5.54</td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-clinical managers</td>
<td>4.0</td>
<td>5.5</td>
<td>20.0</td>
<td>32</td>
<td>27.40</td>
<td>8.30</td>
</tr>
<tr>
<td></td>
<td>2.0</td>
<td>10.0</td>
<td></td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical staff</td>
<td>3.0</td>
<td>8.0</td>
<td>20.0</td>
<td>21</td>
<td>11.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical managers</td>
<td></td>
<td></td>
<td></td>
<td>20.0</td>
<td>32</td>
<td>27.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executives</td>
<td>5.0</td>
<td>7.0</td>
<td>12.0</td>
<td>15.5</td>
<td>10.70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* One person had taken on a new role 2 months after being selected for this study.
The range in the years of experience of the non-clinical manager was that two people had 5 years or less at HRMC, two people had 6 to 10 years, and one had 20 years’ experience. There were some differences in years of experience and time of years in their current department or role.

The clinical staff information indicated that only one person had fewer than 5 years’ experience at HRMC, two people were in the 6- to 10-year range of experience, and the other two people had 15 or more years of experience.

Clinical managers reflected years of service longer than the other three groups already discussed. All five participants had more than 20 years of working at HRMC, and all but one had been in her current department since beginning work at HRMC. That person had been in her position 29 years and only recently taken a director’s role in a different department.

Executive demographics indicated that two out of five executives had 10 years or less service at HRMC, and three executives fell into the 10 to 20-years-of-service range. All executives reported having been in their respective areas since their arrival at HRMC.

It must be noted that these data on years of service at HRMC were captured so that I could examine later on in this study whether there were any implications regarding years of service and utilization of strengths on the job. I wondered whether younger participants or people with a range of years of experience in a group were more accepting of new concepts such as using strengths on the job than those who had been at the hospital longer. The data collected in the focus group sessions neither supported nor contradicted this idea. Participant comments related to these matters are described in later sections of this chapter.
Table 3 displays the years that focus group participants took the SFP and whether they had received any additional training beyond receiving their SFP results. I collected these data to compare later with participant comments. I wanted to assess whether people noted any advantage to having additional training, and whether those individuals who took the SFP earlier might have reflected a better understanding and commitment to utilizing strengths due to taking additional training or study.

The data showed that 11 of the study’s participants took the SFP in 2007, 7 in 2008, and 7 in 2009. The data, plus my review of focus group comments, indicated that participants had very little to say about additional training regardless of when they took the SFP.

Table 3

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Additional Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical staff</td>
<td>1</td>
<td>4</td>
<td></td>
<td>1 person read book on strengths</td>
</tr>
<tr>
<td>Non-clinical managers</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1 person had discussion with managers in department</td>
</tr>
<tr>
<td>Clinical staff</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical managers</td>
<td>5</td>
<td></td>
<td></td>
<td>1 person had entire department take SFP as part of Gallup; had facilitators from EI come to several meetings within the department. 1 attended some training on SFP at Nursing Summit</td>
</tr>
<tr>
<td>Executives</td>
<td></td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>
Moreover, only 4 (16%) of the 25 respondents noted that they had done any additional reading, taken further training on, or engaged in more formal conversations about the SFP among colleagues. The data seemed to indicate that additional training did not have any appreciable influence on strengths-use at HRMC. Participant comments cited in later sections of this chapter seem to support this observation further.

Self-Report on Degree of Strengths-use at HRMC

This segment presents participant self-reports on their degree of strengths-use at HRMC. Participants were asked to respond to two questions about the degree of time they use their strengths at work. I asked these questions to see how participants’ perception of the amount of time using their strengths compared to Buckingham’s (2007a) findings that only 17% of those individuals who took the SFP were actually using their strengths on the job “most of the time” (see Table 4). Scores in Table 4 are not provided for non-clinical staff participants. I did not start to formally collect that information until after the Pilot Test and the non-clinical staff focus groups had been conducted.

The self-reports on degree of strengths-use among the focus groups ranged from an average of 67.75% for the executives, to a high of 90% for the clinical staff. No responses indicated strengths-use “some of the time” or “not at all.” Non-clinical managers rated themselves as using strengths 80% of the time compared with 86% for clinical managers. When asked in a group discussion about the percentage of time they thought they were using their strengths, a clinical manager responded, “Probably even when we don’t think we are, we really are, we are in one way or the other.”
Table 4

*Perceptions of Use of Strengths at Work*

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>No. of Responses</th>
<th>Some of the time</th>
<th>Most of the Time</th>
<th>All of the Time</th>
<th>Not at All</th>
<th>Percentage of Time Responses</th>
<th>Average % by Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executives</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>65, 51, 95, 60</td>
<td></td>
<td>67.75</td>
<td></td>
</tr>
<tr>
<td>Non-clinical Managers</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>75, 80, 80, 65, 100</td>
<td></td>
<td>80.00</td>
<td></td>
</tr>
<tr>
<td>Clinical Managers</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>75, 75, 90, 90, 100</td>
<td></td>
<td>86.00</td>
<td></td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>75, 85, 100, 100, 90</td>
<td></td>
<td>90.00</td>
<td></td>
</tr>
<tr>
<td>Non-clinical Staff</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>0</strong></td>
<td><strong>14</strong></td>
<td><strong>5</strong></td>
<td><strong>0</strong></td>
<td><strong>80.93</strong></td>
<td></td>
</tr>
</tbody>
</table>

The self-report results were vastly different from Buckingham’s (2007a) findings in that only 17% of the people he surveyed, when asked what percentage of a typical day they spent playing to their strengths, answered “most of the time” (pp. 10-11). It must be noted, however, that this study did not replicate what Buckingham did, but rather used it as a point of comparison. In addition, HRMC’s study participants are not a true sampling of the entire full-time staff at HRMC, particularly given those who have not taken the StrengthsFinder Profile. Other possible explanations for why people reported high percentages of strengths-use are: (a) People who decide to work in healthcare professions may already have a predisposition to using their natural strengths, (b) facilitators may not have placed enough emphasis on the distinction between natural talents and passions as strengths versus being proficient at doing one’s job tasks or duties, or (c) strengths-use as defined by Buckingham is hard for people to relate to conceptually separate from talking
about their work tasks. As one clinical manager put it, “We didn’t channel our careers by accident. . . . Those choices were made because they fed our strengths.”

Summary

In summary, research revealed that clinical managers as a group have the largest number of years’ experience at HRMC in terms of both duration and service to their department. It was noted that only 16% of respondents who took SFP had done any additional training on this subject. In addition, this section presented data on participants’ degree of use of strengths at HRMC, and offered some possible explanations why the self-reports seemed to indicate a higher degree of use than Buckingham (2007a) found in his research.

Overarching Themes

Three themes that emerged from the data analysis are described in this section. The first theme, *Foundation in Place*, describes staff, manager, and executive knowledge and use of their individual strengths. The second theme, *Leadership Role in Strengths-use*, examines how leadership sees its role in supporting strengths-use. Finally, *Work Environment Culture and Organizational Support*, describes other factors and conditions which participants said affected their use of strengths.

**Foundation in Place**

It was apparent from the transcripts that all the participants had some understanding of the strengths concept and were comfortable talking about what they learned from their SFP results. In order to effectively describe these multiple perspectives, this section has been subdivided into four subsections, as follows:
1. An analysis of coding results pertaining to strengths-use

2. How people described their strengths

3. Self-reports on the degree of strengths-use

4. A summary of my interpretation of these findings.

Coding Results of Strengths-use

Initially, four codes were used to assess the extent of people’s knowledge and use of their strengths-use at HRMC. The first code, dissatisfaction with the status quo, was applied to comments which indicated that people had some knowledge and skills about their strengths, while also reflecting some excitement about how strengths-use could both help them be more engaged at work and benefit the larger organization. Alternatively, the code which denoted satisfaction with the status quo was used to track comments of people who indicated they were satisfied with things as they are, didn’t see any reason to change, or wanted to leave well enough alone. Clinical managers showed the greatest response rate for how their strengths could be used within their job (39%), whereas the clinical staff reflected lowest (10%) in that area.

Two codes were used to gauge whether people had some knowledge and skills regarding strengths, and some idea of how strengths-use benefits the entire organization. About 70% of the comments indicated respondents had some knowledge of strengths, but showed little indication that they valued or even thought about how to apply them organization-wide. Executives and clinical managers registered the lowest (at 25% per group) on how strengths-use could benefit the broader organization. Although clinical managers scored highest for indicating an enthusiasm for the benefits of strengths-use,
when looked at more closely, their comments tended to be more about using their own strengths than about valuing or encouraging strengths-use organization-wide.

How People Described Their Strengths

People readily joined into the conversations about strengths-use, and stayed engaged throughout the focus group discussions. However, for the most part when people spoke about strengths-use, their responses centered on their job duties and their job description. There was clearly some confusion in group discussions between tasks and skills that people have developed over time at work versus the innate strengths or passions with which they were born. Even as facilitators reiterated Buckingham’s (2007a) definition of strengths, people did not talk in those terms. Instead, they spoke primarily about their jobs and the knowledge and skills they use to perform them. This also may explain the high percentage rate cited in the degree of use data revealed earlier in this chapter.

The non-clinical staff group had the greatest enthusiasm for talking about their own strengths, appreciating the opportunity to take the StrengthsFinder Profile and thinking more broadly about the implications of strengths-use. All the non-clinical staff agreed about the importance of using strengths, with one person commenting that “I need to give myself time to do stuff I really like to do, or I’m going to burn out.” In an animated conversation about using strengths within their teams/departments/units, one non-clinical staff person said, “By doing something outside of your job description you actually end up achieving more than if you were just focused on what was inside your job description.” Another person summed it up by saying, “It’s like a two-front thing—you
get drawn to certain jobs because it fits with your strengths; if you see opportunities to use your strengths, it’s just a natural type of thing.”

The two clinical groups did not exude the same enthusiasm. Clinical staff discussion centered on current duties, and people appeared to be content with the job they were doing. One person said, “I guess when I did the StrengthsFinder Profile what came out was pretty typical of me.” A similar tone was echoed among the clinical managers. When not talking about their own strengths, the managers made fairly non-committal comments like, “It depends on the week. There are some weeks where I probably spend more time not using my strengths. . . . It just depends on what’s going on that week.”

In that same vein, strengths-use discussions seldom migrated into implications for use hospital-wide. People primarily reverted to discussing their job. A good example of this pattern was a non-clinical staff person’s observation: “I think these strengths help you as a person, teach you about yourself. It doesn’t help the whole company.” An exception to that response pattern was non-clinical managers’ comments about their counterparts at Adventist Healthcare (AHC) corporate headquarters in Maryland. Non-clinical managers felt that their strengths and skills were not being appreciated by their corporate colleagues in Maryland.

Another pattern was how managers and executives focused on strengths at the management level and/or upward to the executive level rather than at the staff level. While one executive allowed that it is “very much a role of the executive team to be encouraging. People don’t always realize their true talents or gifts,” the other four executives talked more about their frustrations as executives. The executives spoke in
terms of the areas of weakness in certain managers and staff than about seeing the value of these individuals and working with them to nurture their strengths to be more engaged.

Summary

Overall, it appeared that most focus group participants were comfortable in recalling and talking about their SFP results, particularly as they related to their specific jobs. For the most part, however, respondents did not go beyond their jobs in thinking about how their strengths could be utilized throughout the hospital. This may be because hospitals, like many organizations, seek to “increase efficiency and enhance performance through specialization and appropriate division of labor” (Bolman & Deal, 2008, p. 47). While people did seem to have a clear understanding of a skill or talent that they have developed over the years, there was little grasp or fluency in discussing a strength they were born with that comes so naturally to them they do not even have to think about it.

For reasons described earlier in this chapter, people may have self-reported a higher percentage of strengths-use than their focus group comments reflected. Demographic data and participant comments suggest that people were operating under multiple views of what strengths are; since participants had indicated little additional training, coaching, or reading done on strengths-use, it may have been harder for them to translate their natural talents and passions (listed for them in their SFP) into broader applications at work. Hamel (2007) offers another plausible explanation for this finding when he says, “If folks don’t appear to be creative at work, it’s not because they lack imagination, it’s because they lack opportunity” (p. 57).
Leadership and Strengths-use

The second theme, *Leadership Role in Strengths-use*, provides insight on how leadership promotes or hinders strengths-use. At HRMC, leadership comprises senior executives and clinical and non-clinical managers. This theme is described in the following subsections: (a) an analysis of coding results pertaining to leadership and strengths-use, (b) executive reports about managers’ use of strengths in light of the Servant Leadership philosophy, (c) staff views on managers’ use of strengths, (d) what managers say about their staff’s strengths-use, (e) what managers say about their own strengths-use, and (f) a summary of my interpretations of these findings.

Coding Results of Leadership and Strengths-use

Three codes were collated related to leaders and use of strengths. One code was used to chart comments about where leadership exists, that is, where managers and the executives are seen as supporting use of strengths at HRMC. Another code was used to track comments where the opposite seemed to be happening, where leadership was not evident in supporting strengths-use. The third code for commitment was used to cite visible support by the leadership regarding strengths-use (Appendix M).

The coding results indicated that managers thought a higher proportion of leadership was evident in supporting strengths (55%) than staff thought leadership was evident (37%). In the executive group, 78% of the comments regarding leadership indicated that executives showed a lack of leadership in supporting strengths-use among managers and staff.
Servant Leadership Compared to Executive Talk about Managers

Servant Leadership literature became the context for examining the transcript narratives. Within the Servant Leadership philosophy of management, the leaders’ role is to take responsibility for growing and developing those individuals who report to them. A leader is viewed as a servant to those he or she leads instead of the employee being a servant to the leader. That said, it was dispiriting for me to read that much of the leadership participating in these focus groups was not reflecting or supporting this Servant Leadership approach to management. Instead, the transcript narratives reflected a leadership approach more akin to that developed by Frederick Taylor (1991) in the early 20th century, called scientific or industrial management.

Examples of this older traditional view of leadership were evident among executives in several lengthy discussions about dealing with managers, and the lack of business acumen among clinical managers. In the discussion regarding managers and personnel issues, the tone was fairly negative, with comments among executives about the difficulties of “getting rid of” someone, one person holding the others back, the lines blurring between personal issues and work responsibilities, and a suggestion of not paying someone if he or she was not performing.

Executives also spoke about problems of having clinical managers in leadership positions when “the nature of their work is not the same as knowing how to run a business.” During the conversation about clinical managers and the business side of management, several executives offered ways to “integrate the business side with clinical leaders” because “clinical people don’t think budget.” While one person suggested that “having a clinical manager being a really skilled small business manager is unrealistic,”
by and large, the comments seemed negative and depersonalizing in tone. I noted that an executive’s comment, “You don’t learn from what you do well. You learn from when you mess up,” is definitely not an Appreciative-Inquiry approach to building on others’ successes.

Perhaps the root of the hierarchical mind-set in the executive group was best illustrated in one executive’s statement, “If you’re going to look at leaders, you all have to have the same mind-set.” The mentality that all good leaders must have certain skills was manifested in other executive statements as well, such as, “Good leadership is someone who really enjoys managing people” and “There is a commonality in terms of their (managers’) strengths.”

Trying to put a box around what management and leadership ought to be is clearly at odds with Appreciative-Inquiry, Servant Leadership, and strengths-based notions of people as critical to the success of an organization. Indeed, the real strength of an organization lies in tapping into the diversity of individual talents and skills for the greater good of the whole.

Other topics that executives discussed included the need for transparency, managers not speaking up in larger leadership meetings with them, and some of the reasons why that might be happening. One executive stated, “We talk about transparency. We do a fairly good job.” However, another person noted, “If managers disagree with us in a large group, they’ll back off. They don’t feel comfortable challenging us in a large group.” Executives then discussed being clearer about what they expect of managers, especially because some of the managers “have a hard time making decisions.” On the one hand, executives noted that “you have to look at their capabilities . . . it’s an
investment,” while on the other hand someone said, “I feel quite often there isn’t much
time to spend on strengths,” and “talking about an individual takes a back burner.” Hamel
(2007) speaks to such ambivalence among leaders when he says that “in a high-trust,
low-fear organization, employees don’t need a lot of oversight—they need to be
mentored and supported, rather than bossed around” (p. 89).

Seemingly there was little recognition among executives regarding their role in
these dynamics. The executives did not appear to understand, “It’s usually senior
executives, with their doctrinaire views, who get to decide which ideas go forward and
which get spiked, and this must change” (Hamel, 2007, p. 57). HRMC executives did not
seem to recognize that, as the top leadership group within the hospital, they had the
power to address and resolve the very issues about which they complained.

Even though someone acknowledged that “if we are able to focus on strengths,
from that we should be able to drive higher levels of performances, productivity,” the
larger concern seemed to be that it “would mean we have to sit down and go through that
process. Maybe other things would get worse. It would be exciting but tumultuous.” The
executives did not seem to grasp that “initiative, creativity, and passion are gifts. They
are benefactions that employees choose, day by day and moment by moment, to give or
withhold. They cannot be commanded” (Hamel, 2007, p. 63).

Staff Talking About Managers Strengths-use

The facilitator asked non-clinical staff whether they knew their managers’
strengths. One person answered with an emphatic “yes”; however, others in that group
didn’t know their managers’ strengths or seemed to talk off the point, thus leading me to
conclude that they really did not know the answer.
Non-clinical staff also talked about what they considered to be some barriers to managers’ use of strengths. These ranged from a lack of interest, to not “respecting us or our strengths,” to “not wanting to shake things up or cause a problem when things are running smoothly.” One person cited a manager’s age as a barrier by saying, “He knows he’s already done everything he’s going to do.” Another staff person reported that her manager “laughed at my strengths. . . . He thought it was very funny. I said that’s not nice.”

Research explains the consequences of such a manager’s attitude. “If you take something to your supervisor and he doesn’t listen or care, you begin to stop caring too. People looking for a job should be as concerned about who their manager will be as they are about their job title, their benefits, the company’s reputation, or even the pay” (Rath & Harter, 2010, p. 26).

When the facilitator asked clinical staff about their manager’s use of strengths, their responses were similar to initial non-clinical staff reactions. Several people did not respond directly, or did not know their manager’s strengths. One person cited a current high priority, the hospital-wide computer conversion, as an explanation for why she did not recall them.

However, when managers did take the Profile and share the results with staff, the response was upbeat. One person stated, “Our manager took it with us. We pretty much publicized the results. She was very open with those results.” Another commented, “It was nice that the managers were willing to take it with us, because it does put a certain sense of trust and risk out there.”
In discussions on whether the hospital’s senior executives support managers’ use of strengths, a non-clinical staff person observed, “I don’t doubt that they do, but I don’t have any direct experience of him doing it.” A different person stated, “At first there was a buzz about the StrengthsFinder Profile,” but that since then executives have had other pressing concerns like “new systems conversions; competing demands.” Someone from that group stated, “If they were told this is what you really should be focusing on, ‘Do you utilize your strengths?’ that would be most helpful.”

Like the executive group, both staff groups appeared to share the expectation that all managers should have similar strengths. Participants seemed to think that there was an exact formula that would make managers better at what they do. An example of this thinking was a non-clinical staff person’s comment, “You would think somebody that wants to be a manager should want to be a developer (of people).” Another non-clinical person proposed that “it would be interesting to do research into how many managers have certain skills, what are their top five . . . and where the mind-set is.” Similarly, the clinical staff people discussed what they thought to be the traits of good managers, which included getting things done, being empathetic to staff concerns, being a people person, and knowing at least 99% of the people who work here. What people did not consider was, “When like meets like, there is no creative spark; but when like collides with unlike, there is often a small frisson of inspiration” (Hamel, 2007, p. 174).

Moreover, what was clear from discussions about manager traits is that staff do not see themselves as part of self-managing teams that manage themselves, plan and schedule work, make service-related decisions, and take collective action to remedy problems (Bolman & Deal, 2008, p. 113). Hence, they expected managers to make things
work. Indeed, as one clinical manager said about her staff, “My staff is comfortable with ideas, but when there’s a problem they’re comfortable handing it back over to me.”

When asked, “If you had the ability to create your own job description around your natural talents, what would it look like; and, how could your current job be changed to reflect more of this?” people seemed unable to think outside their current job description to imagine what the new job would be like. In fact, one non-clinical staff person candidly said, “I took this job because I wanted a dumb job. . . . I didn’t want to utilize my strengths. I wanted an easy, stress-less, non-stressful job.”

Research confirms the findings like several cited from these focus group conversations. Rath and Harter (2010) state,

The most disengaged group of workers we have ever studied is those who have a manager who is simply not paying attention. If your manager ignores you, there is a 40% chance that you will be actively disengaged or filled with hostility about your job. If the manager is paying attention, even focusing on weaknesses, the chances of your being actively disengaged go down to 22%. But if your managers are primarily focusing on your strengths, the chance of your being actively disengaged is just 1%, or 1 in 100. (p. 26)

Managers Talking About Staff Strengths-use

Clinical managers tended to concentrate on strengths in terms of their job functions, specialties, and duties. They spoke about how rounding, which started at HRMC in January 2010, provided a helpful mechanism to better know employee strengths. Rounding is periodic walking through a department, talking to staff to see how things are going, opening communication so people think they are cared for, and learning what a manager can do to make their staff’s life better.

Clinical managers also spoke about their involvement in shared governance activities as a way to “grow the people who need to grow in certain areas and have others
in the department help them learn what they need to know.” One manager observed that at the department level, “For the most part we’re doing what they innately do well.” She went on to speak about ways to “bring people together with disparate personalities, people who had perhaps worked with another group for a long time, and now needed to form a team that builds on what their strengths are.”

Furthermore, clinical managers discussed how to empower and delegate to staff. One manager spoke about empowering her staff by bringing in a wound-care nurse so that “we can draw upon her expertise in taking care of the different wounds and skin problems.” Conversely, other managers spoke in terms that Bolman and Deal (2008) would call “bogus empowerment” where participation is often more rhetoric than reality (p. 152). Bogus empowerment was apparent in a clinical manager’s description of empowering a staff member to use her strengths in arranging parties, something that the manager personally did not like to do.

In general, the way clinical managers talked about empowerment was not 21st-century thinking. Hamel (2007) observed,

> In recent years there’s been a lot of rhetoric about involvement, empowerment and self direction. But ask yourself—have the liberties and prerogatives of first and second-level employees (e.g., non-clinical staff and clinical staff) expanded dramatically over the past decade? Do they have more freedom to design their own jobs, in choosing what to work on, or in deciding how to execute their responsibilities? Most of us are unlikely to get excited about a task assigned to us. . . . You can’t expect automatons to be zealots. (p. 61)

The non-clinical managers spoke less than clinical managers about the staff with whom they work or how to help promote their strengths-use. This may have been because non-clinical managers operate more independently of non-clinical staff and have fewer interactions with other similarly trained people than do clinical managers like nursing
directors. On the whole, the pervasive talk about strengths-use among managers was more about themselves than a focus outward to promoting staff use of strengths.

Managers Talking About Their Strengths-use

The clinical managers spoke about themselves as a part of the larger leadership team at HRMC. As a group, these managers cited their longevity and service to this organization (averaging 27 years) and the skills, specialties, and credentials they bring to their work. In addressing what they think supports their strengths-use, a clinical manager noted, “There was awareness (at the executive level) of who’s really good at what.” Another clinical manager said, “I think they look to us for strengths, too. I think it goes both ways.”

Non-clinical managers, however, did not talk about senior executives in those same terms. On the positive side, a manager said, “I think Administration at Hackettstown really tries to understand the people that are here in leadership roles, to understand what makes us tick and gives us fair opportunity to express opinions, give input, and offer suggestions. That’s inherent in the smallness of who we are and the efficiency.” However, on the corporate side, where most of the non-clinical managers’ interactions occur, people conveyed concerns that their strengths are not seen, appreciated, or encouraged by their AHC counterparts. One person summed it up saying, “I don’t feel they [AHC] look to us for our strengths.”

Another person reflected that if you “go up to the grander scale and count the distance, you lose that. How many times have the [AHC] individuals who actually visited here been in your shoes walking around the hospital here, helped with in-services here to convey the importance of a process? I can tell you my [AHC] person has been to this
hospital but has never been in our department and not tried to understand differences in understanding in Hackettstown versus at corporate. There needs to be an effort to better understand who we are.”

Non-clinical managers felt that they had much to contribute, but were not being invited into the decision-making conversations taking place within corporate headquarters in Maryland. Research reinforces the point that “corporate staff in old logic organizations all too often behave like the engineers that control the temperature of large buildings. . . . They end up dictating what the environment will be like, even though they do not have to live in it” (Lawler, 1996, p. 95).

On the whole, the managers, both clinical and non-clinical, never truly got to the heart of where their natural talents and passions lie, or how those talents come into play in their interactions with the people with whom they work.

Summary

The study revealed that executives had a very narrow view of their role as leaders in relationship to strengths-use in the larger organization. Coding and analysis of comments confirmed this observation. While executives did identify some factors that may hinder managers’ use of strengths, they seemed to take little ownership for their part in hindering strengths-use. In addition, the executives did not seem to have a sense of themselves as servant-leaders. Even though this had been a regular topic of discussion at HRMC, executives mostly talked about their investment in staff as taking a back burner to other things, and worried that spending more time on strengths-use “would be tumultuous.” The executives did not appear to grasp that they are the people with the
greatest power and authority in the organization; if they don’t make it happen, then who will?

Moreover, there appeared to be a self-perpetuating hierarchical system within the organization where the manager level and above seemed to be looking at themselves or above instead of looking to see how they could help develop the strengths of their staff. Leaders did not appear to be either understanding strengths well enough, or valuing employees and strengths-use enough, to promote greater use. Indeed, Margaret Wheatley questions such behavior by leaders when she asks, “Why would we seek the boxes of our predications and cut off the expanding capacities of our colleagues?” (Wheatley & Kellner-Rogers, 1999, p. 40).

Without the understanding and support of the Servant Leadership approach to management, implementing the necessary changes to maximize the use of individual strengths in the organization will be very difficult if not impossible. Leaders did not appear to prioritize using staff strengths as they relate to the future of healthcare or the changes that are likely to occur at HRMC. One explanation for this is that leaders “are unlikely to see the future if you’re standing in the mainstream” (Hamel, 2007, p. 187).

Work Environment, Culture, and Organizational Support

The third theme, Work Environment, Culture and Organizational Support, describes other factors and conditions which participants said affected their use of strengths. This includes: (a) analysis of findings on the work environment itself, (b) a discussion of resources, time, and work-related concerns, (c) information on the work culture as people perceive it, particularly as it applies to being like a family, and also as
pertains to long-term service and innovation, (d) the broader view of organizational support for strengths-use at HRMC, and (e) a summary of these findings.

Coding Results of Work Environment, Culture, and Organizational Support

Three codes that identified constraints to strengths-use were combined, as follows: resources not available, time not available, and work-related demands. Out of a total of 99 comments coded for these factors, 28% of the comments reflected concerns about resources, 21% reflected time constraints as inhibiting factors, and 51% pertained to work demands like multiple initiatives, competing priorities, and short- versus long-term planning. In addition, among these three categories, clinical staff comments were coded as having the highest number of concerns in these areas (35%), and the non-clinical staff the least (5%).

Another three codes were combined pertinent to communication (positive or negative), and perceptions regarding working conditions, culture (the meanings and behaviors that groups of people develop and share over time, and organizational support), the extent to which employees perceive that their contributions are valued by their organization and that it cares about their well-being.

Communication was recorded as positive between staff, managers, and executives in 38% of the total comments on this factor, and as negative in 62% of the comments on communication. In coding perceptions pertaining to the work environment and culture, all groups had a nearly equivalent number of comments in these areas (22-23%), with the exception of executives who did not talk about it to the same extent (11%). While some
of the findings discussed here intersect with each other, where possible they have been broken down into several subsections for easier review.

Resources, Time, and Work-Related Matters

People cited resources and time both in terms of themselves and work-related demands; sometimes they saw these constraints as a challenge to stretch beyond what they are currently doing. People talked at length about stress factors in their environment which they feel constrict broader use of their strengths. For example, a non-clinical staff person commented, “I use my strengths a lot. . . . I’ve ended up taking on more stress and more challenges, but they’ve helped me grow.” Another person said that she has the strength of prioritizing so that “the job doesn’t become overwhelming.”

In talking about resource constraints, a clinical staff person reported, “I’ve seen a change and I think it’s perhaps because managers are so overwhelmed with paperwork and the statistics and the financial end of it.” Someone in the clinical group observed, and others concurred, “Budget’s always a barrier;” and another mentioned, “Work gets in the way. There’s a job to be done, deadlines to meet.”

A clinical staff person made the observation that “maybe paperwork doesn’t go through as quickly. It could be a monetary thing. I mean, they can’t just go ahead and change things, so their hands are tied as well.” On the other hand, in talking about a manager’s role in getting to action, a person observed, “I’m just going to say a couple of words about getting things done. I have my experience as being with my manager, that if he’s convinced something needs to be done and if resources permit, it will be done immediately.”
Adding to this conversation, someone said, “I can make one observation overall about this institution. The manager is a position where it’s a very important link between the administration and the other employees. My observation has been that managers interact with administration much better than they do with their employees under them. I think there has to be more interaction and there has to be more positive reinforcement of employees because that will strengthen them and they will work better.” Still another comment was, “If they’re [managers] not being supported by administration, that’s going to trickle down to the people that are working under this manager because they’re unhappy.”

Several clinical staff mentioned the electronic medical record system installed in January 2010 as a competitor with other initiatives like broader use of the SFP. A clinical staff member categorized this distress as “one more frustration in that they are all trying to accustom them to an entirely new system of electronic documentation. It’s a huge, much as it’s good, it’s a huge stressor and it will continue to be probably throughout this year. . . . So in the middle of that, to have this other kind of roadblock put in your way, it happens frequently during the day, unhappy patients, unhappy families, unhappy doctors.”

There was also a long conversation among clinical staff about a new procedure issued by one of the clinical managers on use of a call button during evening hours. Essentially, without conferring with anyone else, the manager made a decision to stop using the intercom system to page nurses on night shifts because it was disruptive to patients’ sleep. It caused a number of problems in trying to locate nurses on the night shift. How the decision was made and communicated, as well as the outcomes of what
happened, indicated the kinds of things that create even more stress in the work environment.

On the whole, although there was discussion in the different focus groups regarding their work environment and challenges, I did not get the sense they were huge barriers to utilizing strengths. It was more that these were things occurring in all organizations; they are an inconvenience, but something people learn to live with. While dealing with paperwork and budgets may not be the favorite pastime for managers, they understand the reasons why things must be done.

With regard to managers being overwhelmed and having to deal with new initiatives and priorities, they suggested that sometimes executives could control these things and help set priorities, realizing that managers can do only so much in a given time period. Participants at times feel overwhelmed because they get more things to do without having current responsibilities re-prioritized. These priorities are not only coming from within the hospital but also from the AHC corporate office.

Culture: Like a Family

In the clinical manager group, one person noted that “the culture is very personal,” and another added, “It’s a combination of what you enjoy but also things the facility needs.” Another said, “It’s the kind of environment that it’s kind of very open conversation.” Clinical managers talked a lot in terms of themselves as being like a family, noting, “We feel very comfortable approaching each other and talking to each other about problems or concerns or issues.” Others agreed. “We know each other, we’ve been here a long time,” and, “We know the good and the bad.”
In other discussions, several managers described themselves as risk takers and innovators, even though for the most part they had not changed jobs or where they worked during their long professional careers. In reading transcripts, I concluded that the family reference applied solely to the clinical manager group and perhaps some of the senior executives with whom they work, not to the staff.

Whereas clinical managers talked positively about communication, for clinical staff, communication was a problem. Also, non-clinical staff spoke about a “culture of niceness” that can get in the way of communication and getting things done. The tension people described was around being direct and getting work done, and doing it in a way that doesn’t make things worse. The “culture of niceness” is not pervasive, however. People cited examples of clinical staff being on overload and being rude to non-clinical support services staff without offering an apology or explanation afterwards.

Staff also spoke about committees and meetings that their managers attended, thus not being able to be located when needed. A typical comment was, “From the administration down, follow-up and feedback a lot of times from them is missing. They need to say, ‘We’re working on this. We haven’t forgotten about you.’” Lawler’s (1996) research supports the importance of this feedback loop. He says, “Individuals, groups and organizations are guided most effectively when they get immediate feedback on what they are doing” (p. 229).

Culture: Long-Term Service Versus Innovation

The issue of long-term service and people having experience working in only one hospital (HRMC) was introduced by a person in the clinical staff focus group. The person said, “I call it being too inbred, meaning people that have only worked at one institution
their whole life; that’s a barrier to change.” She continued, “I’m not saying that that’s a wrong thing to do. . . . I don’t necessarily think that today that’s the wisest idea because you get too, you don’t know any other way, and one of the advantages I think that I have coming from working, that I’ve worked in five institutions over my 40-some-year career in various different positions.” Her observation about diversity of experience was, “You have a broader way of looking at things. You kind of say, ‘well OK,’ not that you’re going to come and say ‘this is the way we did it here.’ People get annoyed by that, rightfully so, but you want to bring that with you.”

What was particularly intriguing about this speaker’s comments was the uniqueness. No one else mentioned anything akin to this concern in any of the other focus groups, and no one picked up on the points the speaker made in the group where she made them. The very absence of the conversation makes one wonder why it wasn’t discussed more broadly or openly. Indeed, Hamel (2007) proposes that “a single brave dissenter creates a license for others to protest and object, thus lowering the threshold of courage for all those who might otherwise have been afraid to speak up” (p. 193). However, that did not appear to happen here beyond the comments voiced by one single dissenter in the clinical staff focus group.

Generally speaking, I found the findings on culture very interesting. The hospital takes a lot of pride in its culture of compassion and friendliness, but does not think of it as being a barrier. As one participant indicated, “being nice gets in the way” when it comes to dealing with issues that involve employees. People who work at HRMC are sometimes so focused on being nice that they have a hard time dealing with real issues because nobody wants to hurt someone else’s feelings.
Summary

In this section, perceptions regarding multiple initiatives and conflicting priorities were described in terms of how stress affects strengths-use at HRMC. Extending those findings one step further would require further reflection at HRMC on how those stressors affect people’s sense of personal health and well-being. Indeed, research on stress-level factors at work indicates that,

while there are many factors that contribute to depression, being disengaged at work appears to be a leading indicator of a subsequent clinical diagnosis of depression. Another study tracked employees for two years to examine the relationship between changes in engagement at work and changes in cholesterol and triglyceride levels. As employees’ levels of engagement at work increased, their total cholesterol and triglyceride levels significantly decreased. (Rath & Harter, 2010, p. 24)

Moreover, a number of discussions on work environment and culture intimated other factors that can support or hinder strengths-use at HRMC. They included participant comments on multiple-initiatives and other work-related demands, the importance of managers in getting things done at HRMC, and examples of how decision-making practices and poor communication can affect work.

There did appear to be some connection between the clinical managers’ length of service at HRMC and how they described it in their focus group: They uniformly saw it as adding value to the larger organization. However, one person in the clinical staff discussion offered a different perspective on clinical managers’ longevity within HRMC: That person suggested that it had a negative impact on openness, creativity, and innovation among staff who had not been there as long.

Clearly, the many differing perspectives among executives, clinical and non-clinical staff groups, and managers created the composite picture of what was happening
with regard to broader strengths-use at HRMC. This multi-dimensional view opened doors for further exploration, discussion, and action.
CHAPTER FIVE

CONCLUSIONS AND IMPLICATIONS

The purpose of this study was to identify conditions and factors that seem to enhance or hinder healthcare managers at HRMC in using their strengths at work. This chapter presents a discussion of my exploratory study’s research findings. I have drawn conclusions in light of the study’s research questions. These conclusions are also discussed in terms of: (a) some of my initial assumptions prior to conducting this research, (b) what I learned from the findings, (c) what others could learn from these findings, (d) how HRMC could be improved based on these results, and (e) some next steps that could be done with these results to add to the knowledge base of leadership studies.

It must be noted that as the President and CEO of HRMC I had several assumptions going into this study about strengths-use at HRMC. However, as a researcher I knew I had to suspend any expectations or judgments, and develop research questions and a data collection and analysis process that provided unbiased insight into what was happening at HRMC with regard to strengths-use in my hospital. I knew from the onset of the study that this was necessary to both advance knowledge and understanding of strengths-use among HRMC leaders, and also to other hospitals and organizations that could benefit from my study. Therefore, throughout this chapter I describe some of the initial assumptions I had as CEO prior to conducting the study. I
also summarize my findings, which in many cases dispelled some of those assumptions, and contribute to the wider research base on strengths-use in organizations.

**Discussion of Research Questions and Related Findings**

**Question 1**

The first question the study asked was: To what degree have managers who have taken the StrengthsFinder Profile (SFP) been utilizing their strengths at HRMC? “Degree” is defined as the percentage of time managers are using their strengths “most of the time” while at work.

This question sought to identify both a percentage of time that managers at HRMC estimate they are using their strengths at work, and also people’s perceptions on whether managers are using their strengths at work. An initial interest I had in asking this question was, that while HRMC had been implementing the SFP for over 3 years among approximately 35% of our full-time employees, I wondered if people’s self-reports on their strengths-use might be some percentage higher than what Buckingham (2007a) found in his research.

In analyzing both the group transcript reports and the data garnered from two survey questions managers responded to regarding this topic, I found that managers rated their percentage of strengths-use quite high. In their self-reports, four out of the five non-clinical and clinical managers participating in this study reported that they used their strengths “most of the time” while at work, and one person in each group responded “all of the time.” Non-clinical managers on average rated their percentage of time for using strengths at 80%; clinical managers rated theirs on average at 86%.
Buckingham’s (2007a) research found that only 17% of the people he surveyed, when asked a similar question regarding what percentage of a typical day they spent playing to their strengths, answered “most of the time” (pp. 10-11). While the HRMC study did not attempt to duplicate Buckingham’s survey, a simple comparison illustrated vastly different percentages in the HRMC managers’ self-reports.

To determine whether this percentage of use estimate pertained to just HRMC managers, or if it was common hospital-wide, I also asked clinical staff and executives in two focus groups to respond to the same percentage of use questions as the managers. Like the manager groups, the results from the other two groups showed a higher estimate of strengths-use than did Buckingham’s (2007a) research. Also, there was some difference in the other two groups from what managers reported: Clinical staff on average rated themselves at 90% for using their strengths; executives rated themselves on average at 67.75% (see Table 4, chapter 4).

The high rating of strengths-use among managers and other groups appeared to be a hospital-wide trend. This trend was obvious in comments within from all the focus groups when participants were asked if they knew their strengths, and to give examples of their use at work. On the other hand, even though strengths-use was described to participants as “your passions and natural talents and skills” those were not the terms that people used in talking about their strengths in the focus groups. While several possible explanations were proposed in chapter 4 as an explanation for these findings, the strongest and most likely explanation is that managers and others overwhelmingly related strengths-use to their professional tasks and the skills they use on the job. This is reflected in manager comments which indicated that managers knew their own
StrengthsFinder Profile (SFP) results; in all cases the SFP confirmed who they were, but comments indicated that there was little effort to take what they learned and consciously apply it outside their job tasks. This was especially evident in staff comments about their managers’ lack of sharing or promoting strengths-use with them or within their department.

Moreover, people seldom spoke of strengths-use at a hospital-wide level. Even though the SFP had been implemented among 35% of HRMC’s full-time employees over a period of several years, managers did not seem to perceive it as having wider implications beyond their own personal edification. In fact, managers’ focus on strengths was more about each other in the management level and/or upward to the executive level than outwards to the staff. Some possible explanations for this may be:

1. There was a possible misunderstanding or not being really clear on the difference between knowledge and skills that they’ve developed over time at work, and the natural talents and passions Buckingham (2007a) describes.

2. Additional training and workshops on strengths building were offered but for the most part didn’t happen; this may have been due to competing priorities at the departmental level in the organization.

3. There was not a systematic effort at the senior executive level to communicate, encourage, and expect strengths-use hospital-wide.

Question 2

The second question this research study asked was: What conditions and factors within HRMC promoted or hindered managers’ use of their strengths on the job?
On the whole, I found that people seemed to appreciate having the opportunity to take the SFP. Staff commented positively when managers encouraged strengths-use, and a clinical manager cited the importance of bringing people with disparate personalities and backgrounds together to build a team that maximizes each other’s strengths.

Clinical managers saw their SFP results as a confirmation of who they are and what they bring to their work. Non-clinical managers saw it as a possible way to affirm the skills and talents they bring to their job with their counterparts at corporate headquarters in Maryland. Non-clinical and clinical managers generally spoke positively about their interactions with HRMC senior leadership. A non-clinical manager said that she thinks senior executives give managers a fair opportunity to express opinions and offer suggestions.

I had frequently spoken with HRMC leadership about the value of practicing Servant Leadership within our hospital; I had thought that Servant Leadership was part of the HRMC culture. The data did not bear this out. I discovered instead that one of the greatest obstacles to managers’ use of strengths is the traditional hierarchical structure in place at HRMC. Even though both manager groups spoke favorably about the leadership structure which they are a part of, they did not see how that very structure impeded strengths-use. Non-clinical managers spoke of their problems in dealing with the hierarchical structure at Adventist Healthcare’s (AHC) corporate headquarters. Other conversations in different focus groups noted a similar problem with the hierarchical structure at HRMC.

Similarly, clinical managers spoke about themselves in ways that made them sound insular from other groups in the hospital. Clinical managers described their years
of experience working at HRMC, of being like a family, and of having the skills and credentials to be successful in what they do. However, they did not talk about the counter-effects of having worked in only one hospital or department in their professional careers, nor how their longevity and attitudes might inhibit more open discussions and collaboration between themselves and those with less longevity and service at HRMC.

Furthermore, whereas clinical managers seemed especially proud of their close working relationships with senior executives, senior executives did not indicate a similar enthusiasm for the managers. Moreover, even though clinical managers spoke of empowering and delegating to others with whom they work, there was little in their discussion that reflected concerted efforts at doing so. While there was recognition of activities associated with rounding and self-governance counsels and committees within the hospital, group discussions intimated that there was a fairly narrow membership, mostly consisting of nurses, conducting these activities.

In general, neither group of managers seemed particularly conscious of strengths-use beyond their own individual level. Moreover, as leaders in the organization they did not seem to grasp their importance in encouraging strengths-use, nor to see their role as servant leaders: valuing and promoting more democratic, participatory, Servant Leadership-type attributes in their work with others. This may be in part due to how senior executives lead at HRMC.

Executives spoke about their roles on the traditional hierarchical ladder at HRMC. They talked a lot about their work challenges, especially those in dealing with managers. They thought managers should have a common set of traits and skills to be good
managers, and that the lack of common traits might be at the root of some of the challenges executives were facing.

Furthermore, executives did not take ownership for their part in the miscommunication and lack of transparency and trust they described observing in managers’ relationships with senior leadership. Executives did not appear to know that hospitals are systems that are the result of interdependencies where people support, challenge, and create new opportunities for each other: that strengths-use is very much a part of that equation. Subsequently, the study results seemed to indicate that since the executives did not see it as their responsibility to support managers’ strengths-use, it was less likely that managers would see it as their responsibility to support strengths-use more widely within the hospital.

The Researcher’s Learning From This Study’s Findings

Participants said both encouraging and disconcerting things about strengths-use practices at HRMC. Although I had some assumptions prior to starting this study, once the research study began I consciously set those assumptions aside, and listened closely to what people were conveying to me through the data collection process, the transcripts, and the facilitators’ feedback. I looked closely at patterns that appeared to be emerging from the data. In addition, I kept a researcher log throughout the data collection activities to monitor and assess both what I was feeling and what I was learning from the data.

What I found especially refreshing in reading the transcripts were the voices of the participants. Their stories reflected candor, openness, and a willingness to describe their impressions of what was working and what could improve strengths-use at HRMC. Because of that candor, the study findings gave me a clearer picture of what had
happened in the past with regard to strengths-use and some insight on where to go from there.

Overall, the findings led me to conclude the following:

1. While the enthusiasm, knowledge, and skills to apply strengths at HRMC were fairly pervasive at the individual level, they were for the most part not being talked about or practiced at department or team levels, or with a view to how they could contribute to our work with patients, our employee engagement, and our productivity hospital-wide. There also did not appear to be a sense of urgency among hospital leaders that it is important to use strengths to grow and develop our staff, especially to face the kinds of challenges hospitals will come up against in the future.

2. Managers reported a far greater estimate of their percentage of strengths-use in the end of group survey questions than was reflected in their focus group comments. Moreover, group comments revealed that managers do not have a clear understanding of what strengths are, nor how to promote their own or others’ use of strengths at work. Instead, managers tended to drift into a kind of fail-safe pattern of associating strengths-use with their own job skills and credentials. It seemed hard for managers to pause and explore what their true passions and natural talents were; they treated them as nearly synonymous with the work they do.

3. In addition, the strengths-use discussions in the focus groups illustrated that HRMC has very little cross-functional management or self-management at the team and department level. Consequently, people are hired to do a job and pretty much function as individual contributors in the workplace. At the same time, the study results signify a
growing desire among managers and staff for better communication, transparency, and participation between them and senior executives on matters that affect their work life.

4. Part of the challenge to making this happen at HRMC is found in the results associated with the second research question, that is, factors and conditions that hinder use of strengths. Again, my assumption prior to beginning the study was that there was a Servant Leadership mentality among the leadership at HRMC. I based this thinking in part on the fact that HRMC is a faith-based organization with a vision, mission, and values akin to Servant Leadership. In addition, as CEO I had discussed the importance of this approach to leadership and its effect on employee engagement many times with the executives and management team. Consequently, I thought that the leaders at HRMC saw themselves as servants to their employees—promoting their use of strengths, their overall health and well-being, and their engagement and satisfaction on the job. The study’s findings seemed to indicate this was not the case. In fact, managers tended to think mostly about themselves and those above them in the hierarchical structure, rather than the staff with whom they work.

5. Furthermore, despite Gallup research on the influence of the manager on staff job engagement, and the fact that HRMC has for several years conducted an annual Gallup Q12 employee engagement survey hospital-wide, managers did not make the connection between their behaviors and staff job engagement and strengths-use at work.

6. The study also showed that HRMC, like many traditional hierarchical organizations, acts with a top-down leadership structure where most of the power, budget, and authority are controlled at the top. Therefore, strengths-use likely hasn’t happened at other areas within the organization without the visible leadership support
behind it. Literature indicates that such leadership requires more than a verbal affirmation of the value of using one’s strengths on the job. It requires time, planning, and resourcing to implement hospital-wide.

What Others Can Learn From This Study’s Results

Study participants did not hesitate to tell the truth as they saw it. They spoke about what they appreciated and would like to see more of in using their strengths. What this indicates is that leaders, who care about the health and well-being of their organizations, must trust and look for answers on how to grow and improve the workplace and work outcomes among the people who work there. That’s the place to start—not in some abstract or theoretical notion or management model of what should be, but rather in asking the first and second line employees what’s going on, and how it could be better.

Furthermore, these findings demonstrate that strengths-use may appear to be a simple and easy concept to understand at first glance, but is very complex and difficult to implement. For over 20 years, many researchers have been surveying, thinking about, writing about, and consulting on how to build strengths-based organizations. Some of that material is far more coherent than others, but it always comes down to this: Each organization must first identify what is happening in their own organization to support or hinder strengths-use, then go in search of the knowledge, wisdom, and practices to customize for the strengths-based work to be done in their own organizations.

While there is no model that fits all situations, there is change management literature that provides guidance on how to plan, develop, and execute a change of this magnitude in organizations. If leaders think of strengths-use in the larger context of
adoption and diffusion of an innovation, our colleagues might be less likely to see it as just one more thing leaders are imposing on them; rather they may see it as something that everyone can participate in as citizens of the wider-based hospital community.

Recommendations for HRMC and Other Organizations Based on the Study Results

What was unique about this study was that unlike much of the strengths-based literature, this research looked more specifically at what was happening at the leadership level of an organization to promote or hinder strengths-use. It did not stay at the individual or even managerial level of the organization. Because of the study’s exploratory nature, once it was clear to me that managers were clearly speaking about themselves as part of the leadership team at HRMC, it occurred to me that such a perception was having an effect both on their strengths-use and their interactions with senior executives and staff. That recognition on my part led to further investigation of what staff, managers, and executives were saying about each other regarding strengths-use; it led to the conclusion that the leadership hierarchy was more of a hindrance than support to strengths-use. In other words, if the senior executives weren’t leading the charge on strengths-use at HRMC, the managers as part of the leadership team weren’t likely to either.

Consequently, I concluded that HRMC must take the next step to learn from this study’s findings and have candid conversations about the role of leadership in this faith-based organization. Part of that discussion has to deal with the role that Servant Leadership practices should have in our organization alongside strengths building, if we are to reap the positive kinds of outcomes necessary for HRMC to meet its future.
Because HRMC is still a hierarchical organization, this conversation must start at the top to get the necessary buy-in of senior executives to champion, resource, and encourage the planning, development, and participation of others across all functions hospital-wide to build a strengths-based culture at HRMC.

In addition, another next step is for me to go back to meet with those who participated in this study, report the findings to them, and ask them what they see as critical to their using strengths on the job. Part of that process will include a discussion of the definition of strengths as their natural passions and talents, and how that combines with their skills and job descriptions to do their jobs. It will be important for me to convey to them that it was their participation and honesty in this study which set the groundwork for moving strengths-use to the forefront of our hospital initiatives in promoting employee engagement.

Moreover, just as this study was an emergent process, so will be the work going forward. I will work with HRMC executives to encourage them to partner with staff and managers to collectively make strengths-use happen hospital-wide. Furthermore, with so many competing priorities at HRMC, it will be important for me to work with others to develop a matrix that measures on a regular, transparent, and long-term basis how well people are utilizing their strengths on the job. As mentioned earlier, this will be an emergent process so it will be necessary to identify barriers as early as possible so that they may be eliminated or removed.

On the whole, as a result of my study I have more insight on how organizations can better implement a change like strengths-use. Buckingham (2007a) and the Gallup organization’s focus seemed to be on how individuals could promote their strengths in
the workplace; that became a starting point for my research study as well. However, what I found was that to get to strengths-use organization-wide, we must consider strengths-use as more than individuals using a new tool: it is a major change that requires an adoption-diffusion approach to planning, managing, and implementing such a change in the larger context of an organization’s strategic goals and competing priorities. In retrospect, as participants in my study mentioned, the SFP was clearly an innovation that was being implemented among other initiatives. This led to confusion about how staff should prioritize such initiatives given the daily demands of their jobs. My conclusion is that it would have been helpful for HRMC to have looked at implementing the SFP and strengths-use more in the context of change-management research and models. This would have allowed us to assess readiness for and likely impact of this change both in its formative stages and over the longer term.

Consequently, my recommendations to organizations currently using or considering using the SFP, or any change initiative for that matter, is to first undertake due diligence in: (a) examining where the change initiative has been implemented successfully and what contributed to its success, and (b) assessing the cost and benefits of purchasing and implementing such a tool. It must be noted that there are other tools in the marketplace, some more researched than others, that organizations should be aware exist. Those tools and models also address how to assess and get to a high performance organization. Each organization needs to complete its own due diligence to select tools and models that address their needs. In all cases, there should be open discussion among people organization-wide to determine whether the tool or change initiative (a) contributes to the vision, mission, and values of their organization, (b) aligns strategically
with organizational goals, and (c) has the leadership commitment and resources to champion use, encourage participation, and provide incentives and rewards for use. In addition, the knowledge and skills must exist within the organization to implement its use. At the operational level, this means that there must be people with the project management and adoption-diffusion planning skills to ensure greater likelihood that an innovation like strengths-use will move from initiation to execution and meet organizational requirements and desired outcomes.

Implications From These Results to Add to the Knowledge of Leadership Studies

Buckingham’s (2007a) research doesn’t seem to investigate what happens beyond the individual to team level to promote strengths-use in an organization. He seems to regard strengths-use as something that begins with a person, builds in density, and then migrates out towards the team or department level. While clearly each employee’s strengths are key to an organization’s success, one should not put the bulk of the burden on employees for pushing forward their strengths into the organization. Most people still work in hierarchical organizations, and as such do not enjoy the freedom to be self-promoting, creative, and innovative in their work. In hierarchical environments, an innovation like the SFP and strengths-use currently requires a joint effort between the top executives and staff to make it happen on the ground. It’s also clear from what was learned at HRMC that such an enterprise is not likely to happen unless strengths-use is combined with Servant Leadership practices.

From a research perspective, a useful follow-up to this study would be action research studies on how to help employees differentiate innate talents and strengths as
compared to some knowledge and skills they’ve developed over the years that relate just to their job description. People have to think outside of their job description without minimizing the skills they’ve developed and bring to their work.

Further research could also be done to more closely examine the effects that demographics like age, longevity, and years of service have on staff willingness to embrace different models or approaches to leadership, like Servant Leadership, outside of the more familiar traditional hierarchies in organizations. Studies could also be done on how hospitals, which for the most part operate under fairly traditional, hierarchical structures, can better increase readiness for innovations like Servant Leadership and strengths-based practices in their organizations.

In addition, hospitals employ highly skilled people who often pride themselves on self-management and their technical skills and expertise. It would be interesting to study what it would take for them to think outside their job descriptions, and realize that following their natural passions is as important as their degrees, training, and certifications. Indeed, the contemporary writer, Atul Gawande MD, is an example of someone who does this. Gawande is an endocrine surgeon at Brigham and Women’s Hospital in Boston, and a journalist who has gone outside of his job description to follow his natural passion of improving patient safety, quality care, and physician performance in hospitals.

Action research and qualitative studies would be good vehicles for conducting this research. Research could also add further knowledge to leadership studies by proposing and evaluating indicators for success and accountability associated with change initiatives like strengths-use in hospitals and other organizations.
APPENDIX A

STRENGTHS
### Theme Groups

**Thirty-Four Routes to Superior Performance**  
34 Themes (4 Groups)

<table>
<thead>
<tr>
<th>Relating Themes</th>
<th>Impacting Themes</th>
<th>Striving Themes</th>
<th>Thinking Themes</th>
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<td>Achiever</td>
<td>Analytical</td>
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<td>Empathy</td>
<td>Competition</td>
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<td>Harmony</td>
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<td>Maximizer</td>
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<td>Individualization</td>
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| TOTAL | TOTAL | TOTAL | TOTAL |
Before beginning, the facilitator should take the first five minutes of the focus group session to ask each person present to fill out the following brief form (Appendix D). Once done, collect the forms and ask each person to identify his or her name, title, department and a personal strength they are known for at work. Then, ask people to introduce themselves by department/unit, role, and years at HRMC. After that, proceed then on to the introductory material and the interview questions. All of this segment should take 15 minutes or less.

INTRODUCTION

Language to Use with Participants in Focus Groups:

As part of a special study, we are conducting focus groups with hospital staff, who took the StrengthsFinder Profile at HRMC, to determine if you have observed or participated in situations where managers (manager here refers to the manager, supervisor or director to whom you report) are using their strengths on the job. The underlying premise of this study is that HRMC’s strength and greatest asset is its people. In particular, our immediate goal is to identify ways the organization can provide more opportunities for managers to use their strengths on the job, and subsequently for managers to support their direct reports in use of their strengths on the job.

When we talk about strengths in this session, we are referring to those natural talents or qualities that make individuals perform their best. You would recognize them as those things that managers do consistently and near perfect every time, and which also make them feel great about doing them. These are activities that may appear simple for them, but areas they have an interest to continue to learn and grow, come up with new ideas, and have the best insights. These are the things that keep individuals interested and focused with almost no effort.

We’re conducting this study, because research has shown that when people spend more time utilizing their natural talents or strengths on the job, it has a positive impact on many aspects of the organization. We are concentrating on managers here because research tells us that managers matter more than executive team members in lowering employee turnover, enhancing productivity, and increasing customer satisfaction. Therefore, this study’s goal is to locate, illuminate, and understand the distinctive management practices and skills that lend the organization its organizational vitality. We are interested in understanding more about what is happening when we are at our best.

The information you provide in this focus group, will be used to better understand the conditions or factors in the HRMC work environment that support our managers in using their strengths on the job, and what hinders their use on the job. Our interest is in learning from your experience. We encourage your candor and open participation in sharing your perspective on these matters. The collected comments, suggestions and experience from the focus group sessions will be summarized and reviewed to identify any common elements that, if changed, could increase the opportunity for managers to use their strengths more on the job. Your confidentiality will be maintained throughout this process and you will not be identified with any of the comments made.
APPENDIX C

PARTICIPANT INFORMED CONSENT FORM
PARTICIPANT INFORMED CONSENT FORM

Identifying Factors that Enhance the Utilization of Strengths by Healthcare Managers

_____ I have been told that Gene C. Milton will be conducting research with members of the staff of Hackettstown Regional Medical Center, Hackettstown, New Jersey who have taken the Gallup StrengthsFinder Profile for the purpose of completing his doctoral degree in Leadership and Administration from the School of Education at Andrews University.

_____ I have been told that the purpose of the research is to identify common elements or situations that if improved and/or expanded would provide opportunities for individuals to use their natural talents or strengths more on the job.

_____ I have been told that my participation in the study will benefit Hackettstown Regional Medical Center in identifying ways to increase the use of natural talents and strengths for employees to be more fully utilized to produce a higher engaged work force and a more efficient and productive workforce.

_____ I have been told that the focus group session will be conducted at Hackettstown Regional Medical Center in Hackettstown, New Jersey and that the session will be 2 hours in length, and be conducted by an independent facilitator.

_____ I have been told the study requires that I have taken the Gallup StrengthsFinder Profile. In addition, I agree to participate in a focus group to discuss my reaction to this data. None of these surveys or focus groups will involve any experiments.

_____ I have been told that by my participation in this study there will be no implied liability whether oral or written of my legal rights.

_____ I have been told that my participation in this study will result in no physical, sociological, psychological risks, stress, discomfort or invasion of my privacy.

_____ I acknowledge that my participation in this study is fully voluntary. I have been told that refusal to participate in the study will involve no penalties or loss of benefits to which I am entitled.

_____ I have been told that I will be audio-taped during the focus session in which I participate; however my identity in this study will not be disclosed in any published documents, and that the focus group sessions, verbal and written material, will remain confidential and not shared within the organization or elsewhere outside of the context of this dissertation study.

_____ I have been told that there will be no cost to me for participating in this study.
I have been told that I will not receive any monetary compensation or other type of inducement for participating in this study.

I have been told that I can withdraw at any time from the research study without penalty.

I have been told that I may contact Gene’s advisor, Dr. Erich Baumgartner, or any impartial third party not associated with this study regarding any complaint that I may have about the study. I may contact him at Andrews University, School of Education, Bell Hall, Suite #173, Berrien Springs, MI 49104 or call (269) 471-3487 for information and assistance.

I have read the contents of this consent form and received from the facilitators verbal explanations to any questions I had. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. I am fully aware that if I have any additional question or concerns that I may contact Gene Milton in writing at his home address of 40 Mallard Drive, Hackettstown, New Jersey 07840; by email at gmilton@hrmcnj.org; or by phone at (908) 850-0864 (home), (908) 850-6802 (work) or (908) 510-3486 (cell).

I may contact either or both facilitators if I feel that confidentiality has been breached after the session ends. Facilitators Catherine Learmonth and Glen Segond can both be reached via HRMC GroupWise email.

I have been given a copy of this consent.

My participation in this study will occur towards the beginning of 2010.

Signature
Date

I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Facilitator
Telephone
Date
PARTICIPANT DEMOGRAPHIC INFORMATION SHEET

Name: ______________________________________________________________

Title: __________________________ Date: __________________________

Group/Department: __________________________

___Clinical ___Nonclinical

Role in Department/Unit: __________________________

Length of Time in Department: __________________________

Years of Service: __________________________

Any additional training on the SFP: __________________________

Please return this form to the facilitator. All information will be kept confidential. Thank you for your participation!
PARTICIPANT DEMOGRAPHIC INFORMATION SHEET
Updated after the Pilot Test

Name: __________________________________________________________

Title: __________________________ Date: __________________________

Group/Department: _____________________________________________

  ___Clinical ___Non-clinical

Role in Department/Unit: _________________________________________

Length of Time in Department: _________________________________

Years of Service: ______________________________________________

When did you take the StrengthsFinder Profile? __________________________

Did you do any additional training on Strengths after your profile was done? If so, briefly explain: ____________________________________________________________

_______________________________________________________________________

Please return this form to the facilitator. All information will be kept confidential.
Thank you for your participation!
APPENDIX E

FOCUS GROUP QUESTIONS

1. Reviewed by Formative Committee
2. Used at the Pilot Study
3. Used With First Focus Group of Non-Clinical Staff
4. Used With Non-clinical Managers, Clinical Staff, Clinical Managers, and Executives
FOCUS GROUP QUESTIONS: REVIEWED BY FORMATIVE COMMITTEE
PRIOR TO PILOT STUDY

Questions 1 – 5 will be asked individually to each focus group. Questions 6 – 8 will be asked of all groups with the same verbiage.

1. Employee: In the past three months, did your manager spend time talking with you or coaching you about applying your strengths at work? If yes, please describe the situation.

Manager: In the past three months have you talked with or coached anyone you supervise on how best to apply their strengths at work? Please give an example.

Executive: In the past three months have you discussed with or coached managers who report to you how they can apply their strengths at work? Please give an example.

2. Employee: In the past three months did your manager either personally or publicly acknowledge when you’ve demonstrated strength at work? (For example, saying something like, “Sam, I really appreciate your help, this seems to be an area you really enjoy.”)

Manager: In the past three months have you personally or publicly acknowledged when an employee who reports to you demonstrated strength at work? Please give an example.

Executive: In the past three months have you acknowledged personally or publicly when managers who report to you applied their strengths on the job? Please give an example.

3. Employee: What do you see as your manager’s natural talents or strengths? What percentage of time in the past three months do you estimate that your manager used his/her strengths on the job? (This is just an estimate. Perhaps each of you could suggest a percentage based on 25% increments and we can get a group average from that.)

Manager: Do you agree with your strengths as identified by the StrengthsFinder profile? What percentage of time in the past three months do you estimate that you used your strengths on the job? (This is just an estimate. Perhaps each of you could suggest a percentage based on 25% increments and we can get a group average from that.)
Executive: Do you know what the strengths of those managers who report to you are? What percentage of time in the past three months would you estimate that managers who report to you used their strengths on the job? *(This is just an estimate. Perhaps each of you could suggest a percentage based on 25% increments and we can get a group average from that.)*

4. Employee: Where are your manager’s strengths evident at work? *(Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).*

Manager: Where are your strengths evident to others at work? *(Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).*

Executive: Where are the strengths of the managers who report to you evident at work? *(Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).*

6. What conditions or factors within the HRMC work environment do you feel support managers in using their strengths on the job? *Please give examples of where these occur.*

7. What conditions or factors within the HRMC work environment do you feel hinder managers in using their strengths on the job? *Please give examples of where these occur.*

8. What role do you think hospital leaders (that is, executives) currently play in supporting or hindering manager’s use of strengths on the job? How can they help support broader use of managers’ strengths at HRMC?

*Thank you for your participation!*
Focus Group Questions

Questions 1 – 5 are specific to the worker type attending a given session.

- If it is a group comprised of either clinical or non-clinical staff, ask the questions designated for an Employee.
- If it is a group comprised of clinical or non-clinical managers, ask the questions designated for a Manager.
- If it a group comprised of Executives, ask the questions designated for an Executive.

Questions 6-8 are generic for all groups.

Facilitator Note: Do your best to elicit a direct response from everyone in the group for each of these questions.

1. What would you consider your own strengths? How much time do you use them on the job? Do you use them more since you took the StrengthsFinder Profile?

2. **Employee:** Has your manager either personally or publicly acknowledged when you’ve demonstrated strength at work (e.g., saying something like, Sam, I really appreciate your help; gathering input is something you really seem enjoy). *If yes, please give an example.*

   **Manager:** Have you personally or publicly acknowledged when an employee who reports to you demonstrated strength at work (e.g., saying something like, Sam, I really appreciate your help; gathering input is something you really seem to enjoy). *If yes, please give an example.*

   **Executive:** Have you personally or publicly acknowledged when a manager who reports to you has demonstrated strength at work (e.g., saying something like, Sam, I really appreciate your help; gathering input is something you really seem to enjoy). *If yes, please give an example.*

3. **Employee:** Has your manager spent time talking with you or coaching you about applying your strengths at work since you took the StrengthsFinder Profile? *If yes, how often would you say this has this happened? (E.g., Once a year during a PDP review). Please describe an example of what occurred and when.*

   **Manager:** Have you talked with or coached anyone you supervise on how best to apply their strengths at work since you took the StrengthsFinder Profile? *If yes, how often would you say this has happened (e.g., two times with all 5 of my direct reports in the last year). Please give an example of when/how this occurred.*
Executive: Have you discussed with or coached managers who report to you on how they can apply their strengths at work since you took the StrengthsFinder Profile? If yes, how often would you say this has happened (e.g., two times with all 5 of my direct reports in the last year). Please give an example of when/how this occurred.

4. Employee: Where are your manager’s strengths evident at work? (Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).

Manager: Where are your strengths evident at work? (Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).

Executive: Where are the strengths of the managers who report to you evident at work? (Examples include but are not limited to 1:1 sessions, in team meetings, in written, email or voicemail communications in work with patients or customers).

5. Employee: What are your manager’s strengths and talents? What percentage of time do you estimate that your manager uses his/her strengths on the job? (Note to facilitator: Remind participants here that when we talk about strengths in this study we are not simply talking about a label generated in the StrengthsFinder Profile. Rather, it is the broader concept that we’re interested in. We are referring to those natural talents or qualities that make individuals perform their best. You would recognize them as those things that people do consistently, and which also make them feel great about doing them. These are activities that may appear simple for them, but areas they have an interest to continue to learn and grow, come up with new ideas, and have the best insights. These are the things that keep individuals interested and focused with almost no effort.

Manager: Do you agree with your strengths as identified in your StrengthsFinder Profile? What percentage of time do you estimate that you use your strengths on the job? (Note to facilitator: This question for managers has two parts that we’re exploring: 1) does the manager know/recall their strengths as identified in the SFP, and 2) what per cent of time do they use their strengths—strengths here in the broader conceptual sense as described above).

Executive: Do you know what the strengths are of those managers who report to you as identified in their StrengthsFinder Profile? What percentage of time would you estimate that managers who report to you use their strengths on the job? (Note to facilitator: This question for executives has two parts that we’re exploring: 1) do they know the strengths of those whom report to them as identified in the SFP, and 2) what per cent of time do they think their direct reports use their strengths—strengths in this case being the broader conceptual sense as described above).
6. What conditions or factors within the HRMC work environment do you feel support managers in using their strengths on the job?  
   *Please give examples of where these occur.*

7. What conditions or factors within the HRMC work environment do you feel hinder managers in using their strengths on the job?  
   *Please give examples of where these occur.*

8. What role do you think hospital leaders (that is, executives) currently play in supporting or acting as a barrier to manager’s use of strengths on the job? How can they help support broader use of managers’ strengths at HRMC?

   *Thank you for your participation!*
FOCUS GROUP QUESTIONS: USED WITH FIRST FOCUS GROUP OF NON-CLINICAL STAFF

Focus group question 1 or something similar can be used to open the conversation with the staff.

Focus group question 2 addresses the first research question: To what degree have managers who have taken the StrengthsFinder Profile been utilizing their strengths at HRMC? (“Degree” here is defined as, percentage of time on the job.)

(Note to facilitator: Remind participants here that when we talk about strengths in this study we are not simply talking about a label generated in the StrengthsFinder Profile; refer to the description of strengths provided earlier in the Facilitator Guide)

1. What do you consider your own strengths? What do you estimate to be the percentage of time you’ve used them on the job since you took the StrengthsFinder Profile? (This is just an estimate. Perhaps each of you could suggest a percentage and we can get an average from that).

2. What are your manager’s strengths and talents? What would you estimate to be the percentage of time your manager uses his or her strengths on the job. (This is just an estimate. Perhaps each of you could suggest a percentage and we can get an average from that).

Focus group questions 3-7 address the second research question two: What conditions and factors within HRMC promote or hinder managers’ use of their strengths on the job?

3. How important is it to you that managers use their strengths at work?

4. If you had any additional strengths-based training beyond taking the StrengthsFinder Profile, did your manager attend as well? How has that training influenced your understanding and use of strengths at work?

5. Where do you see your manager’s use of strengths at work? Please give an example where that is evident (e.g., during interactions with patients, in coaching staff, in recognizing employees for a job well done).
6. Let’s discuss some conditions or factors within the HRMC work environment which you feel may support or hinder managers’ use of strengths on the job.

a. Do you feel that managers have the knowledge and skills to take what they learned from the StrengthsFinder Profile and apply their strengths in the work setting?

b. Do you think there are adequate rewards or incentives for managers to use strengths on the job?

c. Do you think that managers’ participation in the use of strengths is expected and encouraged and if so, by whom?

d. Do you think that managers have the time and resources to promote the use of strengths with staff?

e. Is HRMC’s leadership providing support to managers to build from what they learned in their StrengthsFinder Profile and make greater use of strengths on the job?

7. What do you think has to happen to get to higher levels of use of strengths in the organization? (E.g., Do we need to saturate the organization with strengths finder?)

8. Do you see people at the top promoting a strengths-based culture? What can they do to support broader use of managers’ strengths?
ICE-BREAKER QUESTION

Before we start talking about managers, let’s talk for a few minutes about you. All of you here have taken the StrengthsFinder Profile.

*Remind people that strengths are defined here as something that you might have recognized at an early age that you had an innate talent for and that when you used that innate talent, did things that came easily and naturally to you, and perhaps built upon it by gaining additional knowledge and skills—you felt good, typically had good results, and wished you could do more of. Remember that we are talking about your passion in life and how it is lived out in your work life.*

That said:

Give me an example of one of your strengths.

Did the results of your SFP reflect the example you just gave?

_________________________________

1. Do you know of any natural passions your manager exhibits at work and if so after taking the SFP did it have any noticeable effect upon it/them?

   Did it have any impact on promoting the passion or natural strengths of others within your department?”

   *(Gene’s comment: I am not interested in any change in his/her behavior unless it relates to strengths.)*

2. From what you’ve observed of your manager, describe how your manager’s strengths (the things that seem to come naturally to them, almost as if they don’t have to think about it—it’s just innate and appears to come easily to them) are apparent in their interactions:
   a. With you
   b. With patients
   c. With other colleagues

   *(Give specific examples of how/what/where you see this happening at work).*

3. What do you think currently supports your manager in using his/her strengths—their passion and natural talents—at work?

   a. How or what do you feel could be done to support your manager to accept and use their strengths more—those passions and natural talents they have—on the job?
4. What barriers do you see that may hinder your manager’s use of strengths—their passions, and natural talents—at work? (Note: You can ask more probing questions about knowledge and skills, incentives and rewards, time and resources if needed here).

5. What specific things do you think HRMC’s Administration could do to support your managers’ use of their strengths—their passions and natural talents—at work?

6. What are some barriers that HRMC’s Administration might be able to remove to allow for your manager to make greater use of his/her strengths—their passions and natural talents—at work?

Final Questions (Hand these out on the separate sheet of paper provided in the Facilitator Guide with these questions. Collect them (unsigned) before the end of the group)

A. How often do you use your strengths—that is, your passions and natural talents and skills—at work? This is your natural talents or passion since early childhood, not just doing a good job. Circle one.

   (a) Some of the time, (b) most of the time (c) all of the time (d) not at all.

B. If you were going to define the percentage of time you feel you use your strengths—that is their passions and natural talents and skills—at work, what would it be?
QUESTIONS FOR MANAGERS

1. Give me an example of one of your strengths.

   *Remind participants that “Strengths as defined here are something that a person may have recognized at an early age that you had an innate talent for and that when you used that innate talent things seemed to come naturally and easily to you—you felt good, typically had good results, and wished you could do more of it. We are looking at how these natural talents are used in your job. You may use them a lot or possibly not at all, but we want to know about them and how we could create more opportunities for you to use them. Another word that we mean by strengths is your passion in life and how it is lived out in your job.*

   Did the StrengthsFinder Profile reflect the example you just gave?

2. How are you using your passion, your natural talents on the job?

   *(Gene’s note: We are not talking about what’s in the manager’s job description, but rather those things that appear to come easily and naturally to them, that they don’t have to think about, and which they seem to enjoy).*

3. If you could use more of your strengths—those innate talents and things that come naturally to you—what would that look like in your work day? Give an example of what would look like:

   a. in your interactions with your staff—did you share these with your staff? If not, what got in the way?
   b. in your work with clients or patients
   c. in your interactions with other colleagues

4. Think outside your current job description and tell me: “If you had the ability to create your own job description around your natural talents, what would it look like; and, how could your current job be changed to reflect more of this?”

5. How would using your passion—those natural innate talents, those strengths—on the job affect your job satisfaction, your sense of happiness and well being in your work?

6. How important is it to you that your supervisor supports you and encourages your use of strengths—those passions, natural talents and skills—at work?

   a. What are they doing now that supports you?
   b. What more would you like them to do?
   c. What else can they do?

7. How/What could be done to support you in accepting and using your strengths—those passions and natural talents you have—on the job? What are the barriers to your
use of strengths on the job? (Note: You can ask more probing questions about knowledge and skills, incentives and rewards, time and resources if needed here).

8. How/What specific things can HRMC Administration do to support your use of strengths—your passions and natural talents—at work? What are the barriers that HRMC can remove so that you can use more of your strengths at work?

_________________________________________________________________________

Final Questions (Hand these out on the separate sheet of paper provided in the Facilitator Guide with these questions. Collect them (unsigned) before the end of the group

A. How often do you use your strengths—that is, your passions and natural talents and skills—at work? This is your natural talents or passion you had since early childhood, not just doing a good job. Circle one.

   (a) Some of the time, (b) most of the time (c) all of the time (d) not at all.

B. If you were going to define the percentage of time you use your strengths at work what would it be?

_________________________________________________________________________
QUESTIONS FOR EXECUTIVES

ICE-BREAKER QUESTION

Before we start talking about managers, let’s talk for a few minutes about you. All of you here have taken the StrengthsFinder Profile. *The people who created that tool say that strengths are something that you might have recognized at an early age that you had an innate talent for and that when you used that innate talent, did things that came easily and naturally to you, and perhaps built upon it by gaining additional knowledge and skills—you felt good, typically had good results, and wished you could do more of.*

That said:

Give me an example of one of your strengths/passions.

Did the results of your SFP reflect the example you just gave?

______________________________

In working with HRMC managers—particularly those who directly report to you—you likely have observed or have a feel for what they’re passionate about, and what seems to come naturally to them at work.

1. Give an example of where/when you’ve seen a manager’s (who reports to you) passion, this natural talent—come to life in their work.
   a. What changes did you notice with them or in their department after they took the SFP? Did this increase their passion, decrease it, or have no effect on it?

   *Gene’s comment: I am not interested in any change in his/her behavior unless it relates to strengths.*

2. How are managers’ strengths—the passion and natural talents they have—obvious in their interactions with others?
   a. With you?
   b. With patients?
   c. With staff whom they supervise
   d. With other colleagues?

   *Give specific examples of what you see happening at work.*

   *Gene’s note: We are not talking about what’s in the manager’s job description—but rather, those things that appear to come easily and naturally to them, that they don’t have to think about, and which they seem to enjoy.*
3. What do you think currently supports managers in using their strengths—their passion and natural talents—at work? Give an example.
   a. What have you done to support a manager (who reports to you) in using their strengths at work? Give an example and explain the effect.

4. What barriers do you see that may hinder managers’ use of strengths—their passions, and natural talents—at work? *(Note: You can ask more probing questions about knowledge and skills, incentives and rewards, time and resources if needed here).* Explain the results.
   a. Give an example where you removed a barrier that you felt was hindering a manager’s (who reports to you) use of their strengths—their passion and natural talents—at work.

5. What do you think would have to happen for managers to think outside their current job description and use more of their natural talents—their strengths—at work?
   a. How or what do you feel could be done to support your manager to accept and use their strengths more—those passions and natural talents they have—on the job?

6. What specific things do you as an HRMC leader; think HRMC’s Administration could do to support managers’ use of their strengths—their passions and natural talents—at work?
   a. What could you do to help make this happen?
   b. How would the larger organization be affected?

7. What are some barriers that you and other HRMC leaders might be able to remove to allow for managers to make greater use of their strengths—their passions and natural talents—at work?

Final Questions (Hand these out on the separate sheet of paper provided in the Facilitator Guide with these questions. Collect them (unsigned) before the end of the group.

A. How often do you use your strengths—that is, your passions and natural talents and skills—at work? Circle one.

   (a) Some of the time, (b) most of the time (c) all of the time (d) not at all.

B. If you were going to define the percentage of time you feel you use strengths—that is your passions and natural talents and skills—at work, what would it be?
APPENDIX F

CONFIDENTIALITY AGREEMENT
PROJECT ASSISTANT
CONFIDENTIALITY AGREEMENT
Project Assistant

Identifying Factors that Enhance or Hinder the Utilization of Strengths by Healthcare Managers

_____I have been told that Gene C. Milton will be conducting research with members of the staff of Hackettstown Regional Medical Center, Hackettstown, New Jersey who have taken the Gallup StrengthsFinder Profile for the purpose of completing his doctoral degree in Leadership and Administration from the School of Education at Andrews University.

_____I have been told that the purpose of the research is to identify common elements or situations that if improved and/or expanded would provide opportunities for individuals to use their natural talents or strengths more on the job.

_____I have been told that the study will benefit Hackettstown Regional Medical Center in identifying ways to increase the use of natural talents and strengths for employees to be more fully utilized to produce a higher engaged work force and a more efficient and productive workforce.

_____I agree to serve as a Project Assistant on this study to take notes during the Focus Group sessions, and to transcribe the audio files collected during those sessions. Part of my task will be to remove all identifying information (specifically names and department references) from the notes and the session transcripts.

_____I agree to keep the Project Assistant work for this study, and all else pertaining to this research study, both verbal and written material, confidential and not share it within HRMC or elsewhere outside of the context of this dissertation study.

_____I have read the contents of this agreement and received from Gene Milton verbal explanations to any questions I had. My questions concerning this study have been answered to my satisfaction. I am aware that if I have any additional question or concerns that I may contact Gene Milton in writing at his home address of 40 Mallard Drive, Hackettstown, New Jersey 07840; by email at gmilton@hrmcnj.org; or by phone at (908) 850-0864 (home), (908) 850-6802 (work) or (908) 510-3486 (cell).

_____I have been given a copy of this agreement.

___________________________________________  __________________
Signature                                    Date

___________________________________________  __________________
Witness                                      Date

I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study.

___________________________________________  ____________  ____________
Signature of Investigator         Telephone         Date
APPENDIX G

CONFIDENTIALITY AGREEMENT
FORMATIVE COMMITTEE
CONFIDENTIALITY AGREEMENT
Formative Committee

Identifying Factors that Enhance or Hinder the Utilization of Strengths by Healthcare Managers

I have been told that Gene C. Milton will be conducting research with members of the staff of Hacketstown Regional Medical Center, Hacketstown, New Jersey who have taken the Gallup StrengthsFinder Profile for the purpose of completing his doctoral degree in Leadership and Administration from the School of Education at Andrews University.

I have been told that the purpose of the research is to identify common elements or situations that if improved and/or expanded would provide opportunities for individuals to use their natural talents or strengths more on the job.

I have been told that the study will benefit Hacketstown Regional Medical Center in identifying ways to increase the use of natural talents and strengths for employees to be more fully utilized to produce a higher engaged work force and a more efficient and productive workforce.

I agree to serve as a member of Gene’s Formative Committee for this study, to review the questions for the focus groups that will be held to collect information from executives, managers, and staff pertinent to this study, and provide recommendations to Gene on whether I think these questions will help him achieve the study’s purpose.

I agree to keep the work of this Formative Committee, the focus group questions and all else pertaining to this research study, both verbal and written material, confidential and not share it within HRMC or elsewhere outside of the context of this dissertation study.

I have read the contents of this agreement and received from Gene Milton verbal explanations to any questions I had. My questions concerning this study have been answered to my satisfaction. I am aware that if I have any additional question or concerns that I may contact Gene Milton in writing at his home address of 40 Mallard Drive, Hacketstown, New Jersey 07840; by email at gmilton@hrmcnj.org; or by phone at (908) 850-0864 (home), (908) 850-6802 (work) or (908) 510-3486 (cell).

I have been given a copy of this agreement.

Signature ___________________________ Date ___________________________

Witness ___________________________ Date ___________________________

I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator ___________________________ Telephone ___________________________ Date ___________________________
APPENDIX H

CONFIDENTIALITY AGREEMENT
FOCUS GROUP FACILITATOR
CONFIDENTIALITY AGREEMENT
Focus Group Facilitator

Identifying Factors that Enhance or Hinder the Utilization of Strengths by Healthcare Managers

_____I have been told that Gene C. Milton will be conducting research with members of the staff of Hacketstown Regional Medical Center, Hacketstown, New Jersey who have taken the Gallup StrengthsFinder Profile for the purpose of completing his doctoral degree in Leadership and Administration from the School of Education at Andrews University.

_____I have been told that the purpose of the research is to identify common elements or situations that if improved and/or expanded would provide opportunities for individuals to use their natural talents or strengths more on the job.

_____I have been told that the study will benefit Hacketstown Regional Medical Center in identifying ways to increase the use of natural talents and strengths for employees to be more fully utilized to produce a higher engaged workforce and a more efficient and productive workforce.

_____I agree to facilitate and audio-tape the focus group sessions, to remind the participants of the ground rules pertaining to confidentiality before each session, and to debrief Gene Milton after the session without reference to participants’ names or departments.

_____I agree to turn over the audio-files gathered during the focus group sessions to the project assistant who will forward them to a professional transcription service hired for purposes of this study.

_____I agree to keep the focus group sessions, verbal and written material, confidential and not share it within HRMC or elsewhere outside of the context of this dissertation study.

_____I have read the contents of this agreement and received from Gene Milton verbal explanations to any questions I had. My questions concerning this study have been answered to my satisfaction. I am aware that if I have any additional question or concerns that I may contact Gene Milton in writing at his home address of 40 Mallard Drive, Hacketstown, New Jersey 07840; by email at gmilton@hrmcnj.org; or by phone at (908) 850-0864 (home), (908) 850-6802 (work) or (908) 510-3486 (cell).

_____I have been given a copy of this agreement.

___________________________________________  __________________________
Signature                                             Date

___________________________________________  __________________________
Witness                                                Date

I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study.

___________________________________________  ____________  ____________
Signature of Investigator                            Telephone                                           Date
APPENDIX I

WORK PLAN FOR FOCUS GROUPS
WORK PLAN FOR FOCUS GROUPS

This is a work plan of the activities that have to occur as part of the data collection process and follow up for this dissertation study.

1. Outline the group facilitator role and selection criteria.

2. Select and conduct a formative committee to discuss research sub-questions.

3. Conduct a pre-session with facilitators in advance of the pilot group session.

4. Conduct the pilot group session.

5. Refine the focus group guide and questions (the questions will link back to the original research questions of this dissertation study).

6. Debrief focus group sessions. Alter focus group questions, if needed, and document the reasons and the changes.

7. Transcribe, and hand off data to principle researcher

8. Analyzes data and findings.


10. Hold progress report meetings with dissertation committee throughout the stages of this work plan. Determine timing of these meetings based on how the dissertation committee wishes to proceed.
APPENDIX J

CODE KEY FOR DATA ANALYSIS
**CODE KEY FOR DATA ANALYSIS**

**CODE KEY AS OF May 2010**
Non-clinical staff (NCS), Non-clinical manager (NCM), Clinical manager (CM), Clinical staff (CS), Executives (EX)

<table>
<thead>
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<td>14</td>
<td>33</td>
<td>8</td>
<td>13</td>
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<td>1</td>
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<td>17</td>
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**Theme 1 Data: Foundation in Place**
Total count of 4 codes for this theme: DSQS, SSQ, KSE, KSNE (see explanation key below): 253
Total count for all codes: 826
Percentage of total for Theme 1 codes: 31%

DSQS: Dis-satisfied with the Status Quo.
This code was used when the researcher felt respondents not only had the knowledge and skills (KS) about strengths, but also some excitement about how strengths-utilization could help them be more engaged and also benefit the entire organization.

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<td>19%</td>
<td>14%</td>
<td>33%</td>
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SSQ: Satisfied with the Status Quo.
This code was used to indicate that people were satisfied with things as they are and don’t see any reason to change; they like things as they are and want to leave well enough alone.

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<td>6%</td>
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KSE: Knowledge and Skills Evident.
This code is about more than just having the knowledge about the value of using the strengths on the job. It was used when people indicated that the SFP confirmed who they were, but nothing further happened.

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<td>25%</td>
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KSNE: Knowledge and Skills Not Evident.
This code indicated that people don’t know much about strengths (in the context of their natural passions and talents) other than what they read on their SFP or learned in their focus group. It indicates that they currently don’t appear to have the knowledge, skills, training that would help them in figuring out how to apply their strengths.

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**Theme 2 Data: Leadership Role in Strengths-use**
Total count of 3 codes for this theme: Commit, LE, LEN (see explanation key below) = 164
Total count for all codes: 826
Percentage of total for Theme 2 codes: 20%

Commit: Commitment.
This code indicated visible support by the leadership as perceived by the users. Simple verbal endorsement of using strengths by leaders did not constitute

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<td>commitment.</td>
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| LE: Leadership Exists. This code indicated when leadership (i.e., managers, executives) was evident in supporting use of strengths at HRMC. | 12  | 6   | 23 | 8  | 5  | 54    |
|                                                                                      | 22% | 12% | 43%| 15%| 9% |       |

| LEN: Leadership Does Not Exist. This code indicated when leadership (i.e., managers, executives) was not seen as not supporting use of strengths on the job. | 29  | 8   | 9  | 20 | 18 | 84    |
|                                                                                      | 35% | 10% | 11%| 24%| 21%|       |

**Theme 3 Data: Environment, Culture and Organization**

Total count of 6 codes for this theme: RNA, TNA, WRD, CPOS, CNPOS, ECO (see explanation key below):=278

Total count for all codes: 826

Percentage of total for Theme 3 codes: 34%

| RNA: Resources Not Available. This code indicated where people felt that resources that are needed to successfully carry out the use of strengths on the job are NOT available or easily accessed. These include people’s perceptions regarding a lack of finances, personnel, and materials to support strengths-use. | 1   | 2   | 9  | 5  | 11 | 28    |
|                                                                                      | 4%  | 7%  | 32%| 18%| 39%|       |

| TNA: Time Not Available. This code was used when people indicated a lack of time or apparent willingness at HRMC to provide paid time to learn more about the SFP and how to use their strengths on the job. Participants could also have indicated a lack of time or willingness on their part to devote to learning about and using their strengths. | 2   | 5   | 4  | 4  | 6  | 21    |
|                                                                                      | 10% | 24% | 19%| 19%| 29%|       |

| WRD: Work Related Demands. This code indicated demands that may hinder use of strengths on the job like: Multiple Initiatives/Competing Priorities/ Short vs. Long Term Planning | 3   | 8   | 9  | 26 | 4  | 50    |
|                                                                                      | 6%  | 16% | 18%| 52%| 8% |       |

| CPOS: Communication is Positive. This code indicated where communication among staff and managers, and/or managers and execs is positive and supports the talking about and use of strengths. | 2   | 2   | 4  | 17 | 0  | 25    |
|                                                                                      | 8%  | 8%  | 16%| 68%| 0% |       |
**CODE KEY AS OF May 2010**
Non-clinical staff (NCS), Non-clinical manager (NCM), Clinical manager (CM), Clinical staff (CS), Executives (EX)

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<th>CNPOS: Communication is Not Positive.</th>
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<th>CS</th>
<th>EX</th>
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<tbody>
<tr>
<td>This code indicated when communication between staff and managers, and/or managers and executives did not appear to be positive or sufficient, and therefore hindered strengths-use.</td>
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<th>ECO: Environment, Culture, Organizational Structure.</th>
<th>NCS</th>
<th>NCM</th>
<th>CM</th>
<th>CS</th>
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<td>This code was used to note participant perceptions regarding work environment, culture and organizational support.</td>
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REFERENCE LIST
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GENE C. MILTON, FACHE

EDUCATION

Doctor of Philosophy in Leadership, Andrews University, Berrien Springs, MI 49104

Master of Business Administration, Andrews University, Berrien Springs, MI 49104

Business Administration Degree, Atlantic Union College, South Lancaster, MA

EXPERIENCE

1981-Present  Adventist Healthcare, 1801 Research Boulevard, Rockville, MD 20850

1995  Regional Vice President, Adventist Healthcare, 1801 Research Boulevard, Rockville, MD 20850

1985-Present  President and Chief Executive Officer, Hackettstown Regional Medical Center, Hackettstown, NJ 07840

1984  Senior Vice President and Chief Financial Officer, Hackettstown Regional Medical Center, Hackettstown, NJ 07840

1982  Secretary and Treasurer, Hackettstown Regional Medical Center, Hackettstown, NJ 07840

1981  Vice President, Washington Adventist Hospital, Takoma Park, MD 20912

1976-1981  Florida Hospital, Orlando, FL 32803

1978  Budget Director, Florida Hospital, Orlando, FL 32803

1976  Internal Auditor, Florida Hospital, Orlando, FL 32803

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American College of Healthcare Executive
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